

## Bipolar Affective Disorder in a Patient of Achalasia Cardia: A Case Report of Young Man

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### ABSTRACT

We present a case of 22-year-old known Achalasia cardia, previously treated for depression, presented with irritable behaviour, aggression, over-talkativeness, ideas of self-importance, running away from home and decreased sleep. He was treated for imperforate anus with anoplasty on the first day of birth and for Achalasia Cardia with Heller myotomy at 17 years of age. His Young Mania Rating Scale score was 22, and his Brief Psychiatric Rating Scale score was 50. He was diagnosed as a case of bipolar affective disorder. Marked improvement in the symptoms occurred after two weeks of the treatment with sodium valproate, olanzapine and clonazepam.

**Keywords:** Achalasia cardia, Bipolar affective disorder, Liaison psychiatry.

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### INTRODUCTION

Achalasia cardia is a primary oesophageal motility disorder characterized by the absence of oesophageal peristalsis and impaired relaxation of the lower oesophageal sphincter (LES), leading to the functional obstruction at the gastroesophageal junction.<sup>1</sup> Mental health disorders have been studied among patients with oesophageal diseases for a long, and they remain an area of interest for researchers. Mental health professionals due to ambiguity in their cause or effect relationship.<sup>2</sup> Though oropharyngeal dysphagia can be a common finding among the patients of bipolar affective disorder (BPAD),<sup>3</sup> comorbidity of BPAD and Achalasia cardia is rarely reported. Rather patients of Achalasia cardia are often misdiagnosed as cases of primary eating disorders, which delay the proper management of the primary physical disorder resulting in prolonged misery for the patient.<sup>4,5</sup>

We present a case of BPAD in a young male suffering from Achalasia cardia who has been previously treated for depression and this time presented with a manic episode which has been treated effectively with the routine medication.

### CASE REPORT

The parents brought an unmarried 22 years old male resident of Azad Jammu Kashmir, Pakistan with complaints of irritable behaviour, aggression, over-talkativeness, ideas of self-importance, running away from home and decreased sleep for the past two

weeks. He used to get angry during minor arguments and used to break anything which came into his reach. He used to think he was blessed with extraordinary qualities, so everyone should listen to him. He did not explain those extraordinary qualities but used to talk without stopping for hours. He slept only for an hour, mentioning sleep as a waste of time. His occupational performance has also declined markedly for the past two weeks as he was not opening his mobile shop and was busy giving long sermons to his friends, family and neighbours. His relationship with his siblings and friends became strained due to his tendency to become irritable over minor issues. The patient's family did not report any unusual behaviours or difficulties in daily functioning prior to the onset of the current episode of illness. There was no history of any head injury or illicit drug use.

He was diagnosed with Achalasia cardia at the age of three when his parents took him to the tertiary care hospital in Muzaffarabad with complaints of difficulty swallowing and persistent vomiting. He had a history of vomiting breast milk and difficulty taking semi-solid food at six months, but the parents ignored it and related it to his disliking of the food. He gradually developed dysphagia with solid foods and then liquids. His first surgery was done in 2005, and the symptoms improved. However, he became symptomatic again in 2012 and was referred to Islamabad for balloon dilatation. After a detailed assessment, he underwent Heller's myotomy at the Pakistan Institute of Medical Sciences. In 2013, his family members noticed a marked change in his mood and daily activities. They took him to a psychiatrist, and he was

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diagnosed as a case of a depressive episode. He has treated with fluoxetine 20mg at that time which he took for three months and then left on his own. He remained fine after that till the onset of this episode.

He was treated for imperforate anus with anoplasty on the first day of birth. He started education at the age of five but left his education after the sixth standard due to his poor health. He underwent the first surgery in 2005 and the second in 2012 to treat Achalasia cardia. He was diagnosed with a moderate depressive episode by a consultant psychiatrist in 2013 and was put on fluoxetine 20mg at that time which he took for three months and then left on his own. There was no significant history of any other psychosocial stressors or childhood abuse. There was no positive family history of any psychiatric disorder. His elder sister also suffered from Achalasia cardia and underwent surgical treatment.

He was a young man properly dressed in bright colours sitting anxiously on the sofa. His vital signs and physical examination were unremarkable. He was irritable during the interview and constantly insisted on just listening to him without interruption. He believed he was blessed with extraordinary qualities, so everyone should listen to him. He did not explain those extraordinary qualities but used to talk without stopping for hours. He said that he hears the voice of a religious scholar that often stops him from doing wrong deeds. His long-term and short-term memory were intact, and there was no insight as he said he was completely fine and his parents were having baseless worries about her health and behaviour.

Differential diagnosis included manic episodes with or without psychotic features, bipolar affective disorder, organic psychosis, schizophrenia and Acute Transient Psychotic Disorder (ATPD). Schizophrenia was ruled out as he was completely well without medication between the two episodes of illness.

Investigations were performed according to the bio-psycho-social model. All the baseline biological investigations (Blood CP, LFTs, RFTs, BSR and TSH) were normal. Serum prolactin was within the reference range. The CT-scan brain was also unremarkable. In the light of these findings, no organic cause could be related to his current mental state. Consultation from a gastroenterologist and thoracic surgeon was carried out to look for any change in the status of underlying Achalasia cardia, but that was not significant.

Psychological investigations included the administration of psychometrics. He completed the self-

administered questionnaires with the help of his parents. His YMRS score was 21, and his BPRS score was 53. Beck Depressive Inventory (BDI) scores were within the normal range. BDI score documented by a psychiatrist four years ago during the episode of depression was 22. Social investigations included an interview with the parents and feedback from the siblings.

After the detailed history, mental state examination and the results of psychometrics, he was put on sodium valproate 500mg, olanzapine 10mg and clonazepam 0.5mg daily. He and his parents were briefed in detail about the risks and benefits of all the treatment options available, and they agreed to put her on combination treatment. After two weeks, he showed marked improvement in the symptoms. His over-talkativeness decreased, sleep improved, and flight of ideas and pressure of thoughts settled to the extent that his social and occupational performance started improving. After one month of treatment, his YMRS score was nine, and his BPRS score was 30.

The final diagnosis was BPAD with a current episode of mania with psychotic features. After the appropriate treatment, there was a dramatic improvement in his condition. On follow-up, after 2 to 4 weeks, clonazepam was gradually tapered, and sodium valproate and olanzapine were continued in a similar dose. A detailed briefing was given on their harmful side effects, especially Sodium Valproate, which can cause nausea and other gastric symptoms. A plan was formulated to taper Sodium Valproate once complete remission has been achieved and continues the treatment with a mood stabilizing antipsychotic.

### DISCUSSION

Patients of Achalasia cardia usually require surgery as well as medical treatment. They also have to undergo some lifestyle modifications. This may predispose the patient to various mental health problems. The first episode of our patient was treated on similar grounds as unipolar depression associated with a medical illness. However, this episode involving the symptoms of irritable behaviour, aggression, over-talkativeness, ideas of self-importance, running away from home and decreased sleep changed the diagnosis altogether. This was a clear episode of mania, so the previous episode was also regarded as a depressive episode in the context of bipolar affective disorder.

Psychiatric disorders are prevalent among patients who are suffering from physical disorders. Depression, anxiety, conversion and substance use disorders are common among patients with various

physical illnesses.<sup>2</sup> This patient had an episode of depression three years ago which the psychiatrist treated with the SSRIs. He presented with the symptoms mentioned in the previous section, successfully managed by the mood stabilizer and the antipsychotic drugs. As mentioned earlier, good clinical response and considerable reduction in the scores of YMRS and BPRS after the treatment further supported the diagnosis of BPAD.

Previously eating disorders have been proven to mimic physical disorders, especially Achalasia cardia.<sup>4,5</sup> Therefore, diagnosing a psychiatric disorder in a patient who is already suffering from a chronic physical disorder is a real challenge, and success lies in correctly ruling out all the organic and physical causes before making a definitive psychiatric diagnosis.

The diagnosis of BPAD rests on the clinical criteria set by the ICD-10, and the severity of the manic or depressive episode can be assessed with the help of psychometric tools. Both these aspects were catered for in this case. Ruling out all the physical and organic conditions was key in this case as he was already

suffering from a chronic physical disorder. A detailed investigation by the bio-psycho-social model and psychometrics were key to making this task achievable and can be applied in such a group of patients in future too to make an accurate diagnosis.

**Conflict of Interest:** None.

**Auhtor's Contribution**

MSS: Direct contribution, UBZ:, KE:, HM: Intellectual contribution.

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