Case Description

Patient is a 19 yo African American male with a past medical history of chronic prostatitis and no known past psychiatric history prior to his index manic episode and resulting suicide attempt.

Cannabis induced index manic episode:
Daily medications taken prior to manic: dicyclomine and tamsulosin for chronic prostatitis.

Substance use prior to manic:
- smoked 2 grams of cannabis almost daily for several months. Stopped cannabis use prior to hospitalization due to manic symptomatology.

Manic episode:
Several days of racing thoughts, distractibility, decreased need for sleep, increased energy, irritability as well as intermittent depressed mood, which lead to suicide attempt via attempting to swallow bleach.

Hospitalized after a week and discharged with antidepressives: 10 mg daily and trazodone 50 mg nightly as needed for sleep.

Outpatient management: Soon after hospitalization, amipropamide and trazodone were replaced with quetiapine 50 mg daily.

2nd episode of cannabis induced manic w/psychotic features, lasting: 1 mos. thus meeting criteria for Bipolar I Disorder:

Timeframe: 10 months after last manic episode

Daily medications taken prior to manic: tamsulosin and quetiapine

Substance use prior to manic: Since last episode, patient decreased cannabis use to about 1-2 grams twice weekly. Stopped cannabis use 1-2 weeks prior to hospitalization due to paranoia and auditory hallucinations.

Manic symptoms: Paranoia and A/I worsened, despite 1-2 weeks of cannabis cessation, and he developed decreased need for sleep, racing thoughts, increased energy, and irritability. Manic symptomatology continued for 3 months.

Hospitalized for this time and eventually evidenced by grandiose talk of his rap music and uploading 6 online.

Hospitalization: Hospitalized during this time and eventually admitted to Inpatient Psychiatric Unit and maintained on lisuride 2 mg twice daily.

Outpatient management: risperidone 2 mg twice daily continued, and escitalopram 10 mg daily and hydroxyzine 10 mg three times daily as needed for agitation. Patient is unable to assess due to current state.

No psychiatric family history.

Case strengths include the patient’s negative psychiatric family history, good baseline functioning and social support for detailed history gathering and diagnostic clarity as the patient established psychiatric care with the first author after risperidone discontinuation and exhibited a baseline of psychiatric stability on two separate occasions prior to presenting with his third manic episode.

The possibility of cannabis as a causal risk factor for index manic episodes leads us to consider potential harmful consequences of cannabis legalization, including increased availability, use and decreased harm perception, as there are now 18 states in the United States (US) which have approved non-medical regulated use of cannabis for adults.

In the past 24 years the potency of THC has quadrupled in the US but the percentage of US adolescents who perceive cannabis as harmful decreased by 48% (see Figure 1). Additionally, during this time, daily or near-daily cannabis use increased about 5% among high-school students.

Further research is necessary to determine a causal relationship between cannabis use and index manic episodes. The available evidence, though limited, is consistent in elucidating serious clinical concerns regarding cannabis use and its potential role in irreversible brain changes and the development of bipolar disorder.

This creates an urgency to provide extensive psychoeducation and discourage cannabis use in all patients, especially youth, and not just those psychologically vulnerable

References