Education-Family Physician Corner

Delirious Mania: A Diagnostic and Treatment Dilemma

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Delirious mania is a relatively rare condition in psychiatry. It has been reported in the literature for more than a century; however, it is still not recognized as a separate entity in psychiatry.

We present a case of a thirty-six-year-old Filipina who presented with an acute onset of catatonia. The patient had delirium as well as manic features. She was put on typical antipsychotic haloperidol; however, her response took a long time. The consent of the family could not be obtained for ECT. This is the first reported case of delirious mania in Bahrain.

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Mania is a well-known psychiatric condition which is characterized by an elated or irritable mood. It is associated with increased energy, grandiose delusions, the pressure of talk, the flight of ideas, increased psychomotor activity, insomnia, distractibility and social disinhibition. However, any medical condition or substance misuse must be ruled out before making such a diagnosis. If a person suffers from a manic episode, he will be diagnosed with bipolar affective disorder type I.

Delirium is defined as an acute confusional state. It is not a disease by itself; rather it is a syndrome characterized by disorientation to time, person or place, disturbed behavior and altered consciousness. However, it could be associated with sleep disturbance, delusions and lability of mood. The onset of delirium is usually acute and has characteristically a fluctuating course. A number of factors could predispose to delirium, such as dehydration, metabolic disturbance, old age, psychiatric conditions as well as substance misuse.

The precipitating factors for delirium are metabolic disturbances, such as hypoglycemia, electrolyte imbalance and hypercalcemia, etc. Infections, medications, strokes, post-traumatic events, as well as terminal illnesses could be other causes leading to delirium. The condition is a medical emergency with a high mortality rate of 10% to 26%[1]. In elderly and postoperative patients, delirium could result in long hospital stay and an increased complications and financial burden[2]. The use of haloperidol is the gold standard of treatment. Newer antipsychotics with fewer side effects have been tried, such as risperidone, olanzapine and quetiapine.

The combined mania and delirium is unusual; it does not have an independent nosology in ICD-10 or in DSM-5. Many clinical case reports have identified and described this entity. Delirious mania was first described by Calmiel in 1832. However, Luther Bell was the first to describe this syndrome comprehensively in 1849[3]. Delirious mania is associated with bipolar disorder; hence, patients with this disorder are classified as bipolar I disorder, manic episode with psychotic features. Some authors found that most patients with delirious mania have lethal catatonia; they theorized that delirious mania could be a subtype of catatonia because it responds very well to electroconvulsive therapy[4,5].

Catatonia is commonly associated with psychiatric conditions, such as schizophrenia, bipolar disorder and other neurotic disorders. The patient either suffers from extreme immobility or constant motor hyperactivity. Patients with extreme motor excitement might suffer from exhaustion if not treated promptly. According to DSM-5, catatonia could include any of the following features: stupor, mutism, stereotyping, echolalia, echopraxia, catalepsy, mannerism and waxy flexibility. Benzodiazepines could be used to treat catatonia. Patients with delirium should not be treated with benzodiazepines as it may worsen their condition. However, if the delirium is due to alcohol withdrawal, benzodiazepines, such as chlordiazepoxide could be used along with thiamine for treating such life-threatening condition.

The aim of this report is to highlight an uncommon, life-threatening condition of delirious mania and its management.

THE CASE

A thirty-six-year-old Filipina, working as a housemaid was brought with a history of sudden change in behavior for three days. The change in behavior had begun after the patient received a call from her family in the Philippines that her brother had died. She started to refuse to talk to her sponsor, throwing things in her room, waking up early in the morning, pacing up and down aimlessly, not eating and eventually

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refusing to move from her room. The patient was mute with poor eye-to-eye contact, looking suspicious, not responding to questions and tearful at times. She was not on any medications.

She was restrained several times and given olanzapine (Velotab) 5 mg when needed. The patient exhibited a picture of catatonia and was started on lorazepam 2 mg HS. Four days later, the movement improved and started to respond in writing. Some of her answers were irrelevant through the translator; therefore, it was decided to start risperidone 3 mg HS, procyclidine 5 mg HS. After two days, her condition worsened; she was trying to pull other patients' headscarves, standing on her bed, trying to attack staff, pulling the curtains, became aggressive, banging the doors of the ward without reason and refusing to answer any questions. Three days later, she started to show features of mania: elevated mood, dancing in the ward, hyperactive. She started to talk saying that her mother is in the toilet, her daughter is next to her. When we tested her orientation, she was found to be oriented to person but not to time nor place. A provisional diagnosis of mania and delirium was ruled out. The patient complained of cardiac problem, a cardiology consultation revealed no abnormality. The patient became paranoid thinking that the staff was terrorist group famous in Southern Philippines and they want to kill her by a sword. In addition to Risperidone 4 mg HS and Procyclidine 5 mg BD, valproate 500 mg BD and haloperidol were added and gradually risperidone was stopped. She started to become sexually disinhibited with aggressive behavior toward the staff. The patient developed hypotension; therefore Lorazepam was stopped. One week after, haloperidol increased to 10 mg HS and 5 mg OD, the patient's condition improved gradually. She became oriented to time, person and place; the behavior became normal. However, she still had the delusion that God killed her. All the investigations were normal with no signs of infection or brain injury. Two months after her admission, she improved significantly and told the team that she had a previous psychiatric episode when she was in secondary school. She was oriented to time, person and place, had no catatonic features and her psychosis resolved. She was ready to travel back to her country; therefore, she was discharged.

DISCUSSION

Delirious mania was considered as the most severe type of mania[6]. However, other studies have shown that this condition is presenting in medically ill patients without previous history of Bipolar Affective Disorder[7]. Others found that it is associated with catatonia and considered it part of catatonia[5]. The condition is not yet described as a separate disorder neither in DSM-5 or in ICD-10 classification systems.

Bipolar disorder patients with other medical comorbidities are commonly seen in psychiatry practice. Delirious mania could be misdiagnosed easily. This could probably explain that there is a high incidence of delirium among bipolar disorder patients (35.5%)[8].

The treatment of delirious mania poses a challenge. Studies have shown that this condition respond either to pharmacotherapy or electroconvulsive therapy (ECT). In a study of five cases of delirious mania, two of the patients received ECT; one improved after two sessions and the other had depression. However, in both cases, delirium resolved quickly[9]. The other three patients were treated with antipsychotics and mood stabilizers; their recovery took a long time. In our case, the patients responded well to typical antipsychotics and mood stabilizers. However, our patient's recovery took a long time with some residual manic features. We could not give ECT because consent could not be obtained.

Although delirium and catatonia have different definition criteria, one related to consciousness and the other to movement, they both respond well to ECT; this could indicate that they might be related etiologically[9].

CONCLUSION

Delirious mania was reported in many countries. This life-threatening condition is not mentioned as a separate diagnosis in the international diagnostic manuals. Fortunately, this condition is treatable and the gold standard of treatment is ECT.

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