Editöre mektup / *Letter to editor*

Delirian mania represented with catatonia in an adolescent
(Katatoni ile gelen ergen deliran mani olgusu)

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To the Editor,

Catatonia is a neuropsychiatric syndrome and diagnosed by the presence of three or more of the following symptoms: stupor, catalepsy, waxy flexibility, mutism, negativizm, posturing, mannerism, stereotypy, agitation, grimacing, echolalia and ecopraxia.[1] Although the etiological factors of catatonia not clearly defined, several medical, neurological and psychological factors such as endocrine abnormalities, infections, electrolyte inbalance, epilepsy, travmatic brain injury, schizophrenia, mood disorders, autism spectrum disorders, mental retardation, antipsychotic medications are associated with catatonia.[2,3] As in DSM-IV-TR, catatonia is a subtype of schizophrenia, ın DSM 5, catatonia is defined as a separate diagnostic entity. In this report, we discuss 14 year-old girl who presented with catatonia.

A 14-year-old girl admitted to our outpatient clinic with her parents. The patient exhibited symptoms of not eating, not talking, not moving, crying and laughing by herself, having irritability and insomnia for two days. In Psychiatric examination, she has age appropriate clothing, poor eye contact. She never spoke along the interview, her mood was irritable, as affect was labile. Based on the family report, patient's intellectual function was border level. In psychiatric history, there was only one psychiatric outpatient clinic admission with psychotic symptoms six months ago. She had used antipsychotic medication irregularly in short term. The last application, she has not used antipsychotic medication for a long time. In medical history, she has no neurologic or other medical disorders. She was hospitalized with initial diagnosis of catatonia with suspicion of comorbide psychotic or mood disorder. Baseline blood values, vital signs, EEG, cranial MRI and physical examination were normal. After first lorezepam dosage(3 mg/day), catatonic symptoms regressed, motor rigidity resolved, the patient began to talk too much, speed and amount of the the speech increased. She presented with disorganized thougths and paranoid delusions. Mood elevated and motor activity increased. Place, time, person orientation and consciousness disrupted concurrently. Detailed medical condition was evaluated for delirium to exclude organic pathology. No reason was found. This situation might be related deliran mania as a part of mood episode. Then lorezepam stopped gradually and 15 drops/day haloperidol initiated. After delirious symptoms ended, olanzapin 5 mg/day began and olanzapine dose increased to 20 mg/day. Her parents wanted her to be discharged after psychotic symptoms decreased and genaral state stablized. The patient and parents did not recourse again.

Delirian mania is a serious neuropsychiatric disorder and presented with acute onset mania, delirium and psychosis not related with organic etiology or mental retardation. Catatonia is usually an evident feature of the delirian mania.[4] Delirian mania can be confused with catatonic excitation. Therefore clinicians should be cautious for differential diagnosis. In this report, the patient came with the catatonic symptoms, during the hospitalization, mania and psychotic symptoms became evident and delirium added without organic cause, thus it is important for clinicians to be alert of relationship between catatonia and mood disorders.

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