A 13-year-old white male was admitted to the child and adolescent psychiatry unit at our institution. He was referred to us by his outpatient therapist.

He had become increasingly aggressive (both verbally and physically), agitated, unable to sit still, and was pacing and talking incessantly. His speech was pressured, rapid, and mumbled. He was acting out sexually by masturbation. He also had auditory hallucinations (was hearing a “good voice”) but no visual hallucinations. He had paranoid ideations that someone was breaking into his home, and he was talking to himself and responding to internal stimuli. His sleep and concentration were reduced but his appetite was adequate. Suicidal and homicidal ideations were absent. His symptoms had been getting worse in the weeks prior to admission.

The patient had been previously diagnosed with attention-deficit/hyperactivity disorder (ADHD) at age 3, bipolar disorder (near age 3), oppositional defiant disorder (age 8), enuresis (age 5), and encopresis. He was admitted for multiple psychiatric issues in the past, and in the past 3 months he had been hospitalized in two facilities for a period of about 2 weeks each before admission to our institution.

He was admitted on Vyvanse (Shire; Wayne, PA) 40 mg/day, clonidine 0.1 mg in the morning and 0.05 mg at bedtime, Vistaril (Pfizer; New York, NY) 25 mg three times daily, Seroquel (AstraZeneca; Wilmington, DE) 50 mg in the morning and 800 mg at bedtime, levothyroxine 50 mcg in the morning, fish oil, and senna. Review of relevant previous treatment revealed that risperidone was effective but caused elevated low-density lipoprotein (202 mg/dL).

The patient had never used illicit drugs. He lived with his mother. His father was not involved in his life. He was born full term by normal spontaneous vaginal delivery with no complications. Developmental milestones were achieved appropriately. Family history was positive for bipolar disorder in his mother, who has been effectively treated with paliperidone combined with lamotrigine.

Medical review of systems was positive for a patchy maculopapular skin rash on his trunk, pelvis, and upper extremities accompanied by excessive sweating and sensitivity to heat.

Upon admission evaluation, he appeared his stated age, and was alert and oriented with poor personal hygiene. He was pacing and was restless. His speech was pressured and rambling but with normal volume and tone. He described his
mood as being “okay.” His affect was elated. Insight and judgment were poor.

Laboratory work (complete blood count, comprehensive metabolic panel, thyroid-stimulating hormone) were within normal limits.

D I A G N O S I S

Bipolar Disorder I, Manic

After evaluation by a multidisciplinary team, the patient was diagnosed with bipolar disorder I, manic. His other diagnoses were continued.

Vyvanse and Vistaril were stopped, and Seroquel was tapered off. Levothyroxine 50 mcg was continued but clonidine was changed to 0.05 mg three times daily. Paliperidone was started and was titrated up to 9 mg every morning over a few days. Divalproex sodium extended release (ER) 500 mg at bedtime was started and titrated to 1 g every night at bedtime. Divalproex level correctly measured was 67 mg/mL. The patient did not show improvement until 1 week after reaching the desired daily doses of active molecules. By hospital stay day 14, his speech had slowed down, his focus was better in school, and his work was better organized. He was more independent and needed less redirection. No further sexual acting out was noted. In light of these improvements, it was deemed appropriate to discharge him, on current inpatient medication, to home, with outpatient follow-up.

A follow-up call to his family revealed that the patient had been doing better and had been showing sustained improvement in school performance compared with the previous year. He has not required further inpatient admission.

D I S C U S S I O N

Childhood bipolar disorder poses both diagnostic and treatment challenges. The presence of comorbid disorders such as ADHD renders the management of this condition even more difficult.1 Historically, distinguishing childhood schizophrenia from bipolar disorder has posed enormous difficulties for clinicians as childhood bipolar disorder often presents with psychosis.2 Furthermore, bipolar disorder, once considered a rare disorder in children, is now being diagnosed more commonly, even in preschoolers,3 hence, the need for evidence-based treatments and case reports to help providers make informed decisions when treating patients with this condition.

Treatment guidelines, while advising against the use of unnecessary polypharmacy, recommend starting with an agent that is approved by the US Food and Drug Administration for the treatment of adult bipolar disorder, with lithium approved down to age 12 years for acute mania and maintenance therapy.4 It is noteworthy, however, that the presence of comorbid ADHD as well as other disruptive behavioral disorders predicts a poorer response to treatment,5 with these comorbidities requiring independent clinical attention.

Berwaerts et al.6 conducted a randomized, placebo-controlled study using paliperidone ER as an adjunctive to lithium or valproate for the treatment of acute mania, but failed to find that the combination treatment was more efficacious than monotherapy alone. We, however, report significant improvement with remission of symptoms in our 13-year-old patient with the administration of paliperidone and divalproex.

C O N C L U S I O N

Childhood bipolar disorder poses significant challenges to clinicians, both in diagnosis and treatment. Our clinical experience suggests efficacy in the combination of paliperidone and divalproex in this 13-year-old male with bipolar disorder.

R E F E R E N C E S