A Case of Delirious Mania with Excited Catatonia Complicated by Acute Gabapentin and Valium Withdrawal

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Introduction

● Delirious mania (DM), where both delirium and mania occur at the same time, is a life-threatening medical emergency that remains under diagnosed, in part due to its rarity.

● DM is not its own DSM-V diagnosis, but separately meets criteria for mania and delirium without an underlying medical disorder.1

● DM will have a negative medical and neurological workup.3

● Catatonic features reported in multiple cases of DM.2

● Excited catatonia (EC), with extreme, purposeless stereotyped movements, autonomic instability, latter is harbinger of lethality.4

It is imperative to further understand the phenomenology of DM and EC to provide immediate and aggressive medical management, in order to mitigate further clinical impact on these afflicted patients. Furthermore, early intervention is integral because of the high mortality associated with DM and EC, given the subacute nature of this syndrome, seen to be from three to six weeks.6

Case Presentation

49 year-old Caucasian female with Bipolar I Disorder:

• Found by police in parked car at local gas station, “talking to self”, oriented x 1 (self), word salad-like speech.

• Arrived to ED via EMS. Admitted to psychiatric inpatient unit.

• Pertinent Positive Findings:
  - Pressured speech, elevated, irritable, flight of ideas.
  - Grossly disorganized, responding to internal stimulus, neologisms, word salad, rambling, difficult to redirect.
  - Purposeless stereotyped movements, shuffling gait, psychomotor agitation, echolalia, echopraxia, tachycardia
  - Initiated Zyprexa 10 qhs and Depakote 500 mg BID
  - After 4 days, no improvement noted. Patient continued to be grossly manic, delirious, and with catatonic features.

• Performed organic delirium workup with negative results:
  - Imaging studies unremarkable. CRP, CMP, TSH, RPR, Lyme, HSV IgM, B12 and Folate unremarkable. Ammonia slightly elevated.

• Initiated Rexulti, Gabapentin 800 mg QID, Valium 10 mg QID

• No prior psychosis, no hospitalizations in years, compliant

• Ativan PRN prior to MRI brain.

• Found to have transient improvement in symptoms

• Per outpatient psychiatrist:
  - Rx: Rexulti, Gabapentin 800 mg QID, Valium 10 mg QID

• Ativan switched to Klonopin and up-titrated for acute agitation.

• Zyprexa switched to Geodon 40 mg, and then Invega 6 mg qd.

• Patient hospitalized for 20 days, with some signs of gradual symptom improvement, but not yet stable, nor at baseline.

• Patient transferred to long-term care facility for continued care.

Discussion

● Presence of altered mental status in the setting of an acute manic episode should give high suspicion of DM.5

● In DM, delirium usually resolves prior to mania.4

● DM can cause prolonged mania and thus, longer hospitalization.3

● DM, especially with EC, associated with high morbidity and mortality, predominantly due to cardiovascular complications.3,4

● Catatonia highly responsive to high dose Ativan and ECT. Typical antipsychotics or anticholinergics should be avoided. 3,4

Conclusion

It is imperative to further understand the phenomenology of DM and EC to provide immediate and aggressive medical management, in order to mitigate further clinical impact on these afflicted patients. Furthermore, early intervention is integral because of the high mortality associated with DM and EC, given the subacute nature of this syndrome, seen to be from three to six weeks.6

References


