Quetiapine Treatment for Delirious Mania in a Military Soldier

To the Editor: Delirious mania is a severe psychiatric syndrome characterized by acute onset of delirium, excitement, and psychosis. It was initially described by Calmeil in 1832 as an uncommon but life-threatening psychosis with extreme hyperactivity and mounting fear fading to stuporous exhaustion.[1] Its reported mortality rate reached 75%.[2]

The modern literature pertaining to clinical characteristics and treatment outcomes of delirious mania is sparse, consisting mainly of case series.[3] There have been many controversies about proper nomenclature, with terms such as *lethal catatonia* and *malignant catatonia* proposed along with *delirious mania*.[4] It is thought of as an uncommon syndrome, although it may be underrecognized since several authors have suggested that as many as 15%–20% of all acutely manic patients show signs of delirium.[4] Patients with this syndrome experience significant morbidity and a high mortality rate without treatment.[5]

Delirious mania is marked by acute onset of the excitement, grandiosity, emotional lability, delusions, and insomnia characteristic of mania and the disorientation and altered consciousness characteristic of delirium.[6] Many patients give a history of alcohol, cannabis, and hallucinogenic use.[4]

Bond[7] outlined 6 criteria that distinguish delirious mania: (1) acute onset, (2) presence of hypomania or mania, (3) developing signs and symptoms of delirium, (4) past history of mania or depression, (5) family history of affective disorder, and (6) responsivity to treatment for mania.

Karmacharya et al[3] recently suggested that the definitive treatment for this condition is electroconvulsive therapy (ECT). In cases in which ECT is not available, high-dose benzodiazepines should be used. Clozapine, quetiapine, lithium, and valproate cannot be considered first-line treatments, and these medications take an unacceptably long time to work even when helpful; typical antipsychotics and anticholinergic drugs should be avoided.

There is now, however, no clear consensus on which clinical features are associated with delirious mania or which treatments are effective.[3] We report a case of delirious mania in which remission was successfully achieved with quetiapine 300 mg/d.

Case report. Mr A, a 21-year-old man, is serving as a naval sergeant after withdrawing from his university temporarily. He did not have either medical or psychiatric past history.

In March 2008, when he called his mother from his military unit, his speech had low tone, no special content, and few words compared to usual. The next day, he felt as if telepathic messages were blowing over him at his every breath. He heard a voice of the woman whom he loved one-sidedly when he was a middle school student. The contents of the telepathy were "Brother," "I love you!" and "See you at [a specific time]," with use of a dialect. He felt funny and good when he heard the voice say, "Truth to tell, I have waited for you!" and "I have seen you!" He believed that he could send messages telepathically if he shut up and did not move his tongue. He spent much of his time lying down and exchanging telepathy with her. When he did not receive replies to his telepathic messages, he experienced hearing his thought being sent from him over and over, which made him angry. He slept for only 1 or 2 hours per day and did not feel hungry because he focused on exchanging telepathic messages all night. He was hesitant about telling anyone about his ability. When he felt warm or an ache in his leg, he thought that the feeling suggested a transmission from her. He thought that he could share his imagination with her when he laughed for no reason. He decided to name this phenomenon "cosympathy." Three days after his initial telephone call to his mother, he woke up at about 6:00 AM and tried to leave his military unit to go home. His random talking led to his being sent to the navy medical center. In the navy medical center, he talked incoherently, stating that she loved him too, that he could also exchange telepathy with his mother, and that he thought of himself as God.

The next day, he was hospitalized at the closed psychiatric ward at Pusan National University Hospital, Busan, South Korea, for psychiatric evaluation and management. Brain magnetic resonance imaging, electroencephalogram, and laboratory examination for toxicology were done to evaluate organic causes, but there were no abnormal findings. A day later, the second day of his stay, he showed restricted affect with reduction of speech volume, and he only answered repeatedly, "I do not know" and "No." He was disoriented about place and person. He showed impaired immediate memory, not replying to repeated questions. His thought content was somewhat grandiose, and he rambled on concrete subjects about equalized education, public education, and praying to God. That evening, he became suddenly paranoid and excited, asking, "Where am I?" and "Why am I here?" while talking on the telephone. On the third day of his stay, his attitude during interview was very aggressive, and he demanded his discharge with a loud voice. Treatment with quetiapine 200 mg/d was started under the suspicion of the possible presence of bipolar disorder and brief psychotic disorder (diagnoses that were subsequently ruled out according to *DSM-IV* criteria). His attitude was continuously aggressive, and his mood was slightly expansive in the appearance and words.

After 1 week of hospitalization, his mood became euthymic and his psychotic symptoms were relieved. He was amnesic about the specific period (from returning to his unit after holiday through talking on the telephone on the second day of hospitalization). He was discharged from the hospital 29 days after admission. He is now serving in the navy and is being followed up in the outpatient clinic once a month. He is maintaining euthymic mood and normal thoughts with quetiapine 200 mg/d. He is performing his duty as a driver well.

In the case presented here, onset of symptoms was very acute, and the patient showed elevated mood, very talkative speech, increased speech tone, and the grandiose feature that he could communicate with telepathy. Until the second day of hospitalization, he was confused and disoriented, with delirious mentality that showed impaired immediate memory. Also, from that evening, he became excited with paranoid delusion, acting out verbally. Accordingly, such a course as this suggests the possibility of delirious mania, judging from the comorbid condition of manic symptoms and delirious state.

Delirious mania shows variable symptoms, from distinctive symptoms of delirious mania such as incontinence, inappropriate toileting, and denudativeness to manic or psychotic symptoms such as labile affect, auditory hallucination, hypersexuality, severe insomnia, and pressured speech. The diagnosis and treatment of delirious mania may be difficult since the severity of symptoms may also be diverse. Our case reported here indicates that the usual mood-stabilizing doses of quetiapine can be a useful therapy for delirious mania, a syndrome very tricky to diagnose and treat.

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Potential conflicts of interest: None reported.
Funding/support: None reported.
Published online: April 29, 2010 (doi:10.4088/PCC.09l00830yel).
Prim Care Companion J Clin Psychiatry 2010;12(2):e1–e2