Delirium and Mania With Catatonic Features in a Brazilian Patient: Response to ECT

To the Editor: Mania with delirium is an acute syndrome of excitement, delirium, and psychosis.[1] Frequently, catatonic signs are also present.[2] Modern literature on clinical characteristics and treatment of this condition is still rare, consisting basically of case reports[1–5] and review articles.[2] Moreover, "delirious mania" is commonly ignored in clinical practice,[3] and so, these patients are not promptly and properly treated and have high mortality rates.[6]

Although delirious mania is underdiagnosed, from 15% to 20% of patients with acute mania show signs of delirium.[2,7] Possibly, the lowering of consciousness is due to the decrease in sleeping and feeding, which, in turn, are secondary to overactivity.[8] Mania has been associated with catatonia also. Two-third of catatonic patients suffer from mood disorder, usually mania, and about 20% of the manic patients exhibit catatonic features. Moreover, excited catatonia is clinically very similar to a manic episode.[7,9] On the other hand, general medical conditions are also commonly associated with both catatonia and delirium,[9] so a mixture of manic and confusional or catatonic symptoms represents a diagnostic challenge.

We report a case of a woman with bipolar disorder who presented with a manic episode associated with confusional and catatonic symptoms.

Case Report

A 46-year-old woman was hospitalized with severe psychomotor agitation. She had had five earlier psychiatric admissions, all of them due to manic episodes, which were characterized by delusions of grandeur and persecution, insomnia, psychomotor agitation, and combativeness. The first episode had been 11 years ago, when she was diagnosed with bipolar disorder. There was no history of depressive episodes.

During the last 3 years anterior to current admission, the patient had been euthymic, taking the following medications regularly: lithium (900 mg/day), haloperidol (10 mg/day), promethazine (50 mg/day), chlorpromazine (100 mg/day) and diazepam (10 mg/day).

In the 4 days before hospitalization, she exhibited agitation, insomnia, alcohol abuse, and combativeness, having assaulted her 9-year-old son. On admission, she was extremely agitated and hostile; she cried and screamed, threw herself on the floor, spoke very fast, swore profusely, and refused to respond to any questions. Also, she was delusional and had auditory hallucinations, hearing the voice of a woman who wanted to harm her. In sum, she was presenting a dysphoric manic episode with psychotic symptoms.

Due to the seriousness of the psychomotor agitation, it was necessary to use mechanical restraints and intramuscular medication. Subsequently, medication was administered orally and, during most of the time, she received haloperidol (15 mg/day), lithium (900 mg/day), promethazine (75 mg/day), and clonazepam (4 mg/day).

At admission, the patient was submitted to clinical evaluation. Physical examination revealed cough with expectoration and coarse rales on lung auscultation, but no fever. Lung condensation was found in thorax X-ray. A blood test showed 15,000 leukocytes. Consequently, she was diagnosed with pneumonia and used the antibiotic amoxicillin for 10 days, with rapid and full remission of respiratory syndrome. Other basic laboratory tests were normal. Serum level of lithium was 0.9 mEq/dl. During hospitalization, this result varied between 0.6 and 1.6 mEq/dl, and no intoxication signs with lithium were observed. No neuroimage exam was made.

In the first 2 days of hospitalization, the patient continued to be agitated. Also, she showed negativistic behavior, not accepting food and refusing to cooperate with the assistant doctor. She kept her eyes closed during medical visits and did not answer the majority of questions.

Then, her psychomotor agitation changed, acquiring a bizarre nature: she walked aimlessly from one side to the other of the infirmary courtyard and took all her clothes off for no apparent reason. She also presented some episodes of urinary incontinence. Sometimes, she sexually accosted other patients and members of the medical staff. The patient also continued to present auditory hallucinations, but, at this time, instead of voices, she heard the noise of the flushing of a bathroom toilet.

Since the third day, the patient showed several signs of lowering of consciousness: besides her disorganized behavior, she was somnolent and disoriented, ignored people around her, had difficulty in

paying attention to questions, had evident memory gaps in relation to the previous days, and also exhibited perplexity. Moreover, she presented visual and skin hallucinations: she made movements as if she was withdrawing insects from her skin and putting them on the palm of her hand so as to show them to the doctor. Delirium symptoms remitted about 2 weeks later.

Later, the patient became stuporous; she remained restricted to her hospital bed and showed negativism, echolalia, and significant muscle rigidity. Following this, catatonia was adopted again, in an excited form, associated with manic symptoms. For some days, both forms of catatonia, stuporous and excited, alternated.

After more than 2 months of hospitalization, there was not a satisfactory clinical response. The patient was still presenting a mixture of severe manic symptoms with some catatonic signs, such as a disorganized behavior and aimless overactivity. Therefore, she received a series of six sessions of bilateral electroconvulsive therapy (ECT), which lasted for 14 days. Before the beginning of ECT, the lithium daily dose was reduced to 600 mg. After a progressive clinical improvement of manic and catatonic symptoms, the treatment yielded a complete remission.

After hospital discharge, the patient presented a complete amnesia related to her early hospitalization period, reinforcing the hypothesis of a delirium syndrome. Pharmacological treatment was continued, and the patient remained asymptomatic for at least the next 12 months.

Discussion

Several features exhibited by this patient were cited in other case reports of "delirious mania," such as acute onset of symptoms,[2,4] excitement,[2] aggressiveness,[1,10] disorientation,[1,2,10] hallucinations,[1,10] catatonic signs,[2,10] urinary and fecal incontinence,[1,4,5] denudative behavior,[4] and amnesia.[5]

The delirium syndrome in our patient was probably caused by the pneumonia. However, alcohol abuse, the use of the psychiatric medications, and even manic overactivity, leading to an exhausting and sleepless state, may also have contributed to this. This case alerts us to the importance of an early diagnosis of delirium and of the investigation of an organic etiology when cognitive symptoms are present. Classical description of delirious mania notes that, in these cases, delirium is functional in origin.[3] Nevertheless, we would question whether it is possible to develop delirium without an organic abnormality.

After delirium remission, the catatonia remained present, so it was necessary to make a differential diagnosis with other medical conditions that can be associated with a catatonic syndrome. Since the patient used a typical antipsychotic, haloperidol, malignant neuroleptic syndrome (MNS) should be considered. However, this possibility was ruled out because she did not have fever, and extrapyramidal symptoms were mild.

The patient received antipsychotics and lithium, a combination used successfully in a case report,[3] but considered harmful by other authors, by increasing the risk of toxicity and MNS.[11] Mania with delirium is often severe and terrifying, often leading to a prescription of intramuscular antipsychotics, which can induce malignant catatonia, particularly in those patients who are dehydrated or have hydroelectrolytic disturbances.[12] The patient was also medicated with a benzodiazepine, clonazepam, a class of drugs often indicated for the treatment of catatonic symptoms,[13] although contraindicated for cases of delirium, except for alcohol withdrawl.[14] Finally, the patient had a good response to ECT treatment, which has been indicated as rapidly effective for various types of catatonia, cases of severe mania, and also for some cases of delirium.[4] A successful treatment of delirious mania with ECT has been presented in several case reports.[1,2,4,10]

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There are no queries in this article.