

Case Report Article

Oral rehabilitation in a patient with bipolar affective disorder: clinical case report

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Abstract

Objective: This study, through a literature review, aimed to present the key aspects found in Bipolar Affective Disorder (BAD), as well as present a case report of a patient who received dental care in the Discipline of Dentistry for Patients with Special Needs of PUCPR. **Case report:** Female patient, 30 years of age, leukoderma, diagnosed by medical and psychological exams as suffering from BAD and slight mental retardation. The most evident characteristics inherent to the primary illness included swings in mood and affection as well as bipolar or manic depressions. The special school where she studied and worked referred her to receive dental care in the Discipline of Dentistry for Patients with Special Needs of PUCPR. Her main complaint was the lack of upper front teeth and the esthetic. The treatment plan included adequacy of oral environment through basic periodontal therapy and production of removable partial dentures. **Conclusion:** People with BAD requires extra care with regard to behavioral management.

Introduction

Bipolar disorder (BAD) is a changing in mood characterized by episodes of extreme excitement and depression, among which there is a latency period [13]. It affects between 1% and 2% of the general population, with an equal prevalence between males and females [4]. About 50% of patients with BAD report the occurrence of other cases in the family, especially among male monozygotic twins, where the prevalence may reach 80% [2].

BAD can be classified into disorder I, disorder II, dysthymia, cyclothymia, and bipolar disorder without specific cause. In disorder I, one or more manic or mixed episodes occur; in disorder II, one or more depressive episodes accompanied by at least one hypomanic episode occur. Dysthymia is a milder form of chronic depression, which can last up to two years and takes place between 6% and 8% of the adult population. Cyclothymia consists of a brief recurrent episode of hypomania and mild depression, symptoms ranging from depression to manic more quickly than other bipolar patients and cycles are short. Finally, the BAD without specific cause consists of partial syndromes such as recurrent hypomania without depression [12]. Although no age range of greater prevalence exists, the greatest onset of disease is between 15 and 24 years of life and if BAD is properly diagnosed and treated, may undergo remission for a period of five years [6].

The main medical findings are chronic fatigue, migraine, asthma, bronchitis, multiple chemical sensitivity, and hypertension. They are also predisposed to obesity, metabolic syndrome, type 2 diabetes, and cardiovascular/cerebrovascular diseases. Of course, these conditions are exacerbated if there is no primary and preventive health care [8].

Although drug therapy is the treatment of choice for patients with BAD, this is not enough by itself because the psychological rehabilitation is necessary; notwithstanding the drugs used have deleterious effects on oral health: marked developing of caries, xerostomia, alterations in taste, and bruxism [13]. In particular, the lithium carbonate used in these patients cause hypertrophy of the salivary glands, generalized stomatitis, ulcers on the mucosa, pain and myofascial dysfunction syndrome, xerostomia, and cervical caries lesion [9].

Because treating people with BAD includes a combination of psychoeducation, self-management,

pharmacotherapy, and health care, this study aimed to report a case of a patient diagnosed with BAD who received dental care in the Discipline of Dentistry for Patients with Special Needs of PUCPR.

Case report

A female patient, 30 years old, leucoderma, diagnosed by medical and psychological tests as having BAD and discrete mental retardation was referred for dental care for by the school where she studied and worked. As the characteristics inherent to her condition were the mood swings, low self-esteem, and manic depressive disorders. Her main complaint was the lack of upper incisors, which, according to her, contributed to her mood changes (figure 1), but reported no pain symptoms.



Figure 1 - Initial photograph evidencing the loss of maxillary central incisors and maxillary left lateral incisor

Past medical history revealed the internment in a psychiatric hospital at the age of 12 for a period of three years and she was diagnosed with mild mental retardation. She used carbamazepine at a dose of 200 mg, for mood stabilization, but reported extreme difficulty to undergo previous dental procedures because of the impatience and the sudden change of mood.

At clinical examination, the patient presented straight profile, lip sealing, and nasal breathing. At intraoral clinical examination, she showed significant loss of teeth (table I) and gingivitis.

Table 1 - Initial oral condition. The patient had DMFT index significantly higher than the mean value for the population at the same age range living in South of Brazil: 14 teeth were lost due to caries or periodontal disease; two teeth had caries (one requiring fixed prosthesis); eight filled teeth (three with dental amalgam and five with resin composite)

Tooth condition	Notation according to FDI and surface(s)
Lost by caries or periodontal disease (14)	18, 17, 16, 14, 11, 21, 22, 27, 28, 38, 37, 36, 35, 47
Dental amalgam restoration (3)	13 D, 24 OM, and 25 OD
Resin composite restoration (5)	26 MOB, 44 O, 45 O, 46 OV, and 48 OB
Caries (1)	12 ML
Need for fixed prosthesis (1)	23
Sound (8)	15, 34, 33, 32, 31, 41, 42, and 43

The treatment plan includes adequacy of the oral environment through basic periodontal therapy, oral hygiene instruction, endodontic treatment of the tooth 23, followed by restorative phase with multiple restorations, manufacture of metal core and post, provisional crown on a tooth 23, and maxillary and mandibular removable partial dentures (RPD) (figure 2). The patient was followed-up since RPD installation.



Figure 2 - Final photograph with RPD. The episodes of mood oscillation significantly decreased after RPD installation

Discussion

According to the literature, the prognosis for the BAD is considered relatively favorable, although the results were not so encouraging [7]. People with BAD during childhood or early adolescence have a different course of the disease when compared to those developing BAD at adulthood, since adults have more frequent episodes of euphoria and depression [5].

In this study an adult patient, aged 30 years, diagnosed as having bipolar disorder, was treated at the clinic for patients with special needs of the Pontifical Catholic University of Paraná. During the dental treatment, the mood swings, which is characteristic of the disorder [4], was evident throughout the months and contributed to increase her anxiety. It is known that fear and anxiety are relatively common when a person is placed in front of a health professional, however significantly increase when the professional is a dentist [10], so in patients with BAD because of mood swings, extra care is required. The dentist accounts for identifying the factors causing anxiety and fear and implementing different strategies of management behavior by minimizing them [11].

In this case report, behavioral management was important, as she swung between euphoric states and depressive moments. The dental treatment itself was only started after trivial dialogues, which on one hand minimized the discomfort and the initial distrust regarding to the procedures, but on the other hand increased the period of treatment.

Among the most common oral diseases in patients with psychiatric disorders are periodontal disease and caries due to low self-esteem, negativity, and apathy [1]. The final result is a significant increase in tooth extractions. In this case report, DMFT index was equal to 24 (D = 2, M = 14, F = 8), number much higher than the mean DMFT of adults aged 35 years living in southern Brazil [3].

Thus, the established treatment plan aimed at the adequacy of oral cavity with hygiene instructions, periodontal prophylaxis, and restorations, returning oral health. This was followed by endodontic treatment of the upper left canine tooth, which went smoothly, although with some episodes of further unrest by the patient.

At the final stage of restorative treatment, she opted by maxillary and mandibular RPD due to the difficulty of maintaining oral hygiene. RPD eliminates the need for additional niches, which further contribute to the accumulation of food residue. At the subsequent appointments, there was a distinct improvement in mood and self-esteem of the patient, important aspects from the psychotherapeutic point of view [6]. The patient was followed-up at every four months to monitor oral health.

Conclusion

The treatment of people with BAD requires extra care regarding to the behavioral management. Longer appointments are needed to establish a greater connection between the dentist and the patient. Strategies should be developed to motivate the patient constantly.

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