Moria: An Unrecognized Frontal Lobe Symptom

To the Editor: Moria (pathological giddiness) and Witzelsucht (fatuous joke telling) were described in Germany in the 19th century.[1] Moria has no official diagnostic criteria, and in our experience, moria is an unrecognized symptom in the United States. In fact, moria was not diagnosed in our patient by several psychiatrists, neurologists, and neuropsychologists for 6 years despite its consistent presence.

Case report. The patient is a 45-year-old divorced white woman with a history of alcohol abuse who resides in the United States. Six years ago, she had a serious hemorrhage from esophageal varices secondary to cirrhosis that led to varices banding complicated by a cardiorespiratory arrest with brain anoxia and coma lasting 2 weeks.

Since that time, she had persistent moria (pathological giddiness) and Witzelsucht (persistent fatuous joke telling) but had been incorrectly diagnosed with hypomania, although she did not meet criteria for *DSM-5*[2] hypomania. The crucial reason is that she had no episode of elevated mood that "represents a noticeable change from usual behavior."

Additionally, in our experience, the patient's moria was not expansive to other people (it is not contagious), which is different from hypomania. For example, in many interviews, she kept laughing very loudly and said that when she was born, people called her "the Chinese boxer," which became her nickname. (It appears that she was referring to her swollen face after her delivery.) She kept repeating this very inappropriate statement each time we met—we doubt even the patient's mother would consider this comment funny. All authors (and other clinicians) agreed that the patient's "jokes" were not funny despite her laughing in an exaggerated and loud manner.

A head computed tomography scan with angiography 2 years before this admission described bilateral frontal and parietal encephalomalacia with diffuse mild-to-moderate volume loss. In the last 2 years, this patient became a revolving-door patient (with several psychiatric admissions per year) who had been difficult to place in a community setting because of her poor judgment. She arrived in our psychiatric ward refusing medications for her psychiatric symptoms. Further analysis was needed to confirm the moria diagnosis.

Abnormalities noted using Andreasen's scales[3,4] for psychotic symptoms included marked inappropriate affect, mild decrease in spontaneous movements, severe inattentiveness in mental status testing, moderate grandiose delusions, moderate derailment, severe tangentiality, moderate illogicality, moderate circumstantiality, severe loss of goal, moderate self-reference, severe phonemic paraphasia and moderate semantic paraphasia.

Screening procedures[5] used for cognitive deficits in chronic psychiatric inpatients showed the patient was unable to do even the first sequence of the Trail Making Test, Part B.[6] In the Frontal Assessment Battery[7] (range up to 18), she had a score of 9 with abnormalities in lexical fluency (score 2/3), motor series (score 0/3), conflicting instructions (score 1/3), and inhibitory control (score 0/3). A score in the EXIT-25[8] interview >15 indicates executive impairment. She had a score of 24 with abnormalities in number-letter task, word fluency, design fluency, anomalous sentence repetition, thematic perception, interference task, autonomic behavior number II, social habit I, motor impersistence, finger-nose-finger task, go/no-go task, Luria hand sequences I and II, echopraxia II, grip task, serial order reversal task, and counting task. She showed utilization behavior[9] with a toothbrush. In the Kolb and Milner test[10] for oral and arm praxias, the patient (1) completed 8 of 15 oral sequences, which is 53% (and clearly lower than the 75%–80% for patients with left and right frontal lobe lesions in the original study) and (2) failed to complete any of the 6 arm sequences, 0% (versus 75% in patients with left parietal lesions and 80%–85% in patients with right or left frontal lobe lesions).

In summary, this patient with moria demonstrated clear impairment in frontal lobe tests including a complete inability to do Part B of the TMT,[5] a score of 9 of 18 in the Frontal Assessment Battery,[7] a score of 24 in the EXIT-25,[8] utilization behavior,[9] a severe abnormality in Kolb and Milner's oral sequence,[10] and total inability to complete any arm sequence.

Hecaen and Albert[11] described moria as "an atypical hypomania" and insisted on its "puerile or silly attitude." However, its lack of specific diagnostic criteria in *DSM* or *ICD* may explain why it is missed. Regarding the list of hypomanic symptoms, our patient had persistent grandiosity, formal thought disturbance, and distractibility, all of them explained by her frontal lobe impairment. She did not have (1) changes in the need for sleep over time, (2) more talkativeness than usual, (3) increase of goal-directed activities, and (4) excessive involvement in risky behaviors.

This patient description and the translation of the original article[1] will help to increase awareness of the existence of moria[1] among US clinicians and distinguish it from hypomania (which was diagnosed in this patient).

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