Pharmacologic and Ethical Considerations in COVID-19 Patients With Mania

Tyler J. Thompson, MD; Kaushal Shah, MD; Amir Gassemi, MD; Emily J. Jennings, MD; and Sahil Munjal, MD

Psychiatric emergencies in COVID-19 patients place a unique burden on the health care system.[1] Many of these patients are on medical floors with psychiatry consultation, posing infection risks to staff and patients that require a balance of nonmaleficence and general welfare. We will discuss 2 patients who were admitted to general medical services with mania and COVID-19.

Case 1

A 51-year-old man with schizoaffective disorder presented to the hospital with mania precipitated by medication nonadherence in July 2021. He was asymptomatic for COVID-19 and tested positive during psychiatric admission screening, requiring admission to a medical floor until his 14-day isolation was complete. No medications for COVID-19 were administered, and he remained asymptomatic. He demonstrated agitation, homicidal ideation, and poor insight into his COVID-19 status with frequent attempts to elope without masking that exposed others to COVID-19. To target his manic symptoms, he was restarted on his home medications of quetiapine 400 mg twice/day and ziprasidone 40 mg twice/day. He was additionally treated with divalproex sodium 1,000 mg twice/day, lorazepam 2 mg 3 times/day, and as-needed intramuscular haloperidol 5 mg. Mechanical restraints were discontinued after the patient was stabilized. As his mania resolved, lorazepam was tapered and discontinued. At the time of discharge, this patient had 2 days of his 14-day COVID-19 isolation remaining, and he demonstrated understanding of both his psychiatric diagnosis and COVID-19 status and was motivated to isolate and mask. He no longer required psychiatric hospitalization and was discharged home.

Case 2

A 24-year-old man with a history of bipolar disorder was diagnosed with mild symptomatic COVID-19 in an outpatient clinic, started on fluoxetine for anxiety, and subsequently presented with mania. This patient required psychiatric admission; however, he was admitted to a medical floor per hospital policy. No medications for COVID-19 were administered. While admitted, he was agitated and paranoid with attempts to elope without masking, exposing others to COVID-19. He required mechanical restraints for 4 days of his admission. His manic symptoms were managed with risperidone 2 mg twice/day, divalproex sodium 500 mg twice/day, lorazepam 1 mg 3 times/day, and as-needed oral and intramuscular haloperidol 5 mg. Restraints were discontinued after 4 days. After completing the 14-day isolation for COVID-19, his symptoms of mania had resolved, and he no longer required psychiatric admission. He was discharged home on divalproex sodium 500 mg daily and 750 mg nightly and risperidone 4 mg nightly.

Discussion

These cases outline the practical and ethical challenges of managing acute mania in COVID-19 patients. Verbal de-escalation remains the first line for agitation, though this can be difficult when wearing proper personal protective equipment and minimizing time in a patient's room due to viral exposure.[2] In COVID-19 or other infectious diseases, a conservative management of mania may risk the spread of infection.[1]

Literature on agitation in patients with COVID-19 encourages the judicious use of medications and avoidance of mechanical restraints.[3] Polypharmacy was preferred for these patients given the severity of their symptoms and risk to others due to COVID-19. Guidelines for the treatment of mania recommend combination therapy with an atypical antipsychotic and a mood stabilizer, such as lithium or valproic acid.[4] In patients with mania and COVID-19, we recommend a triple combination therapy of an atypical antipsychotic, a mood stabilizer, and a benzodiazepine, as used in our 2 cases. For the use of benzodiazepines in acute mania, lorazepam is preferred.[5] In the cases presented here, rational polypharmacy allowed for discontinuation of restraints as quickly as possible, thereby decreasing risk of complications.[6] Both patients' symptoms of mania resolved before discharge.

Benefits of polypharmacy must be weighed against the risk of spreading infection. The patient in case 1 experienced urinary retention and a fall. These side effects were managed with tamsulosin and fall precautions, and his medication regimen was continued.

Treatment of mania in COVID-19 requires a balance of ethical principles including nonmaleficence and justice. Providers should maintain a low threshold for polypharmacy with close surveillance for signs of instability or side effects.

Conclusion

Managing patients with acute mania on medical floors is difficult

under normal circumstances, and with concomitant COVID-19, the balance of appropriately treating their psychiatric condition while mitigating the risk of infection of others becomes more precarious. We propose utilizing rational yet aggressive polypharmacy with a triple combination of an atypical antipsychotic, mood stabilizer, and lorazepam when managing mania in patients with COVID-19 on medical floors.

Article Information

Published Online: September 7, 2023. https://doi.org/10.4088/PCC.22cr03480

Prim Care Companion CNS Disord 2023;25(5):22cr03480

Submitted: December 26, 2022; accepted March 24, 2023.

To Cite: Thompson TJ, Shah K, Gassemi A, et al. Pharmacologic and ethical considerations in COVID-19 patients with mania. *Prim Care Companion CNS Disord.* 2023;25(5):22cr03480.

Author Affiliations: Atrium Health Wake Forest Baptist, Department of Psychiatry and Behavioral Medicine, Winston Salem, North Carolina (all authors).

Corresponding Author: Tyler J. Thompson, MD, 1 Medical Center Boulevard, Winston Salem, NC 27157 (tjthomps@wakehealth.edu).

Relevant Financial Relationships: None.

Funding/Support: None.

Patient Consent: Consent was obtained from the patients to publish the case reports, and information has been de-identified to protect anonymity.

References

1. Mahgoub N, Agarkar S, Radosta M, et al. Inpatient psychiatry unit devoted to COVID-19 patients. *Compr Psychiatry.* 2021;107:152237.
2. Syed S, Couse M, Ojha R. Management challenges in patients with comorbid COVID-19 associated delirium and serious mental illness: a case series. *Int J Psychiatry Med.* 2021;56(4):255–265.
3. Wong AH, Roppolo LP, Chang BP, et al. Management of agitation during the COVID-19 pandemic. *West J Emerg Med.* 2020;21(4):795–800.
4. Yatham LN, Kennedy SH, Parikh SV, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) and International Society for Bipolar Disorders (ISBD) 2018 guidelines for the management of patients with bipolar disorder. *Bipolar Disord.* 2018;20(2):97–170.
5. Bradwejn J, Shriqui C, Koszycki D, et al. Double-blind comparison of the effects of clonazepam and lorazepam in acute mania. *J Clin Psychopharmacol.* 1990;10(6):403–408.
6. De Berardis D, Ventriglio A, Fornaro M, et al. Overcoming the use of mechanical restraints in psychiatry: a new challenge in the everyday clinical practice at the time of COVID-19. *J Clin Med.* 2020;9(11):3774.