MANIC STUPOR

Sir,

The differential diagnosis of stupor is extensive, and includes both medical causes (e.g. drug intoxication, brain tumors) and psychiatric causes (e.g. depression, schizophrenia). While mania is classically characterized by increased psychomotor activity, the syndrome may very rarely manifest as stupor. We illustrate our point with a case report.

CASE REPORT

Mr. AR, a 24-year-old carpenter, was brought into treatment for first-episode psychiatric illness. According to reports, AR's altered behaviour began suddenly, 2 days earlier and comprised hostility towards all and sundry, prolonged spells of shouting and abusiveness, mindless violence, almost total absence of sleep, and refusal of food. There was no past, personal, or family history of significance in medical and psychiatric domains. There was no history of drug or alcohol use, head injury, sezures, or any other medical antecedent.

Mental status examination was conducted with AR under physical restraints. AR was observed to be dirty, dishevelled, restless, and markedly hostile. He did not speak spontaneously, and attempts to converse with him met with streams of profanity. No useful clues could be obtained about his thoughts.

The syndromal diagnosis made was one of catatonic excitement, secondary to an unspecified psychotic process. AR was treated with parenteral haloperidol. Physical examination, conducted before and repeated after sedation, was within normal limits.

AR received a total of 40 mg of intravenous haloperidol during the first 24 hours. The next morning, the nursing staff reported that he could not be roused. On examination, he was found lying unresponsive, with his eyes shut. He vigorously resisted attempts to raise his eyelids or move his limbs. Physical examination, conducted with these restrictions, revealed no abnormality. His medication (haloperidol) was stopped and a hemogram, serum electrolytes, blood sugar, renal function tests, liver function tests, EEG, ECG, and CT scan were carriedout ; all were normal.

Late during the day, AR broke into a sudden fit of screaming. He jumped out of bed and violently overturned a trolley of drugs. He was overpowered while menacing another patient. He was again restrained. No medication was administered. Later, and during the next day as well, he continued to lie in catatonic stupor. He had to be fed through a Ryle's tube, and needed catheterization to drain a distended bladder.

AR was treated with electroconvulsive therapy (ECT) and rapidly responded to 6 bilateral treatments administered thrice weekly. Early during the first week of ECT, clear cut manic symptoms were uncovered as the stupor remitted. These symptoms included elated mood, pressure of speech, flight of ideas, and grandiose ideation. Interviews at this stage revealed that, during the phase, of catatonic stupor. AR had experienced profound happiness and dreams of great deeds; these had been so intense, indeed, that he had been wholly immersed in his thoughts, and had been no desire to move. The diagnosis was revised

to mania, with manic excitement and manic stupor dominating the initial presentation.

Lithium and antipsychotic medication were commenced at the end of the ECT course and AR was discharged in a mildly hypomanic state. During follow-up, AR experienced one more manic episode and one depressive episode one and three years after the index admission; these confirmed the diagnosis of bipolar illness.

The unusual feature of this case was the development of manic stupor. Although this condition is described in classical texts (e.g. Hamilton, 1974), in clinical practice most psychiatrists never see a case in their lifetime. It is seldom easy to make the diagnosis prospectively. Usually, several differential diagnoses are entertained, including neuroleptic malignant syndrome, for such patients have often received neuroleptic drugs. The stupor ultimately resolves either spontaneously or with the help of antipsychotic drugs, benzodiazepines, or ECT, and the diagnosis of manic stupor is restrospectively made once the stupor remits and the manic symptoms are uncovered.

Descriptions of manic stupor are very rare, the most recent being those by Fink (1999); none have appeared in Indian literature. What is notable about the present case is that the stupor was prolonged (it lasted more than two days), and a theme of ecstasy, rather than delirious behaviour, predominated.

REFERENCES

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CHITRANJAN ANDRADE, MD Additional Professor, Department of Psychopharmacology, NIMHANS, Bangalore-560029 & N SANJAY KUMAR RAO, MD MRC Psych., Specialist Registrar, Liaison Psychiatry Mental Health Unit, Royal Victoria Infirmary Newcastle-upon-Tyne, NE128AG, U.K.* ****Correspondence***