Reviewer's report

**Title:** Clinical Features of Delirious Mania: A Series of Five Cases and Brief Literature Review

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**Reviewer:** Mark Detweiler

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Clinical features of delirious mania: a series of five cases and brief literature review.

- Major Compulsory Revisions

The authors report five cases of delirious mania and compare these to other cases in the literature. The authors have done an excellent job of summarizing the features of the their five patients alongside some of the other cases of delirious mania in their extensive tables.

The authors stated goal (page 4, 2nd paragraph) is “providing additional information about the diagnosis and treatment for delirious mania which could be helpful to clinician and researchers alike”. With their substantial comparison of cases, a brief literature review is not ideal as it requires that the readers to analyze the reported data in order to assess whether the tabulated data presented do or do not provide any new insights about delirious mania. To make the manuscript more contributory to the literature, the authors should consider a more thorough literature review to compare and contrast their data and then present any new findings gleaned from their five cases.

In many cases medication doses, days on each medication prior to change were not included. This does not allow the reader to follow the treatment decisions and also assess the risk of neuroleptic malignant syndrome or drug toxicity in the differential diagnosis of each case.

Methods: the authors need to supply the specific details of their literature search including the key words used.

Case 1:

Second paragraph, sentence 2: “…he presented with delirium and mania at the same time…” Are the authors implying that the delirium and mania started concurrently or that this was the point along the disease course and make no assumptions about disease course prior to presentation?

When the patient was transferred to another hospital, what treatment was given?

What were the medications 2 months after discharge?
Case 2:
3rd sentence: “… haloperidol, 2 mg to 5 mg /day;” Was this as needed or scheduled?

Please explain the medications scheduling including the quetiapine dose.

What was the full medication list when the patient was discharged in “partial remission”?

Case 3:
2nd paragraph: please enter bupropion and olanzapine doses.

Please add doses of paroxetine and lithium.

What was the final discharge list of medications?

Case 4:

Was the initial mania secondary to the prodrome of the aspiration pneumonia and respiratory failure? The case for delirious mania in this case appears tenuous. Consider rule out of delirium due to general medical conditions with catatonic symptoms. This merits more information for clarification

Paragraph 3 first sentence: “…aripiprazole 10 to 15mg/day..”, what was the dose?

Case 5:

Paragraph 2, sentence 6: “…left upper weakness, but he totally recovered when he was admitted to the hospital with no exact information of lesion of cerebral infraction”. This sentence is unclear. Please include doses, days on each medication and medication form (e.g., immediate release, extended release) for aripiprazole, paroxetine, valproate and quetiapine.

Was the patient’s drug compliance poor prior to and after the intracranial hemorrhage?

Discussion

Have all ages in the same decimal notation: e.g., 38.86 years should be 39 years as all other ages have no decimal notation.

Paragraph 2, last sentence: “this might suggest…for pure delirium”. There is ample literature supporting this. Suggest a broader literature review for an evidence based observation.

Paragraph 3, first sentence: include the references for the four patients noted for other studies.

Paragraph 3, sentence 4: the authors need to cite relevant literature for an
evidence based observation.

Paragraph 3, sentence 11: “All these reports seem to support …reported [4].” It is well reported that the disease course of delirious mania that usually begins with hypomania and progresses to mania and then to delirious mania; thus, speculation on this fact is not instructive.

Paragraph 3, sentence 12: As in the preceding sentence, this sentence can be removed as there is ample literature (using names other than "delirious mania") describing the course of delirious mania both treated and untreated.

Paragraph 4, fist sentence: Without careful documentation of the medication doses, the number of days on each dose, with the lack of washout times between changing multiple doses of medications of questionable strengths, the statement suggesting an absolute rule out of possible NMS would require more information for the reader to comprehend the conclusion.

Specific clinical symptoms:
Paragraph 1, sentence 6: “Some of …distinct symptoms”. Please clarify and be specific.

Paragraph 2, sentence 5: “…more than the upper limit of the dose…” Have you ruled a factor of medication toxicity as described by Fink and Taylor? Polypharmacy especially with psychiatric medications it is one the primary causes of delirium?

Paragraph 2, sentence 6: “Unlike …these symptoms”. As stated, the sentence gives no information to the reader. Please make it specific.

- Discretionary Revisions

Case s 1 and 4:

The use of lorazepam 4 mg at night as a hypnotic may have muted the mania symptoms based on existing literature findings. This role of lorazepam in treatment is mentioned in the discussion; its role in case outcome may merit additional discussion.

Case 3:

4th paragraph: having depression emerge during ECT for mania or delirious mania is not uncommon. Consider some discussion of this with references in the discussion section.

Case 4:

First sentence paragraph 2: suggest adding …obvious manic and catatonic symptoms of …".
With a 15 year history of bipolar disorder and 4 previous hospitalizations for manic episodes, the risk of delirium of this 50 year old patient is greatly increased due to the brain changes documented for bipolar patients (Psychiatric Annals February 40;2010); i.e., the brain age of this patient is may be equivalent to that of a geriatric person. Thus the risk of delirium due to incipient pneumonia is highly probable. The question that may merit attention, as the authors are discussing the role of age in delirious mania, is how vulnerable is the aging bipolar, schizophrenic or schizoaffective disorder patient’s brain to delirium and delirious mania?

Discussion
The authors have not make any mention about the differences in presentation and treatment, using the proposed nosology of Fink and Taylor mentioned in the text, of their cases regarding the differences between non-malignant delirious catatonia versus malignant delirious catatonia (vedi Van Den Eede et al. 2005).

Treatment
Paragraph 1, sentence 4: “…mania switched to depression…”. Here is where this clinical phenomenon of switching from mania to depression during ECT may merit some discussion with references.

Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:
I declare that I have no competing interest