
Letter to the Editor

BIPOLARITY in DIFFERENTIAL DIAGNOSIS of CHILDHOOD-ONSET PSYCHIATRIC SYMPTOMS

Dear Editor,

I have read with great interest the article titled “Differential Diagnosis Between Schizotypal Personality Disorder and Autism Spectrum Disorders: A Case Report,” published in the Spring 2015 issue of your journal (Ünver et al. 2015). This report is very informative in terms of conceptualizing the differential diagnosis of autism spectrum disorders and the schizotypal personality disorder. This diagnosis has a close relationship with schizotypy and autistic symptoms, as well as in terms of understanding their shared clinical symptoms. The clinical follow-up and psychometric assessments that point to the existence of autistic symptoms, in addition to schizotypal features, make this case very valuable. I would like to add a few comments about the diagnostic confusion encountered in this case.

First, the appearance of autistic symptoms, beginning from age 2, makes this case prone to a diagnosis of a probable developmental disorder. Behavioral problems that emerged

later also support this theory. Although the patient’s mystical/metaphysical preoccupations, magical and paranoid thought content, bizarre appearance, and impaired social communications have been considered in favor of a cluster A personality pathology, even at his early age, some remarkable symptoms contributed to the diagnosis in this case. Disregard for authority in social relationships, addressing adults with the word “you” in a careless manner, sitting on the teacher’s table, beliefs about having magical skills, and offensive reactions to adults’ offers have been emphasized in the description of the patient. Moreover, reference thoughts, indifference in social relationships, instability of affect, and impulsive behaviors, as well as low frustration tolerance, episodic sexual content thoughts, and behavior problems, are the other distinct symptoms of this case. I suggest that the bipolar spectrum should be included and evaluated carefully in the differential diagnosis, considering all these additional clinical data.

The authors reported clinical worsening after an antidepressant treatment and no response to methylphenidate. While these findings support a consideration of bipolar diagnosis, some data have been presented regarding the complexity of the diagnosis of early onset bipolar disorder. Episodic nature has been reported as an important diagnostic feature, and a positive familial history has been also emphasized as a considerable factor in the diagnosis of childhood bipolar disorder (Baroni et al.2009). However, some conflicting data support a nonepisodic course with chronic irritability as being associated with bipolar disorder (Grimmer et al.2014). Additionally, the early onset of bipolar disorder has been related to an increased comorbidity and poor prognosis (Perlis et al. 2004).

In this case, I feel that the medications he was discharged with , including aripiprazole and quetiapine, may be effective in terms of treatment of a possible bipolar disorder. At this point, I conclude that it is crucial to monitor the episodic course and positive familial history that are important in early onset bipolarity, particularly in the differential diagnosis of such cases.

Onur Durmaz, MD, Balıkesir Military Hospital, Department of Psychiatry, Balıkesir, Turkey.

e-mail: drodurmaz@gmail.com

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