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Recognition of Asperger's Syndrome in adolescent patient with Bipolar Disorder: A case report

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ÖZET:

İki uçlu bozukluğu olan bir ergende Asperger Sendromunun fark edilmesi: Olgu sunumu

Asperger sendromu (AS) sosyal etkileşimde zorluklar ve sınırlı ilgi veya etkinliklerle karakterize yaygın gelişimsel bir bozukluktur. Özellikle psikiyatrik ek tanıların görüldüğü ergenlik veya yetişkinlik döneminde tanı genellikle atlanmaktadır. Bu yüzden AS'nin farkında olmak tedavi ve diğer psikiyatrik durumların taranması adına önemlidir. Bu yazıda iki uçlu bozukluk ek tanılı ve ancak on yedi yaşında AS tanısı konulabilen bir ergen olgu sunulacaktır.

Anahtar sözcükler: Asperger sendromu, iki uçlu bozukluk, ergen

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ABSTRACT:

Recognition of Asperger's Syndrome in adolescent patient with bipolar disorder: a case report

Asperger's syndrome (AS) is a pervasive developmental disorder characterized by impairment in social interaction and restricted repetitive behaviors or interests. This disorder is rarely recognized in adolescence or adulthood especially because of unawareness for AS among clinicians and the confounding effects of the comorbid psychiatric conditions. Diagnosing this neurodevelopmental disorder is critical for optimal treatment approaches. Here we present a seventeen-year-old boy with bipolar disorder and late-diagnosed AS.

Key words: Asperger's syndrome, bipolar disorder, adolescence

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INTRODUCTION

Asperger's Syndrome (AS) is characterized by impairments in social interaction and restricted interests and behaviors of the type seen in autism. In contrast to autistic disorder, there is no clinically significant delay in language, cognitive development, self-help skills, or curiosity about the environment (1). The most common comorbid diagnosis in individuals with AS and high-functioning autism is depression, occurring in as many as 41% of patients. Other psychiatric disorders or symptoms that have been reported include anxiety disorders (8%), bipolar disorder (9%), schizophrenia (9%), suicide attempts (7%), hallucinations (6%), mania (5%), psychotic disorder not otherwise specified (3%), schizoid personality disorder (3%), and obsessive-compulsive disorder (OCD) (1%) (2).

There are medications that can help children with mood disorders in the autistic spectrum but many children are never diagnosed properly, nor do they come to the attention of mental health professionals (3). In an epidemiological study, at least 41% of the children with developmental disabilities were found to be affected by comorbid psychiatric disorders, but less than 10% of the children with comorbid psychiatric disorders had seen a specialist (4).

In the view of this information, here an adolescent patient with bipolar disorder and previously undiagnosed AS will be presented.

CASE REPORT

MK, a 17 year-old male was referred to our outpatient unit with problems in social interaction, worries about his future occupation, impulsive behavior, unhappiness, aggressivity and tics. Information regarding his

developmental and psychiatric history was taken from him and his mother. According to his mother he was introverted and always played alone during childhood. At primary school he was interested in geography, memorized sizes of all countries and knew the number of soldiers in their armies. He always had one-sided monologues with his peers about his special interests. He also had clumsiness in motor activities. These problems have been going on since his childhood but his family didn't apply for help to a psychiatry clinic until 13 years old. At this age he was diagnosed with psychotic depression, and subsequently had many depressive episodes with/without psychosis and two hypomanic episodes. He was being treated with olanzapine 5 mg/day and risperidone 2 mg/day for four years. He still had problems at socializing with peers but he is successful especially in math, physics and history. He wants help for social disability from our psychiatry clinic. The family history was positive for schizophrenia and possible Asperger's syndrome that his cousin and his grandfather suffer respectively.

Psychiatric evaluation revealed depressive mood and affect. He was willing to talk, had eye contact. Amount and speed of speech was normal but his volume decreased. He didn't define any hallucination or delusion. He had low concentration. His medical history and workup, including physical and neurological examinations were unremarkable. Electroencephalography and cranial computerized tomography results were normal. His intelligence quotient in Stanford Binet test was 134.

After clinical evaluation, the diagnosis of bipolar disorder was confirmed and he also received additional diagnosis of Asperger's syndrome. We managed his treatment with risperidone 3 mg/day and carbamazepine 400 mg/day for impulsivity, tics and bipolar disorder.

DISCUSSION

We reported an adolescent case with bipolar disorder and a previously undiagnosed Asperger's syndrome. A diagnosis of depressive episode and motor tic disorder were also made on the basis of patient's symptoms.

The differential diagnosis of patients with AS is difficult since it may coexist with such psychiatric conditions like Tourette's disorder, attention deficit hyperactivity disorder (ADHD), anxiety disorders, mood disorders, learning disability, motor clumsiness, antisocial behavior (5,6). In our case other diagnoses considered were schizotypal personality disorder and schizophrenia. A schizotypal personality was excluded because he had no odd behavior and thinking, and often unconventional beliefs and patient's behavioral problem has been continued since early childhood. Schizophrenia was excluded because there was no prodromal period and his psychotic symptoms were limited only with his depressive episodes. The issue of comorbidity of Asperger's syndrome with other conditions has been repeatedly raised. In childhood, significant attentional problems may be present. In adolescents and adults there is an increased risk of psychosis, particularly schizophrenia but it remains unclear whether this risk is greater than that in the general population. However depression appears to be the most frequent comorbid condition in adolescents and adults (7). Our case with a history of having many depressive episodes is also consistent with the literature in this respect. It is also known that children with developmental disabilities have a two-to-six-times greater risk of experiencing comorbid psychiatric conditions than their developmentally normal peers. The presence of comorbid affective disorders in these children may more severely impair an individual with already limited cognitive functions and social skills (8). These comorbid conditions make it difficult to diagnose the underlying developmental disorder especially in adolescence or adulthood of these children. For instance the diagnosis of AS may not be recognized in adults due to the presentation of psychotic, affective or obsessive-compulsive symptoms to adult psychiatrists unfamiliar with pervasive developmental disorders. Conversely the symptoms of comorbidities like mood disorders can be masked by other symptoms or behaviors seen in this population.

Treatment is also more substantial since the comorbid conditions affect the life quality of this population. It is important to emphasize that there is a limited number of controlled trials regarding the use of psychopharmacological interventions in this population (9). Atypical antipsychotics, lithium, valproate, carbamazepine are commonly preferred among pharmacological options in children with bipolar disorder (10). So we preferred to use risperidone and carbamazepine to control the symptoms.

In conclusion, this case emphasizes the difficulty in

assessing a patient with a previously undiagnosed pervasive developmental disorder and a major psychiatric disorder. Our report also aims to increase clinicians' awareness in the diagnosis of a developmental disorder like AS particularly during adolescence and adulthood of this condition. The possibility of undiagnosed AS because of comorbidities like mood disorders should be born in mind when assessing patients at risk.

References:

1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders (4th ed). Text Revision Washington, DC: American Psychiatric Association; 2000.
2. Karen Toth, Bryan H. King Asperger's Syndrome: Diagnosis and Treatment. Am J Psychiatry. 2008;165:8.
3. Frazier AJ, Doyle R, Chiu S, Coyle JT. Treating a Child with Asperger's Disorder and Comorbid Bipolar Disorder. Am J Psych. 2002;159:13-21.
4. Einfeld SL, Tonge BJ. Population prevalence of psychopathology in children and adolescents with intellectual disability, I: rationale and methods. J Intellect Disabil Res. 1996;40:91-8.
5. Gillberg C. Asperger syndrome in 23 Swedish children. Dev Med Child Neurol. 1989;31:520-31.
6. Szatmari P, Archer L, Fisman S, Streiner DL, Wilson F. Asperger's syndrome and autism: differences in behavior, cognition and adaptive functioning. J Am Acad Child Adolesc Psychiatry. 1995;34:1662-71.
7. Klin A, McPartland J, and Volkmar FR: Asperger syndrome, in Handbook of autism and pervasive developmental disorders, F.R.Volkmar, et al. (eds): Hoboken, Wiley: 2005.
8. DeJong SA, Frazier JA: Bipolar disorder in children with pervasive developmental disorders, in Child and Early Adolescent Bipolar Disorder. Edited by Geller B and DeBello M.New York: Guilford Press, 2005. p. 51-75.
9. Tanguay PE. Pervasive developmental disorders: a 10-year review. J Am Acad Child Adolesc Psychiatry. 2000;39:1079-95.
10. Madaan V, Chang KD. Pharmacotherapeutic strategies for pediatric bipolar disorder. Expert Opin Pharmacother. 2007;8:1801-19.