When the Bell Rings:
Clinical Features of Bell's Mania

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Bell's mania, also known as delirious mania, is a syndrome characterized by the overlap of the symptoms of delirium and mania.[1,2] It is not an infrequent condition, with a prevalence ranging from 15% to 25%.[1,3] Proper diagnosis has important treatment implications. We report a case of a patient with Bell's mania to highlight the main features of this syndrome and the importance of proper diagnosis and clinical management.

Case Report

Ms A is a 72-year-old woman with a history of bipolar disorder type I (*DSM-5* criteria). She was treated in the past with lithium carbonate and more recently was stable with sodium valproate 500 mg/d and fluoxetine 20 mg/d. Additionally, she has a medical history of psoriasis, hypertension, obesity, and monoclonal gammopathy.

In January 2019, she was admitted to the emergency department after being found wandering the streets with incoherent speech. The psychiatric evaluation revealed time disorientation, hostile behavior, irritable mood, increased energy, sleeplessness, impulsivity, loud and rapid speech, and auditory and visual scenic hallucinations. Episodic amnesia of the recent past was also present. She admitted having stopped her medication the week before.

Brain computed tomography scan revealed moderate, slightly asymmetric, cortical temporal and frontal atrophy (more prominent on the left). She had an unremarkable physical examination. However, blood and urinary analysis were compatible with acute renal lesion and urinary tract infection.

She was admitted to our inpatient psychiatric ward due to a manic episode with delirium-like features. Ms A was treated with fosfomycin 3 g, sodium valproate 700 mg/d, quetiapine 175 mg/d, and trazodone 100 mg/d.

During the early hospitalization days, mood swings between dysphoria and depression were evident. She showed a progressive response to treatment and on the eighth day of hospitalization was euthymic with no changes in consciousness. She was discharged with the diagnosis of delirium due to a urinary tract infection (*DSM-5* code F259.0) and bipolar affective disorder, a severe manic episode (*DSM-5* code F296.43).[4] Episodic amnesia for the period before her admission persisted after discharge.

Discussion

Bell's mania is an important syndrome with diagnostic and prognostic particularities. Despite the lack of scientific consensus regarding the clinical criteria for Bell's mania, the Bond-defined delirious mania criteria[5] include (1) acute onset of symptoms, (2) presence of mania, (3) features of delirium, (4) history of mania, (5) family history of bipolar disorder, and (6) responsivity to treatment for mania. Our patient fulfills 4 of the 6 Bond criteria, namely the presence of mania (*DSM-5*), delirium (*DSM-5*), history of manic episodes, and responsivity to treatment for mania. Family history and the acuteness of the situation could not be confirmed, as the patient lived alone. Rather than considering Bell's mania a subtype of mania or even a subtype of delirium, Mann et al[6] classified this syndrome as an independent entity.

With regard to treatment response, these patients can be divided into 2 groups: the first composed of catatonic or autonomically unstable patients and the second of patients without those findings. In the first group, the antipsychotic medication should be discontinued. Electroconvulsive therapy is the first-line treatment, with benzodiazepines being an effective second-line choice.[1,7] Given that our patient did not have catatonic or autonomically unstable features, and since mood stabilizers and atypical antipsychotics are recommended for that particular subgroup,[1,5,8] we chose sodium valproate and quetiapine prescription. In the past, high levels of morbidity and mortality were evident, and their decrease in use over the years is attributed to diagnostic and therapeutic improvements.[8] Regardless of the subgroup, if an organic condition, namely an infection, is present, it should be properly treated.[8,9]

This condition has been described as an extreme and possibly lethal situation.[9] Furthermore, the use of antipsychotics in the first group (catatonic or autonomically unstable) of patients is contraindicated, as it may contribute

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to the delay of appropriate care and can even lead to death. Since antipsychotics are regularly prescribed in acute manic episodes, awareness of patients with catatonic or autonomically unstable features is extremely important.

In conclusion, Bell's mania is an important differential diagnosis for a manic or delirium episode with therapeutic and prognostic implications. Further investigation is necessary to clarify the epidemiology of and appropriate approach to this condition.

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