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DELIRIOUS MANIA: REMINISCENCE OF KRAEPELIN'S TRICHOTOMY OF MANIC-DEPRESSIVE ILLNESS

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Abstract:

A 54 years old male presented to our psychiatric service with pressured speech, grandiose delusions, irritability, aggression, decreased sleep, and disorganized behavior. Based on initial psychiatric evaluation, a diagnosis of bipolar disorder, current episode manic, severe with psychotic features was made and treatment with oral Carbamazepine 100 mg thrice daily and Risperidone 3 mg twice daily was started. On day 2 of his hospitalization, he developed altered mental status with worsening disorientation and memory impairment. Workup of delirium, including magnetic resonance imaging (MRI), was done which was unremarkable. As a result, a diagnosis of delirious mania was made. Although delirious mania is yet to gain a formal diagnostic classification, successful detection of delirious mania is important as it carries higher inpatient mortality rate. This case highlights delirium as a presentation of bipolar mania treated with pharmacotherapy.

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INTRODUCTION:

Delirious mania is a neuropsychiatric syndrome characterized by the rapid onset of the delirium of unknown cause in a patient with bipolar mania[1]. It has been known since the nineteenth century in the form of several denotations like "Bell's mania", "Delirium Acutum' and "Delirium Grave"[2], and was first classified as a subtype of manic-depressive illness by Emil Kraepelin in 1921, who categorized mania into 3 types: acute, delusional, and delirious[3,4]. Currently, there is a lack of clear consensus regarding the diagnostic criteria and management of this disorder. Here we present a case of delirious mania and the briefly review its treatment strategies.

Case presentation:

This is a case of 54 years old male with a past psychiatric history of Bipolar 1 disorder who presented to our clinical service with increased energy, euphoria, grandiose delusions, distractibility, unprovoked agitation and irritability. He reported feeling "like God" and that it was difficult for him to catch up on his thoughts. He was diagnosed with Bipolar 1 disorder at age 19 and had remained in partial remission on lithium monotherapy until age 25. At the age of 25, lithium was replaced with carbamazepine due to his concerns of weight gain. A review of medical records showed noncompliance with medications and frequent relapses.

Based on initial psychiatric evaluation, a diagnosis of bipolar disorder, current episode manic, severe with psychotic features was made and treatment with oral Carbamazepine 100 mg thrice daily and Risperidone 3 mg twice daily was started. On day 2 of his hospitalization, the patient became disoriented and started showing bizarre behavior, including intrusiveness and posturing. Besides, he demonstrated memory impairment and often forgot his room and events occurring in the recent past. Considering his worsening disorientation and acute confusional state, a thorough medical workup for delirium was done. Physical and neurological examinations were unremarkable. Complete blood count, electrolytes, renal, thyroid and liver function studies, urinalysis, blood alcohol, and toxicology assays were within normal limits. Magnetic Resonance Imaging (MRI) of brain was unrevealing. Therefore, a diagnosis of delirious mania was made. Electroconvulsive therapy (ECT) was discussed as a treatment; however, informed consent could not be obtained due to patient's lack of capacity and absence of substitute consent. Carbamazepine was titrated up to 200 mg PO thrice daily. His psychiatric condition improved significantly in three weeks, and he continued to show improvement in his mental status examination as well as in immediate, recent and long term memory. A complete neuropsychological evaluation was performed to rule out residual deficits in attention, concentration, memory and executive functioning, however, patient showed normal functioning in all dimensions of neurocognitive functioning. He was subsequently discharged on oral Carbamazepine 200 mg thrice daily and Risperidone 3 mg twice daily.

DISCUSSION:

Delirious mania is a complex neuropsychiatric syndrome of sudden onset, with hyperactivity, great excitement, sleeplessness, disorientation, and without any clear evidence of a definite etiology. At present, it is unclear whether this syndrome represents a phenotypic variant or a more severe form of bipolar mania[9]. In addition, sthe presence of bipolar disorder as a diagnostic criterion is also less well established since similar phenomenological presentations have been reported in medically ill patients without a previous history of bipolar affective disorder[10]. Historically, delirious mania has been categorized under manic-depressive reactions, catatonia and toxic infectious disturbances[11]. The condition is not yet described as a separate disorder neither in DSM-5 nor in ICD-10 classification systems.

The pathophysiology of delirious mania is complex and not yet fully understood, although impaired dopaminergic signaling has been implicated. Mash et al. (2009) conducted quantitative analyses of the dopamine transporter and heat shock protein 70 in post-mortem brain samples of individuals with excited delirium and exhaustive mania. They reported that brain dopamine transporter levels were lower in individuals with excited delirium as compared to age-matched controls, providing pathologic evidence for increased risk of chaotic dopamine signaling in excited delirium [12]. More research will further enhance our understanding of the neurobiological mechanisms of delirious mania.

The treatment of delirious mania poses a challenge. Studies have shown that this condition responds either to pharmacotherapy or electroconvulsive therapy (ECT), although, response time to ECT is relatively shorter[11]. In a study of five cases of delirious mania, two of the patients received ECT; one improved after two sessions and the other developed depression. However, in both cases, delirium resolved quickly [13]. The other three patients were treated with antipsychotics and mood stabilizers; their recovery took a long time.

CONCLUSION:

Delirious mania has been reported in many countries. This condition is not mentioned as a separate diagnosis in the international diagnostic manuals. Fortunately, this condition is treatable and ECT remains the gold standard treatment for it. In our case, we treated the patient of delirious mania with an antipsychotic and a mood stabilizer as informed consent could not be obtained for ECT.

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