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Case Report On Bipolar Affective Disorder

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ABSTRACT:

INTRODUCTION: Bipolar disease (formerly known as manic despair) is a mood disease that causes drastic modifications in mood from excessive manic levels to depressive low stages. The manic segment is characterized by emotions of elated temper and exaggerated self-significance, talkativeness, little need for sleep, increased sociability, racing thoughts, unstable or irrelevant conduct, and extended sexual urge for food. this period of mania is regularly followed by way of a length of despair, with the symptoms mentioned previously (lack of interest or delight in formerly exciting sports; most important adjustments in appetite; sleep troubles; fatigue, a feeling of worthlessness or hopelessness; issues with concentration and making choices; and the Bipolar disorder (BD) is a life-threatening illness with a 12-fold increased risk of suicide when compared to healthy persons and substantial somatic and mental associated morbidity costs.

Patients History :- A 24 year old female k/c/o mania with mood disordered and come to the AVBRH Sawangi (M) Wardha on dated 12/04/2021 with chief complaint of excessive taking, hyperactivity, aggressiveness. Patient having no any other complaint like breathlessness. The following observations were made while taking the history: She was an introvert in her upbringing, isolating herself and having strained relationships with her family members. She was afraid of losing friends and teachers, as well as receiving lower grades. She failed her 11th board examination due to disobedience pharmaceuticals

Medical Management: Patient treated with group therapy antipsychotic drugs, antibiotics, anti inflammatory drugs, diuretics.

Nursing Management: Administered fluid replacement i.e. , monitor vital sign hourly .

Conclusion: Patient was admitted to the A.V.B.R. Hospital in Sawangi Meghe Wardha in psychiatric ward with the chief complete of excessive taking, hyperactivity, and aggressive behavior, all of which are reduced due to some medication and injections. On admission, the patient's diagnosis was Mania, and all basic investigations, including as blood tests and X-rays, revealed that the patient's condition was stable.

Keywords: BPAD, Delusion, Ecstasy, Elation, Hallucination, Mania, And Psychosis.

INTRODUCTION:

Mania takes place for a length of 1 week or more where the affected character might also revel in a exchange in ordinary behavior that extensively impacts their everyday functioning.[1]

Temper ailment (unipolar and bipolar disorder) are presently 4th main contributor to the global burden in 2000. temper disorder can also represent the Bipolar sickness with depressive sickness at one pole. the opposite pole known as as mania is characterized via euphoric temper, irritability, hostility , disphoria, reactivity, agitation, aggressiveness, destructiveness, extended psychomotor hobby, sexual indiscretion and reduced want for sleep lasting for a minimal period of one week. the standard length of manic episode is around quarto 6month. Persistent mania with the aid of definition method presence of manic signs in excess of two years without remission.[2] More than one sclerosis (MS) is an inflammatory autoimmune disorder that focally damages the white rely inside the mind and spinal wire.[3] It affects 1 in 1000 human beings and is the most common central frightened gadget disorder for teens within the Western global.[4]
firstofall,neurological signs are temporary becauseof demyelization, however repeated demyelization steadily endsin diffuseand continual neurodegeneration. Furthermore, preceding studies have shown improved psychiatric signs and better occurrence of psychiatric and mood issues.[5]

Bipolar illness (BD) is a mood disorder characterized through intense mood fluctuations with episodes of mania or hypomania and melancholy. Mania, a trademark of BD, is even as the affected person is in a kingdom of expanded mood and electricity, throughout which the affected individual critiques signs and symptoms collectively with euphoria or irritable temper, racing mind, over hobby, and decreased need for sleep. BD influences more than 1 in 100 human beings worldwide.[6]

The prevalence of BD in MS sufferers has been stated to be two times than that of the general populace.[7] For sufferers identified with BD and MS, there is no clean method to distinguish whether mania end up brought on from BD or from a MS flare-up. but, it's far critical to figure the reason of manic episode considering that control is precise for BD-brought on mania vs. MS-induced mania. Herein, we describe a affected person recognized with BD that later evolved MS who provided to us for the duration of a manic episode. Through this example, we motive to observe the BD instead of MS origins of manic episodes and speak applicable literature.

Patient's specific information:-

A 24 year old female k /c/o mania with mood disorders come to the AVBRH Sawangi (M) Wardha with complaint of excessive taking hyperactivity aggressiveness.

Primary concern and symptoms of patients:-

A 24year old female was admitted in AVBRH in Psychiatric ward with complete of excessive taking, hyperactivity, aggressive behavior. and also complaint of elevation of mood.

Medical, family and psycho-social History:-

Patient had no any medical history. Patient belongs to nuclear family. There are 4 members are alive including patient. All family members are healthy. All family members are maintained good relationship with Doctor and Nurse.

Clinical Findings:-

General examination
State of health: unhealthy
General condition – not satisfactory
State of consciousness: conscious
Body built: Moderate
Hygiene: poor
General Parameter:
Height: 144cm
Weight: 46 kg
Vital parameter:
Blood pressure: 122/80mhg
Temperature: 98.6° F
Pulse: 100beats/min.
Respiration: 25 breath/ min.
SPO_2: 97%
Systemic Examination
CVS – $S_1 S_{2+}$

Timeline:
Historical and current data from this treatment episode, arranged as a timeline.

Physical and Mental Assessment:-

Physical and mental health Examination status
Vital signs were stable during the physical examination. She had other issues as well, such as insomnia and a loss of appetite. The following findings were discovered during a mental status examination: Increased psychomotor activity, grandiose delusion (she said) She possesses Lord Shiva's superpower, extreme talkativeness, and mood improver.

Diagnostic Differential:-
In the examination of individuals who appear with symptoms similar to mania, there are various differential diagnoses to consider. Patients may show a variety of physiological and psychiatric symptoms. Disorganization One of the most prevalent scenarios that can be mistaken for Caffeine or other stimulant intoxication is referred to as mania. Cocaine, amphetamine (including methamphetamine), PCP, and other hallucinogens as well as nicotine

Investigation:-

Serum creatinine was 0.75 mg/dL, serum urea was 15 mg/dL, serum sodium was 142 mEq/dL, serum potassium was 5.1 mEq/dL, and serum chloride was 101 mEq/dL, according to the results of the blood test. She was subjected to a variety of tests, including psychometrics. The results of the assessment—the Young Mania Rating Scale (YMRS)—had The manic episode was assigned a score of 37 and was identified as such. Based on the International Classification of Diseases and Related Health Problems (ICD 10).

Therapeutic Interventions:-

Medical Management:-

The client underwent treatment consisting of psycho pharmacotherapy, electroconvulsive therapy (ECT), and different psychotherapies. Psychopharmacological remedy may additionally encompass T. chlorpromazine one hundred mg PO 0-zero-2, T. lithium three hundred mg PO 1-0-1, Syp. Divalproex sodium 250 mg/mL PO 10 mL-zero-10 mL, Cap. Pantop D1 cap PO (BF) 1-zero-1, Syp. Sucralfate 10 mL PO 1-1-1, and Cap. bifilac 1 cap PO 1-1-1. She had two ECT classes with no results; she had additionally received numerous different psychotherapies, along with man or woman and family counseling, supportive remedy along with yoga and music therapy, and deep breathing techniques. She became released from the 1/3 ECT session. Her physical and mental fitness stepped forward due to her efforts.

Discussion:

In1986, Schiffer et. al. proposed a link between BD and MS after coming across ten sufferers with each BD and MS out of over seven hundred, persons, when epidemiologic data expected only 5.4 sufferers.8Co-occurrences of BD and MS were said in case research occasionally. Carta et al. currently performed a case observe with 201 MS patients to evaluate the hazard of BD in MS patients and determined an OR of 44.4% for bipolar spectrum issues. specifically, bipolar type 2 diagnoses (7.five%) have been greater commonplace than bipolar kind 1 diagnoses (99%).[9]

The exact mechanism and pathophysiology of BD and MS co-presentation are nonetheless unknown. it is unclear whether BD is a precursor to MS or if the 2 ailments proportion a shared underlying etiology that manifests at similar times. more current research have observed genetic links between BD and MS in the human leukocyte antigen (HLA) DR2 gene and mitochondrial translocation.[10,11]

Know-how the aetiology of this hyperlink can also reveal whether there are synergistic outcomes or crosstalk among MS and BD therapies.
even as mania is a trademark symptom of BD, MS also can present with an expansion of psychiatric signs and signs and symptoms, which include mania, euphoria, depression, hallucinations, and periods of pathologic laughing and sobbing (dubbed "pseudo bulb").[12]
In MS sufferers, focalneuronaldemyelination can interfere with verbal exchange among frontal lobe mind regions that control emotion, resulting in emotional ability and heightened feelings, which might be common signs and symptoms of a manic or depressive episode.[13] The traits of MS flare-up mania are similar to those of Non-MS Mania. Psychosis, on the other hand, has been reported to be a long way much less not unusual among MS sufferers.[14]

Differentiating the starting place of the manic episode is critical from a scientific viewpoint because the remedy method for an MS flare-up and a BD manic episode differs. as an instance, whereas lithium and sodium valproate had been discovered to be effective in treating mania in BD sufferers, no managed trials in their efficacy in mania in MS patients were published.[15] Moreover , manic episodes caused by pharmaceuticals cannot be dominated out. In MS patients, steroid remedy can frequently result in a mild level of mania.[16] Studies on bipolar were reported Bodliya et. al.[18], Goel et. al.[19], and Sinha et. al.[20] were reported. Related studies were reviewed[21-25].

Sufferers with an own family history of alcoholism or another sort of emotional ailment are more vulnerable to this etiology. Various drugs, inclusive of tizanidine, baclofen, and dantrolene, can potentially produce hypomania whilst used.[17]

Conclusion:

Bipolar ailment is a popular psychiatric sickness marked by using affective instability and cognitive impairments, especially for the duration of manic periods. Bipolar ailment's neurophysiology seems to be worried with abnormalities in the ALN and adjacent brain areas. Moreover, studies advocate that bipolar disorder has a great degree of heredity, despite the fact that the role of particular genes has no longer been firmly mounted. For people tormented by bipolar disease, there are a number of a hit pharmacological remedy alternatives. Future research that integrate cognition, neuroimaging, and genetic methodologies may be useful in identifying bipolar sickness prevent characteristics and, in the long run, increasing motive remedy techniques and enhancing the outcomes of persons with bipolar infection. in relation to BD sufferers who have had a mania episode, MS should be taken into consideration within the differential because both conditions can cause manic symptoms. For correct clinical remedy, the onset of mania has to be diagnosed thru an intensive neurological examination, neuroimaging, and comprehensive patient-family psychiatric statistics.

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