Lysing Catatonia to Uncover the Driving Illness:

An Alternative Diagnostic Perspective on Bell's Mania

To the Editor: I commend Forster et al[1] for presenting a complex case of an adolescent with catatonia in the context of acute stress. I would like to offer an alternative diagnostic perspective regarding the evolution of symptoms described.

Forster et al[1] report an adolescent with no prior psychiatric history who developed catatonic features after an acute academic stressor. The authors interpret the course as catatonia evolving into Bell's mania with a complicated treatment course. However, the report notes initial improvement in catatonic symptoms after lorazepam. A few days later, he re-presented to the emergency department with impairments in activities of daily living. At that juncture, an alternative conceptualization is persistent/refractory catatonia or an unresolved underlying disorder that drove the initial catatonic syndrome.[2] Catatonia is a transdiagnostic syndrome rather than a discrete primary disease.[2] Although catatonia can be lysed with lorazepam and/or electroconvulsive therapy (ECT), failure to address the underlying etiology leaves the primary disorder driving the catatonic syndrome untreated.[3] This sequence appears to have occurred in this case: Despite escalating catatonia-directed therapies (increased lorazepam, amantadine, and multiple ECT sessions), the patient subsequently developed symptoms of an acute manic psychosis. Cases of psychosis emerging following the lysis of catatonia have been previously reported.[4] The authors interpret this evolution as Bell's mania; however, the report does not describe any features of altered consciousness or disorientation required for diagnosis.[5,6] The emergence of psychosis with manic features after partial lysis of catatonia more parsimoniously suggests an underlying bipolar diathesis presenting with acute mania. Bipolar disorder is the most frequent psychiatric cause of catatonia, particularly during manic episodes.[3] This interpretation is supported by the patient's subsequent improvement with antipsychotic treatment.[7]

It is important to emphasize that identifying the underlying etiology of catatonia is critical; cases such as this illustrate how a focus on the phenomenology of the syndrome can overshadow the primary psychiatric diagnosis. While not stated explicitly, each of the patients described in the report by Bond[5] exhibited features of catatonia during their illness course. Remarkably, treatment targeting manic psychosis with an antipsychotic and a mood stabilizer achieved rapid improvement. The absence of any prior cases of manic psychosis with features of delirium in the adolescent population warrants the question of whether disorientation is truly a syndromal feature in the context of mania or whether it represents an independent concomitant delirium syndrome in older patients presenting with acute mania. While it is well understood that delirium cannot be directly attributable to a psychiatric illness, it is evident that acute mania predisposes to circadian rhythm changes that would precipitate delirium.[8,9] A close review of published cases may help answer this.

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