Manic episode

It is a **mental illness** classified as an affective disorder (F30). It may occur alone or alternate with depressive episode as part of bipolar affective disorder.

Symptoms

A **manic episode** is manifested by an exaggeratedly elevated, irritable or expansive mood. If this state lasts **4 days**, we speak of **hypomania**. A state lasting **more than a week** is called **mania**. For a correct diagnosis, the patient must also exhibit at least 3 of these symptoms:

- increased activity
- restlessness
- talkativeness
- incoordination
- distractibility
- thought jet
- decreased need for sleep
- increased sexual activity
- irresponsibility (manifested, for example, by the need to spend)
- inappropriate or risky behaviour
- increased sociability to excessive familiarity

It is the loss of social inhibitions that is hardly tolerated by society and is often the reason for admission to treatment. Within psychotic mania, manic episodes may be accompanied by delusions and hallucinationss of an expansive and grandiose nature. Delusions with religious motives occur in 50% of patients, and paranoid persecutory delusions (feeling of persecution, exaggerated relationality) are reported by 28% of patients. The hallucinations may not be present in the first episode but only in subsequent episodes, and they are also religious and ecstatic.

Cognitive functions are *accelerated*. The patient speaks more rapidly, often unintelligibly despite a burst of thoughts, and reaction time and the ability to recall associations are faster. Behaviour is *highly impulsive*, unyielding, and may show signs of aggression. *public outrage* is also common (shouting loudly, tearing clothes, running naked...).

Prevalence

Lifetime prevalence is estimated at **1% of those affected**. Initial symptoms may present as shorter hypomanic episodes, increasing in frequency, intensity and duration as time progresses and developing into a manic disorder. The tendency to develop is stronger in persons with *psychosocial stress*.

Etiopathogenesis

In manic disorder, there is utilization of serotonin, confirming the therapeutic effect of serotonin precursors. Lithium is also used for treatment, which also shows some effect on serotonin. During the episode, adrenalineu and noradrenalineu levels are increased. Monoamine hypothesis' demonstrates the induction of mania following the administration of levodopa (a dopamine precursor), amphetamine and pyrebedil (a dopamine agonist). Another possible cause may be second messenger disorder, resulting in disrupted neurotransmitters interactions.

Treatment

Treatment involves the use of **mood stabilizers**, especially thymoprophylactics, which have acute **antimanic as well as antidepressant effects**. Lithium, carbamazepine or valproate are also used as preventive measures. Generation III anticonvulsants, which have a broad spectrum of action and do not require blood level monitoring, are also now widely used. In the context of severe manifestations, a combination of antipsychotic and benzodiazepine is used.

Links

Related articles

- Schizophrenia
- Depression
- Personality disorders

Literature

- RABOCH, Jiří – ZVOLSKÝ, Petr, et al. *Psychiatrie.* 1. edition. Praha : Galén, 2001. 622 pp. ISBN 80-7262-140-8.