Revisiting delirious mania

After treating a young woman with delirious mania, we were compelled to comment on the case report “Confused and nearly naked after going on spending sprees” (Cases That Test Your Skills, CURRENT PSYCHIATRY. July 2014, p. 56-62).

A young woman with bipolar I disorder and mild intellectual disability was brought to our inpatient psychiatric unit after she disappeared from her home. Her family reported she was not compliant with her medications, and she recently showed deterioration marked by bizarre and violent behaviors for the previous month.

Although her presentation was consistent with earlier manic episodes, additional behaviors indicated an increase in severity. The patient was only oriented to name, was disrobing, had urinary and fecal incontinence, and showed purposeless hyperactivity such as continuously dancing in circles.

Because we thought she was experiencing a severe exacerbation of bipolar disorder, the patient was started on 4 different antipsychotic trials (typical and atypical) and 2 mood stabilizers, all of which did not produce adequate response. Even after augmentation with nightly long-acting benzodiazepines, the patient’s symptoms remained unchanged.

The patient received a diagnosis of delirious mania, with the underlying mechanism being severe catatonia. A literature search revealed electroconvulsive therapy (ECT) and benzodiazepines as first-line treatments, and discouraged use of typical antipsychotics because of an increased risk of neuroleptic malignant syndrome and malignant delirious mania.1 Because ECT was not available at our facility, we initiated benzodiazepines, while continuing an atypical antipsychotic and mood stabilizer. The patient was discharged after her symptoms improved rapidly.

We agree it is prudent to rule out any medical illnesses that could cause delirium. Interestingly, in our patient a head CT revealed small calcifications suggestive of cysticercosis, which have been seen on imaging since age 13. We suggest that this finding contributed to her disinhibition, prolonged her recovery, and could explain why she did not respond adequately to medications.

Diagnosing and treating delirious mania in our patient was challenging. As mentioned by Davis et al, there is no classification of delirious mania in DSM-5. In addition, there are no large-scale studies to educate psychiatrists about the prevalence and appropriate treatment of this disorder.

Our treatment approach differed from that of Davis et al in that we chose scheduled benzodiazepines rather than antipsychotics to target the patient’s catatonia. However, both patients improved, prompting us to further question the mechanism behind this presentation.

We encourage the addition of delirious mania to the next edition of DSM. Without classification and establishment of this diagnosis, psychiatrists are unlikely to consider this serious and potentially fatal syndrome. Delirious mania is mysterious and rare and its inner workings are not fully elucidated.

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Reference

Correcting an error

In his informative guest editorial “Forget the myths and help your psychiatric patients quit smoking” (From the Editor, CURRENT PSYCHIATRY. October 2016, p. 23-25), Dr. Anthenelli makes a common statistical error, which may mislead readers, namely, confusing “percentage” with “percentage points.” He reports a difference in the rates of serious neuropsychiatric adverse events between a non-psychiatric cohort (2%) and a psychiatric cohort (6%) as “4%” (p. 25), when the percentage (relative) difference is 300% (ie, 3-fold). The absolute difference in rates is 4 percentage points, which may be what he wanted to report.

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