Psychiatria Danubina, 2025 Vol. 37, No. 2, pp 254-256 https://doi.org/10.24869/psyd.2025.254 *Case Report*

Bell's mania: Is this concept still valid? A case report.

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INTRODUCTION

Delirious mania (DM) or Bell's mania is a severe condition combining mania, psychosis, and delirium (Lee et al., 2012), with sudden onset of insomnia, disorientation, confusion, bizarre hallucinations, delusions, and emotional instability.

DM was described by Calmiel (1832) who related a psychiatric syndrome of sudden onset with excitement, psychosis, hyperactivity, fear, which were transformed into stuporous exhaustion (Karmacharya et al., 2008). Bell (1849) reported inpatients with melancholia, mania, talkativeness alternating with mutism, tachycardia, hypertension and fever, which could fluctuate during the day. He reported a 75% mortality rate, and patients had little or no memory of the episode after recovery (Bipeta & Khan, 2012). Even though considered rare, its incidence ranges from 15% (Jacobowski et al., 2013) to 35% (Ritchie et al., 1996) across reports.

Several authors have been describing particularities of DM. Griesinger (1867) highlighted anxiety as the main symptom; Kraepelin (1921) included DM as a subtype of mania. Similarly, Klerman (1981) included DM as a final stage of mania within a dimensional model for mania classification. Fink and Taylor (2001) stated DM as mania episode plus disorientation and obnubilation; the presence of hyperactivity, disorganization and stereotypies make them to suggest DM as subtype of catatonia.

Although the concept of "delirious mania" has evolved since the first descriptions, so far there is no consensus about its clinical characteristics and is not included in the manual diagnostics. Most of the literature comes from case reports and there are few of them described in Brazil. We aim to report a case of DM to provide more information on this condition, described since 1832, although absent from current diagnostic guidelines.

CASE REPORT

We report a 42-years-old, Brazilian man, single, principal in a junior high school, with no family psychiatric history. His personal history includes a controlled hypothyroidism and a major depression episode in 2017, treated with escitalopram 15 mg/d.

Two months before his admission he presented a significant activation, irritability, impulsiveness and increased productivity that lasted one week; so, escitalopram was discontinued and introduced lithium carbonate 600 mg/d. He had no improvement and ten days prior hospitalization, he became sleepless, talkativeness, with psychomotor agitation, disorganized behavior and persecutory delusions. His medication was changed for divalproex sodium (500mg/day), risperidone (1mg/day) and clonazepam (2mg/day). However, his symptoms worsened, when he was admitted to a psychiatric inpatient unit.

On admission he was awake, apprehensive stance, globally disoriented, lethargic and unable to sustain attention. He presented a perplexed face; affective distance and his speech was slow and tangential, preventing us to assess delusions and hallucinations, at that time, but we did not observe behavior suggestive of hallucinations and absent insight. He scored 25 at the Young Mania Rating Scale, on the following items: sleep (4), irritability (4), language (4), content (6), appearance (3) and insight (4).

Besides mania episode, we thought in hypoactive delirium and performed a clinical workup (full blood count; full chemistry; liver and thyroid function tests; urinalysis; C-reactive protein; syphilis and human immunodeficiency virus serology; electrocardiography; chest x-ray; and CT scan of the brain); and neurological evaluation, which revealed preserved on motor and sensory skills, reflexes, 12 cranial nerves functioning, balance and coordination. His clinical evaluations were normal, refuting the hypothesis of delirium. On admission lithium carbonate 600 mg/day was introduced.

We increase the lithium carbonate to 900 mg/day on the 4th day. Over the 6th day he showed unsystematized persecutory delusions, became hostile and refused to eat,

so we introduced haloperidol (5mg/d). There was a steady improvement throughout the hospitalization. By the 9th day, the patient was fully oriented, exhibited a significant reduction in hostility, resumed eating, and communicated with a linear but slowed speech, without any signs of delusional thinking.

On the 12th day, he achieved full recovery, using haloperidol 5mg/d and lithium carbonate 900 mg/d. However, he had few and fragmented memories about the episode. After 14 days he was discharged.

Given the presence of mania followed by delirium plus negative clinical screening, we suggest the hypothesis of DM for this patient.

DISCUSSION

Delirious mania was described by Bond with the following characteristics: (1) acute onset with or without irritability, insomnia or emotional withdrawal; (2) presence of hypomania or mania; (3) development of delirium symptoms; (4) past history of depression or (hypo)mania; (5) family history of bipolar disorder; and (6) response to treatment for mania. These characteristics have been observed by other authors, having been suggested as a diagnostic guide (Bond, 1980). Although Bell's mania is not included in current diagnostic guidelines, the simultaneous presence of mania and delirium have been used as clinical indicators (Jacobowski et al., 2013; Lee et al., 2012).

Since Bell's description, the conceptualization of delirious mania has been discussed within bipolar disorder, as a subtype of catatonia and even as a hyperactive delirium (Kendirlioglu et al., 2023). In fact, the main diagnostic confounder remains the delirium. Therefore, the diagnosis of delirious mania should be done after a negative clinical evaluation (Karmacharya et al., 2008).

Our patient presented rapid progression to mental confusion, leading us to consider differential diagnoses; the absence of signs of catatonia excluded such diagnosis. All clinical screening was negative, refuting the hypothesis of delirium. Regarding diagnosis, our case is in line with the previously reported (Bell, 1849; Bipeta & Khan, 2012; Bond, 1980; Jacobowski et al., 2013; Karmacharya et al., 2008; Lee et al., 2012; Mash, 2016) reinforcing the suggestion of DM.

Delirious mania had been successfully treated with a combination of lithium carbonate and haloperidol. Currently, the usual treatment for mania is recommended, with mood stabilizers and second-generation antipsychotics (Jacobowski et al., 2013), considering benzodiazepines and electroconvulsive therapy for patients with fever, tachycardia, hypertension, and muscle rigidity (Jacobowski et al., 2013; Kendirlioglu et al., 2023; Lee et al., 2012).

The case we presented was similar with the Bell's and Bond's descriptions, including the treatment response. Actually, the patient fulfilled five of the six criteria proposed by Bond (Bond, 1980), above listed as (1), (2), (3), (4) and (5).

The controversies in the DM literature precludes the establishment of consensus diagnostic. Therefore, all clinicians should consider Bell's mania diagnosis when faced with the combination of mania and delirium. Accurate diagnosis favors long-term management and can help prevent recurrences of the disorder.

CONCLUSIONS

Delusional mania remains a diagnostic challenge and it is still underdiagnosed. We believe that its inclusion in diagnostic guidelines could help its recognition. Considering that its presentation follows a relatively characteristic course, we suggest that any patient with mania rapidly progressing to delirium should be considered delirious mania. Additionally, the Bond's criteria proved been useful to guide diagnosis.

List of abbreviations

Delirious mania: DM

Ethical Considerations: Does this study include human subjects? YES

Authors confirmed the compliance with all relevant ethical regulations.

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