LETTERS TO EDITOR

MANIC STUPOR OR STUPOR RESULTING FROM TREATMENT OF MANIA?

Sir,

Dr. Chittaranjan Andrade shared a case in a letter to the editor in the July 2001 issue of Indian Journal of Psychiatry (Andrade, 2001) and he, as proposed by Dr. Fink (Fink, 2001) must be congratulated for bringing this treatable, life threatening condition to the notice of psychiatric fraternity and we must also thank Dr. Fink for giving guidelines to manage excited manic patients in the same letter. But confusion lingers regarding the two letters mentioned above. The same symptoms which Dr. Andrade has proposed to present as symptoms of manic stupor in the given case has been explained on the basis of neurotoxicity by Dr. Fink. These are mutism, negativism, and probably rigidity. The explanation proposed by Dr. Fink seems to be more plausible as the symptoms seem to be anti psychotic induced.

The discussed case had an excitatory psychosis and was provisionally diagnosed as catatonic excitement, secondary to an unspecified psychotic process, which was later on retrospectively, was revised to a diagnosis of mania when patient was more communicable and cooperative. He was given a total of 40mg of intravenous Haloperidol during the first 24 hours after which he developed the above-mentioned symptoms. Later during the day he had an occasion of "breakthrough excitement" which was considered as a point in favour of diagnosis of mania (personal communication with Dr. Chittaranjan Andrade).

Though NMS was ruled out and there is no doubt of mania being the diagnosis in this case (personal communication with Dr. Chittaranjan Andrade), still patients with such acute excited states which have been variously described as Bell's mania, manic delirium, delirious mania, catatonic mania and oneiroid state (Fink, 1999) are prone to neurotoxic state induced by parenteral administration of high potency antipsychotics and when this state is accompanied by fever and autonomic instability, the syndrome is labeled "neuroleptic malignant syndrome", a type of malignant catatonia (Fink, 1996). This patient seems to have suffered from a similar neurotoxic state though not having NMS.

REFERENCES

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'Correspondence Response

MANIC STUPOR: DIAGNOSIS AND TREATMENT

Sir,

The confusion alluded to can be best resolved through the explanation that catatonic stupor is a syndrome of differing etiologies. All physical examinations and laboratory investigations in our patient resulted in normal findings. There was no evidence of hyperthermia, autonomic instability, and other characteristic features of the neuroleptic malignant syndrome (NMS).

Might the stupor, instead, have comprised
a hypothetical neuroleptic-induced neurotoxic state of a nature different from the NMS? It is very unlikely why would neuroleptic-induced neurotoxicity suddenly give way to catatonic excitement and then return the patient to a state of stupor? A patient experiencing a drug-induced state of suppression would be expected to remain in the state of suppression until the effect of the drug wore off; thereafter, he would be expected to remain in the recovered state.

These arguments underline our contention that our patient exhibited manic stupor not as a neurotoxic process but as a rarely seen phenomenologic variant of the manic syndrome. As the patient himself expressed it, during the phase of stupor he experienced profound happiness and dreams of great deeds which were so intense that he was totally immersed in his thoughts and had no desire to move.

On a theoretical note, did our patient suffer from a catatonic excitement which placed him at risk of neuroleptic-induced neurotoxicity? And, as Fink (2001), suggested, should we have eschewed haloperidol in favour of benzodiazepines to contain his excitement? I respectfully submit that there is no empirical evidence that all excited patients are at risk of neuroleptic-induced neurotoxicity. It is conceivable that, just as catatonic stupor is a heterogeneous syndrome, catatonic excitement is likewise heterogeneous. Neuroleptics may be potentially harmful in certain excited states but not in others; if so, these states require empirical characterization. It is also conceivable that neuroleptics may be potentially harmful in the presence of certain variables such as dehydration (Fink, 2001); if so, these risk variables also require identification. Regrettably, the field of catatonia is still a murky area.

As a final note: Bell’s mania, manic delirium, delirious mania, catatonic mania, lethal catatonia, and oneiroid states are not necessarily synonymous. These syndromes were described by different authors at different points in time. No author differentiated this syndrome from the other descriptions.

REFERENCE

Fink, M. (2001) Treating manic stupor, Indian Journal of Psychiatry, 43, 286-287.

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