

**Acute onset mania with cycling between excitement and stupor**

Sir,

Mania is commonly characterized by motor activation that can sometimes peak in extreme excitement and depression by retardation that can sometimes peak in a state of stupor. Paradoxically, stupor may (rarely) complicate mania; although this was recognized by Kraepelin over a century ago,\[1\] down the decades, cases of manic stupor have seldom been described in literature.\[2,3\] We present herein two patients who experienced stupor associated with mania; our cases are interesting in that the onset of excitement and the switch to stupor was abrupt in both cases; one patient, additionally, showed cycling between excitement and stupor.

**CASE REPORTS**

**Case 1**

A, 22-year-old farmer, had a 6-day history of irritable mood, loud and excessive talk, excessive and unnecessary spending, excessive working in the fields without experiencing fatigue, increase in appetite, and decrease in sleep. He boasted of divine powers and the ability to change the future. Aggressiveness developed, abruptly followed by reduced communication. By the 5th day, he stopped talking, stared mutely, refused food, and even neglected bowel and bladder needs.

There was no history of head injury, fever, or any other past or present feature to suggest a medical origin of these symptoms. General medical examination and laboratory investigations, including hemogram, serum electrolytes, and hepatic and renal function tests, were all within normal limits.

The patient was mute and immobile. He maintained eye contact without blinking. Other catatonic signs at different points in time included negativism, posturing, grimacing, verbigeration, rigidity, automatic obedience, and stereotypy. He required nasogastric feeding and urinary catheterization. The Bush–Francis (BF) Catatonia Rating Scale score was 22. The dominant clinical picture was one of stupor.

Parenteral lorazepam at 8 mg/day for 3 days elicited no improvement. Thrice weekly, bilateral electroconvulsive therapy (ECT) was initiated. There was progressive improvement from the first ECT with resolution of catatonia by the third treatment; manic symptoms, however, reemerged. On inquiry, he reported that during the period of stupor, he was blissful, disinterested in worldly matters, and in close contact with God. He described experiences related to Hindu mythology. His Young Mania Rating Scale (YMRS) score was 31.

Valproate and quetiapine were initiated, and ECT was continued to a total of six treatments. He was discharged in almost complete remission after a hospital stay of 16 days.

**Case 2**

B, a 31-year-old peon, had a 5-day history of grandiosity with claims such as that he could become the Prime Minister...
and change the world. He was irritable, talked excessively, participated intensely in activities, and slept little. After 3 days of such behavior, there was an 18–20 h period of mutism, laughing without reason, and food refusal; manic symptoms subsequently reemerged in greater force. He spent or gave away large sums of money, became agitated and aggressive, and eventually required physical restraint. His YMRS score was 38.

He was treated with parenteral haloperidol and (oral) valproate. One day later, he again stopped talking and refused food and water. Other catatonic signs included rigidity, negativism, grimacing, posturing, and immobility; the dominant clinical picture was one of stupor. His BF score was 18. Ten hours later, mania spontaneously reemerged. Upon inquiry, the patient reported that during the period of stupor, he was in a state of delight and believed that he had vast sums of money and held a high position in society.

Medical history, physical examination findings, and laboratory investigations, etc., were all unremarkable as with Case 1. Stupor did not recur, and the patient was subsequently managed with lithium and quetiapine and was discharged in almost complete remission after 20 days of hospital stay.

**DISCUSSION**

Devine\(^2\) reported what may be one of the earliest cases of manic stupor on record; the case description, however, is merely one of catatonic symptoms associated with possible mania, with no description that would lead to a definitive diagnosis of mania, or of stupor as a clinical feature. The earliest report of manic stupor in Indian literature appeared in 2001.\(^3\)

Our first case is rare but not exceptional. Manic stupor is unlikely to develop de novo and so is likely to be preceded by manic excitement of varying intensity. Our second case, however, is unusual in that we have found no report in literature of bipolar patients who rapidly and spontaneously fluctuate between manic excitement and manic stupor as did this patient.

Could the patients have experienced a mixed mood state with fluctuation between manic excitement and depressive stupor? We do not think so because, during the periods of stupor, the mood and thoughts of both patients were clearly characteristic of a manic syndrome.

On a concluding note, in ICD-10, manic stupor is specifically included under mania with psychotic symptoms (F30.2); in DSM 5, manic stupor is not listed as such but would be classified under mania using “with catatonia” as a specifier. The diagnosis, however, should be made only after ruling out medical causes of catatonia, including the neuroleptic malignant syndrome in patients who have received antipsychotic medication.

**Financial support and sponsorship**

Nil.

**Conflicts of interest**

There are no conflicts of interest.

**Mohapatra Debadatta, Sahoo Ashrumochan\(^1\), Chittaranjan Andrade\(^2\)**

Department of Psychiatry, All India Institute of Medical Sciences, Bhubaneswar, \(^1\)Department of Psychiatry, SCB Medical College, Cuttack, Odisha, \(^2\)Department of Psychopharmacology, National Institute of Mental Health and Neurosciences, Bengaluru, Karnataka, India.

E-mail: 2000debee@gmail.com

**REFERENCES**

1. Krasuski J, Janicak P. Mixed states: Issues of terminology and conceptualization. Psychiatr Ann 1994;6:269-76.
2. Devine H. A case of manic stupor. Br J Psychiatry 1912;58:320-3.
3. Andrade C, Rao NS. Manic stupor. Indian J Psychiatry 2001;43:285-6.