ABSTRACT
Disorientation in manic inpatients has been widely documented worldwide. The condition is still not well recognized. Also, the illness is commonly associated with another general medical or neurological condition which makes the diagnosis a difficult task. Here we are documenting a case of Delirious Mania in an elderly individual, which has been scarcely reported in Indian context.

Keywords: Delirium, mania, disorientation, elderly

INTRODUCTION
“Delirious Mania” is used to describe patients with mania and associated delirious symptoms which are not a consequence of any medical etiology. The illness manifests as symptoms suggestive of mania (e.g. emotional lability, increased motor activity, decreased need for sleep, grandiosity etc) along with those characteristic of delirium (e.g. clouded consciousness, disorientation, flocillations etc). Some authors refer to a transition from mania to Delirious Mania, which is characterized by onset of confusion and an increase in the severity of mania. A dreamlike clouding of consciousness is reported to possibly occur. The syndrome is also called Bell’s Mania after Luther Bell. In 1949, Bell documented an account of 40 patients who were reported to have symptoms suggestive of this rare entity. The mortality was reported in 75% patients who received the diagnosis.

CASE REPORT
A 65-year-old married male, was brought to adult psychiatry outpatient (OPD) by his daughter and son-in-law with a history of acute onset, episodic illness of 10 years duration. The patient is a known case of Bipolar Affective Disorder with multiple manic and depressive episodes with history suggestive of rapid cycling since 2012 and was on Lithium therapy. The patient has a strong family history of Bipolar Affective Disorder in mother, maternal aunt, maternal grandmother and a nephew.

In June 2014, he was brought to Psychiatry OPD, Dr. RML Hospital with a manic episode associated with tremulousness of hands along with fluctuating disorientation in time, place and person, and flocillations. General physical examination revealed tremors in hands and stable vitals and no focal neurological signs were found. On Mental State Examination (MSE), there was increased psychomotor activity and distractibility. The patient showed flight of ideas and had delusion of grandiosity. He was diagnosed to have “Bipolar Affective Disorder, current episode Manic with psychotic symptoms” as per International Classification of Diseases, tenth edition (ICD-10). On investigation, patient was found to have Lithium toxicity (Serum Lithium levels 1.23). Lithium was stopped and he was started on Valproate 300mg BD, Tab. Olanzapine 15mg OD, Tab. Lorazepam 2mg HS with reorientation clues, and sleep hygiene. Over the next one week, sensorium improved with clearing orientation. The manic symptoms responded more slowly. On the next OPD visit, he was observed to have depressive symptoms and was started on Olanzapine-Fluoxetine combination and improvement was reported. There was an asymptomatic period of about 1 week. This was followed by increase in tremors along with fluctuating disorientation, flocillations and sun-downing with decreased sleep, increased psychomotor activity, increased irritability, increased talkativeness and irrelevant talks. He reported visual hallucinations of gold/sand like particle on his fingers and floor that he would keep trying to pick, or picking 'lint' from other people’s clothes. He would have other vivid visual hallucinations at night of his house burning down and men kidnapping his grandson. He was also reporting delusion of reference. The patient was admitted this time for diagnostic clarification and further management. On MSE, tremors were present with an increased psychomotor activity and distractibility. Flocillations could be seen and the patient was disoriented to time, place and person. He had a perplexed affect and reported of persecutory ideas and visual hallucinations. Patient was found to have over familiarity, increased speech output and grandiose ideas even in the time intervals when the delirium would resolve. The same diagnosis of “Bipolar Affective Disorder, current episode Manic with psychotic symptoms” as per ICD-10 was kept. But, it was noted that he had associated features suggestive of delirium.
Differential diagnosis of Delirious Mania was kept and neurology opinion was sought. Investigations including hemogram, serum electrolytes, thyroid function tests, folate, Vitamin B-12 levels and MRI were within normal limits (WNL). Absence of any other medical condition favored Delirious Mania as the primary diagnosis. Tab. Valproate was increased to 500mg BD and tab. Quetiapine 25mg was added. Patient was discharged on the same medications, following improvement with clearing of sensorium within 5 days and manic symptoms later.

DISCUSSION
Delirious Mania describes an interaction between neurology and psychiatry. The case presented above highlights the occurrence of a neurological condition in the absence of any apparent neurological deficit in the presence of a psychiatric syndrome. The case mentions the significance of the entity called “Delirious Mania”.

Carlson and Goodwin reported that Delirious Mania has a high frequency of occurrence in a longitudinal study where 33% of 20 manic patients developed delirium during the course of illness. While Delirious Mania has been defined as the most severe type of mania\(^1\), the condition is commonly misdiagnosed as acute psychotic episodes of organic delirium, while on assessment they meet the criteria for mania with associated delirium, thus being a source of therapeutic challenge\(^2\). However, in view of presence of catatonic signs and its good response to Electro Convulsive Therapy (ECT), Taylor and Fink described DM as a form of catatonia\(^3\). Various efforts have been made to understand this entity.

A study reported that patients with Delirious Mania had longer inpatient stay, acute onset of symptoms, hyperthermia, catatonia, autonomic instability, sleep disturbances, coprolalia, and persistence of delirium for over a week, in comparison to those without associated medically unexplained delirium\(^4\). In 2001, two cases of elderly patients with Delirious Mania were reported. Both improved with Divalproex. The authors also concluded that mania should be a differential diagnosis of elderly patients who present with confusion, disorientation, and perceptual disturbances, especially if there is a history of bipolar disorder\(^5\). Regarding management, Karmacharya et al suggested that the definitive treatment is ECT. Clozapine, Quetiapine, Lithium, and Valproate, according to them should not be used as first-line treatments\(^6\). Supporting the above conclusion, Nicolato et al reported successful treatment of Delirious Mania with a combination of olanzapine and ECT but advised to be alert against the possibility of occurrence of neuroleptic malignant syndrome\(^7\).

Swartz et al\(^8\) suggested consideration of Delirious Mania as the diagnosis once an “organic aetiology” has been excluded. The case draws focus to the fact that the occurrence of delirious mania is frequent, though underreported\(^8\). The diagnosis of Delirious Mania in this case was in keeping with the Bond’s Criteria\(^9\), i.e. (i) acute onset of symptoms, (ii) presence of mania, (iii) features of delirium, (iv) past history of mania, and (v) response to antimanic treatment. One of the differential diagnoses was Neuroleptic Malignant Syndrome which was ruled out in our patient. Another point favouring the diagnosis of Delirious Mania is the recurrence of symptoms of delirium with no evidence ever of any other medical condition as the causative etiology.

Atypical antipsychotics are proposed to be effective in DM, except in presence of catatonic features\(^10\). Also, mood stabilizer has shown improvement in the literature\(^11\). The benefit of GABA agonist has also been reported earlier\(^11\). ECT is frequently mentioned in western literature\(^12\).

The case also elicits that longitudinal follow up is necessary for accurate diagnosis. The importance of early recognition of disturbances in sleep-wake cycle should be emphasized to the patient’s relatives as a possible warning sign of relapse or recurrence of this condition\(^1\). Extreme and incessant agitation or excitement in a manic episode should alert us to the possibility of delirium\(^2\).

The above mentioned case offers an insight into presentation of delirious mania and how it should be considered as a possible differential diagnosis. It is a rare phenomenon with unknown etiology with no nosological status in ICD 10 and DSM 5. The symptoms of delirium might manifest later in the course of the illness, which usually limits the reporting of such cases. The condition needs attention because of its high morbidity and fatal outcomes, and needs to be managed aggressively.

REFERENCES
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