

## CASE REPORT

## Late-Onset Mania in a 73-Year-Old Male: A Case Report

Tejaswini S. C<sup>1</sup>, Kavya Ilager<sup>2</sup>, Vishwanath Alamela<sup>3</sup>, Narayan R. Mutalik<sup>4</sup>

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## ABSTRACT

**Background:** Late-onset mania, typically defined as onset after the age of 60 years, is rare and frequently associated with secondary organic, neurological, or metabolic causes. Primary bipolar disorder presenting for the first time in late life poses diagnostic challenges and requires careful evaluation.

**Case Presentation:** This report discusses a 73-year-old male with no past psychiatric or significant medical history who developed a first-episode manic presentation characterized by irritability, elevated mood, grandiosity, increased psychomotor activity, and reduced need for sleep. Extensive laboratory investigations and neuroimaging were normal. The patient was diagnosed with bipolar disorder, type I, current episode manic with psychotic symptoms (ICD-11). He responded well to low-dose atypical antipsychotics and remained stable at follow-up.

**Conclusion:** This case emphasizes the need for systematic evaluation of late-onset manic symptoms to differentiate primary bipolar disorder from secondary causes. Awareness of such presentations supports early diagnosis and tailored geriatric psychopharmacology.

## KEYWORDS

• Late-Onset Mania • Geriatric Bipolar Disorder • Elderly Psychiatry • Secondary Mania • Mood Disorder In Elderly

## AUTHOR'S AFFILIATION:

<sup>1</sup> Junior Resident, Department of Psychiatry, S.N. Medical College & HSK Hospital, Bagalkot, Karnataka, India.

<sup>2</sup> Senior Resident, Department of Psychiatry, S.N. Medical College & HSK Hospital, Bagalkot, Karnataka, India.

<sup>3</sup> Assistant Professor, Department of Psychiatry, S.N. Medical College & HSK Hospital, Bagalkot, Karnataka, India.

<sup>4</sup> Professor & Head, Department of Psychiatry, S.N. Medical College & HSK Hospital, Bagalkot, Karnataka, India.

## CORRESPONDING AUTHOR:

Tejaswini S. C, Junior Resident, Department of Psychiatry, S.N. Medical College & HSK Hospital, Bagalkot, Karnataka, India.

E-mail: tejaswinipradeep7@gmail.com

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## INTRODUCTION

Mental disorders affect approximately 14% of individuals aged 70 years and older, reflecting a substantial burden of psychiatric morbidity in later life.<sup>1</sup> Mental health in old age is shaped by physical illness, social context, cumulative life experiences, and stressors specific to ageing<sup>1</sup>. Although bipolar disorder usually begins earlier in life, manic episodes may rarely present for the first time in old age and can have an abrupt onset.<sup>2,3</sup> Such presentations require careful evaluation to distinguish primary mood disorders from secondary causes.<sup>2-3</sup>

Manic episodes in individuals above 60 years are uncommon compared to younger adults, yet their clinical relevance is increasing due to global demographic aging. The estimated incidence of first-episode mania in individuals older than 70 years is markedly low, around 0.1–0.5 per 100,000 population per year.<sup>5</sup> In contrast to younger adults, late-onset mania is far more likely to have underlying secondary causes, such as cerebrovascular disease, metabolic or endocrine abnormalities, neurodegenerative disorders, infections, or medication-induced states.<sup>6,7</sup>

Studies demonstrate that nearly 70–90% of elderly individuals presenting with mania have evidence of secondary aetiologies.<sup>8</sup> However, primary bipolar disorder can rarely emerge for the first time in old age, often without preceding depressive episodes. Differentiating between primary and secondary mania is crucial because the underlying aetiology strongly influences prognosis, treatment planning, and risk of recurrence.<sup>9</sup>

Late-life mania presents diagnostic complexities due to overlapping cognitive symptoms that mimic delirium, dementia, and neuropsychiatric syndromes. Furthermore, age-related pharmacokinetic changes affect psychopharmacological strategies, requiring cautious titration and vigilant monitoring.<sup>10</sup>

Here, we report a detailed case of a 73-year-old male with first-onset mania, with no organic or medical comorbidities, and discuss its evaluation and management within the context of current literature.

## CASE PRESENTATION

A 73-year-old male, married, and living with family, with no past psychiatric or significant

medical history, was brought with 8-month history of behavioural changes. The illness had an acute onset and continuous course. The patient exhibited elevated mood, increased self-confidence, irritability, over-talkativeness, and grandiose ideas. He became excessively social, overfamiliar, and displayed increased goal-directed behaviour such as assuming the role of a social leader. His need for sleep decreased to 2–3 hours per night without tiredness. There were no perceptual disturbances or depressive features. No history of head trauma, substance use, stroke, hypertension, or diabetes. Family history was negative for psychiatric illness.

**Mental Status Examination:** The patient appeared well-groomed, with increased psychomotor activity, pressured speech, elated affect and flight of ideas. Thought content revealed grandiosity, cognitive functions intact (MMSE: 29/30), and partial insight.

**Investigations:** Routine blood investigations, including complete blood count, renal profile, LFT, thyroid profile, electrolytes, urine routine were within normal limits. MRI brain showed no abnormalities. Diagnosis: Bipolar type I disorder, current episode manic with psychotic symptoms as per ICD-11 criteria after exclusion of possible organic aetiologies.

**Treatment:** The patient was started on low dose quetiapine 25 mg/day, titrated slowly up to 100 mg/day. Risperidone was added due to persistent psychotic symptoms despite initial quetiapine titration, starting at 1 mg and titrated to 3 mg per day along with trihexyphenidyl (THP) 2mg at bedtime. He showed marked improvement within 3 weeks. At 3-month follow-up, he remained euthymic on maintenance antipsychotic doses.

## DISCUSSION

Late-onset mania is a rare psychiatric condition with distinctive etiological considerations. While primary bipolar disorder can manifest in later life, most cases are related to secondary organic or neurological causes.<sup>4,7,11</sup> This case illustrates a scenario where, despite the age of onset, no organic pathology was detected, leading to a diagnosis of primary late-onset mania.

In this case, lack of metabolic or neurological abnormalities and normal neuroimaging strongly supported a primary psychiatric aetiology. Primary bipolar disorder occurring

solely in old age is rare. Dols *et al.*<sup>7</sup> highlighted that most late-life manic syndromes are secondary; however, genuine primary mania does occur and often responds well to standard treatment.

Ischemic lesions, particularly in right frontal or subcortical regions, are strongly associated with late-onset manic symptoms. Brooks and Hoblyn<sup>11</sup> emphasized that vascular mania is one of the most common causes of secondary mania.

Young and Klerman<sup>12</sup> noted that late-onset bipolar patients may exhibit more irritability and psychosis than younger patients, consistent with this case.

Diagnostic challenges such as distinguishing late-onset mania from delirium, dementia with behavioural disturbances, and late-onset schizophrenia-like psychosis are critical.

Almeida and Fenner<sup>13</sup> reported that intact cognition on screening tests supports a diagnosis of primary mood disorder rather than dementia. Our patient's MMSE score of 29/30 and absence of fluctuating consciousness effectively ruled out delirium or dementia.

Elderly patients also require cautious psychopharmacology due to reduced drug metabolism and increased sensitivity to side effects. Depp and Jeste<sup>10</sup> recommend the principle of "start low, go slow," which was followed in this case with gradual titration of quetiapine and risperidone.

The patient showed good clinical improvement, which aligns with the findings of Tohen *et al.*<sup>14</sup>, who demonstrated that elderly patients respond well to atypical antipsychotics when dosing is carefully individualized.

Primary late-onset mania generally has a favourable prognosis when promptly treated, although continuous monitoring is essential due to increased vulnerability to metabolic side effects and relapse risk.

## CONCLUSION

This case highlights the significance of comprehensive evaluation in elderly individuals presenting with manic symptoms. Although secondary causes dominate late-life mania, clinicians should recognize the possibility of primary bipolar disorder, particularly when extensive investigations are normal. Early intervention with cautious

psychopharmacology can result in excellent outcomes and improved quality of life.

## Patient Consent

Written informed consent was obtained from the patient and his family for publication of this case report.

## Conflict of Interest

The authors declare no conflicts of interest.

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