Reviewer's report

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

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Reviewer: William Bobo

Reviewer's report:

The authors present a revised case series and selective literature review, the objective of which is to describe the clinical features, course and treatment of delirious mania.

• This report continues to address a topic of clinical importance, and one that would be of interest to the journal readership.
• The cases more clearly illustrate the clinical challenges in identifying and treating delirious mania.
• The introduction and discussion are much improved, and the section headers are helpful. The historical notes added to the discussion are interesting and appreciated. The discussion now tracks the evolution of the concept of delirious mania, including its confusing history. However, the exact objective of the paper still needs to be more clearly stated, and several statements in the discussion need to be defended more robustly.
• The authors have been responsive to reviewer comments, and manuscript is clearly improved. I hope that the suggestions provided below will be helpful for further revision.

Major Compulsory Revisions:

1. Introduction: the objective of the paper is now provided. As it reads, the objective was “to provide additional information about delirious mania and to clarify this challenging disorder using different assumptions that could be helpful to clinicians and researchers alike.” What exactly is meant by “clarify(ing)” delirious mania, and exactly what “assumptions” are being referred to? I think that the cases do a nice job of illustrating the core features of delirious mania and highlight several challenges in recognizing and treating the syndrome. Perhaps the discussion provided can aid clinicians in recognizing and appropriately treating the syndrome as early as possible, before it progresses to its malignant form.

2. Methods, inclusion of cases: Why exactly was it necessary to select only cases with a history of bipolar disorder? If patients satisfied diagnostic criteria for mania and delirium simultaneously and no organic cause could be found, would this have sufficed? If the implication is that delirious mania is a presentation of bipolar disorder, this should be defended in the discussion. The conclusions
seem to state otherwise (that delirious mania is best regarded as being separate from mania).

3. Case reports: The case reports are improved. The clinical rationale for the diagnosis of delirious mania is now provided in the discussion. However, for each case, please take extra care to clearly illustrate (perhaps by describing separately) the features of delirium and mania (and catatonia where they occur). These critical points are still not always clear.

4. Discussion:

(a) The authors argue that delirium is the core feature of delirious mania, but the rationale is unclear. If a patient presented with delirium and no mania, one would also not often initially consider delirious mania. Additionally, why would it be more important to identify delirious mania for life-threatening delirium, not mania. If a patient with mania presents with catatonic signs and vital sign instability in absence of overt delirium, why would this be of lower priority?

(b) The argument that delirious mania should not simply be considered as an acute presentation of bipolar disorder only is well-defended. One of the distinguishing features, the more rapid onset of mania and psychosis (hours to days) in delirious mania than with bipolar mania (weeks), is mentioned, but only in passing. More details about this clinical clue should be provided.

Minor Essential Revisions:

5. Abstract: Abstract: consider simply stating that delirious mania is a severe and potentially life-threatening neuropsychiatric syndrome characterized by the simultaneous and acute onset of mania and delirium, for which no organic or toxicological cause can be found. In the methods section of the abstract, consider simply stating that you describe five cases of delirious mania admitted to an acute inpatient psychiatric unit between January 2005 and January 2007; and that a discussion of the case material is provided in the context of a selective review of the clinical literature describing the clinical features and treatment of delirious mania.

6. Discussion:

(a) Karmacharya’s paper is cited, wherein some more specific signs that may distinguish delirious mania from other syndromes are presented. Many of these are catatonic signs. It may be important to note that catatonic signs can also complicate mania, in absence of delirium.

(b) More attention is now paid to catatonia as a potential complication of delirious mania. Two points:

-- first, I am not sure that malignant catatonia, NMS and serotonin syndrome are completely synonymous. Malignant catatonia is diagnosed when catatonia is accompanied by autonomic instability and hyperthermia. Perhaps NMS and serotonin syndrome are subtypes of malignant catatonia?
-- second, assuming that delirious mania is sometimes accompanied by catatonia, what are the clinical implications? How might this influence treatment decisions other than to consider ECT earlier? Should antipsychotics be withheld initially, at least until the catatonia resolves?

Discretionary revisions:

7. Discussion: Table 3-1 is confusing and only summarizes what is already presented in the case reports. This table can be deleted.

8. Limitations: Consider stating--the cases illustrate the challenges to be encountered in real-world clinical care of patients with delirious mania; however, the diagnostic workup procedures and criteria for selecting and sequencing treatments were not uniform for each case.

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

Quality of written English: Needs some language corrections before being published

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

Declaration of competing interests:

In the last five years, I have received research support from Cephalon, Inc., and served on speaker bureaus for Pfizer, Inc., and Janssen Pharmaceutica.