

## Letters to the Editor

### Level of Functioning in Hypomania of Bipolar II Disorder

Dear Editor:

According to the DSM-IV-TR, hypomania in bipolar II disorder (BD II) must not display marked impairment of functioning, compared with mania, and the change in functioning may be increased or decreased without reporting which is more common (1). Because of the marked impairment of functioning criterion, the DSM-IV-TR's unclear boundary between mania and hypomania can lead to misclassification (that is, symptoms are the same, apart from psychosis). If the change in functioning in hypomania were more often increased, the difference between mania and hypomania could be clarified.

This study examines whether the level of functioning in hypomania of BD II was more often increased than decreased. In a private practice, 140 consecutively presenting BD II outpatients were interviewed during remission with the Structured Clinical Interview for DSM-IV-Clinician Version (SCID-CV) (2), as modified by Benazzi and Akiskal (3). Remission was defined as a Global Assessment of Functioning (GAF) scale score of 80 to 90 for at least 1 month (1). In Italy, private practice is first or second (after family doctors) in the line of treatment of mood disorders. Private practice is more representative of the BD II population than national mental health and university services, where most severe disorders are usually seen. Patients with substance-related and borderline personality disorders (BPDs) were excluded to avoid confounding the diagnosis of BD II (4) and because they are very rarely seen in the private practice setting (5). Details about study methods are in previous reports (3,6). Interviewing during remission should have reduced the negative cognitive bias of depression (7), which can lead to underreporting positive events. The SCID-CV question on functioning was supplemented by Angst and colleagues' detailed questions about

increased functioning during hypomania (8). Increased functioning was defined according to the DSM-IV text description: there had to be an observable change in functioning (that is, "superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities" [1]). The GAF score had to be 100. The level of functioning most common during an individual's hypomanic episodes was used to rate the subject's functioning as increased, mildly decreased, or never showing marked impairment.

### Results

The patients' mean (SD) age was 41.8 (11.7) years; 69.3% ( $n = 97$ ) were women, and 30.7% ( $n = 43$ ) were men. More than 1 hypomanic episode was present in 84.3% ( $n = 118$ ). Increased functioning during hypomania was found in 73.6% ( $n = 103$ ), and mildly decreased functioning was found in 26.4% ( $n = 37$ ).

These findings suggest that almost 3 out of 4 subjects with BD II, seen in private practice, may have increased functioning during hypomania. Results are in line with classic descriptions of hypomania (9,10), which report that most hypomanic episodes show improved functioning. Kraepelin's description of hypomania, based on hospital patients (11), postulates that some impairment is more likely. Hecker, who worked in private practice, usually found increased functioning (10). Dunner and colleagues' first definition of BD II required no hospital treatment for hypomania and no marked impairment (12). Later, Dunner and Tay required no impairment (13), suggesting that hypomania usually has improved functioning.

A limitation of this study is the exclusion of subjects with substance-related disorders and BPD. This subgroup of BD II would be called "dark" by Akiskal and colleagues (14), because the associated cyclothymic temperament usually causes impaired functioning. The present study's BD II is called "sunny" (14), because features of cyclothymic

temperament (which have similarities with BPD and substance-related disorders) are lacking. Patients with "dark" BD II are more common in tertiary care settings, where the most severely ill patients are seen (40% "dark") (14). In our setting, most patients with BD II were "sunny" (that is, they had increased functioning during hypomania). By focusing on increased functioning during hypomania, false negatives should be reduced (that is, sensitivity should be higher) and the high BD II underdiagnosis (15) should also be reduced—at least in nontertiary care settings. Because subjects with BD II were interviewed during remission, a bias leading to an overestimation of positive aspects of hypomania and an underestimation of possible negative aspects (a common bias during hypomanic episodes) should be significantly reduced.

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## Premenstrual Complaints Before and After 40 Years of Age

Dear Editor

Premenstrual syndrome (PMS) may represent a continuum in a woman’s reproductive life, but the mood and physical changes differ in presentation and severity from menarche to menopause (1,2). Daily self-rating forms that record symptom pattern and severity are commonly used to confirm the diagnosis of PMS or premenstrual dysphoric disorder (PMDD) (3). Many studies have investigated the severity and chronological relation of symptoms to the menstrual cycle (4,5), but few studies have systematically looked at the impact of premenstrual symptoms in women as they approach perimenopause (2,6–8).

Although there is a definite overlap, it is expected that physical symptoms may be more dominant in women who are later in their reproductive years (8). Thus, we conducted a pilot study, using self-rating scales to compare the severity of presenting symptoms and levels of distress in women with PMDD under age 40 years ( $n = 12$ ) vs women age 40 years and over ( $n = 12$ ). We used 3 questionnaires applied to premenstrual complaints: the Symptom Questionnaire (SQ) (9), the Sheehan Disability scale (SDS) (10), and the Self-Assessment of Symptoms Questionnaire (SAS). The SQ and SDS are validated scales. We based the SAS on mood and physical symptoms commonly reported during the menopausal transition.

Subjects diagnosed with PMDD gave written informed consent. They

completed the questionnaires during the luteal phase (once only), and they reported menstrual history and general demographic data. We conducted independent *t*-tests to determine the effect of age on distress levels, as measured by the questionnaires.

Our preliminary findings indicate that there are no significant differences between the 2 groups in the mean total scores of distress levels and functional impairment. However, independent *t*-tests demonstrated a significant between-group difference ( $P < 0.05$ ) on certain individual items: the group aged under 40 years reported more impairment in social life and leisure activities and more feelings of irritability. The group aged 40 years and over reported more frequent waking at night as well as more early waking. Nevertheless, these results should be viewed with caution because there were few participants, the questionnaires were only completed once, and the measures were not designed specifically for PMDD. The study also did not control for the use of selective serotonin reuptake inhibitors (SSRIs). Seven of the subjects over age 40 years reported current use of SSRIs for PMS, which may have influenced the ratings of mood symptoms. However, taking this into account, our results still indicate that the highest mean score in both groups was irritability, which supports the view that irritability is one of the dominant factors of PMDD (11,12).

Our preliminary findings suggest that specific mood and physical symptoms may change throughout the reproductive years, rather than as a whole across the overall clinical picture. Once the diagnosis of PMDD is made, emphasis on certain symptoms throughout the different phases of a woman’s reproductive transition may assist in treatment recommendations.

We encourage a larger controlled study using standardized questionnaires to capture the premenstrual symptom profiles at various stages of the reproductive cycle.

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## Norwalk Precipitates Severe Lithium Toxicity

Dear Editor:

Despite 50 years of medical experience with lithium, lithium toxicity remains a significant and primarily iatrogenic health problem (1). The efficacy of lithium is marred by a narrow therapeutic index and significant potential toxicity (2). Lithium toxicity can occur by overdose (intentional or accidental) or, more commonly, from alteration in its clearance by the kidneys. We present a case of lithium toxicity in an elderly patient subsequent to a “Norwalk virus-like” infection, wherein delay in making the correct diagnosis led to unnecessary suffering and prolonged hospitalization.

## Case Report

The patient is a 75-year-old woman with a long history of bipolar illness and

dementia, living in a retirement home. She was brought to our outpatient clinic for her routine quarterly follow-up, but this time, she was comatose. All attempts to rouse her failed. Her lips were dry and cracking. The person who accompanied her knew nothing about her condition and had been contracted to provide transportation only. The note accompanying her indicated that she had had a "Norwalk-like virus 6 days ago for about 2 days" and that she had become lethargic since then. She had continued to receive the same dosage of lithium. Laboratory tests performed 48 hours prior to her presentation at the outpatient clinic revealed a serum lithium level of 1.85 mmol/L, an elevated white blood cell count of 29.5, absolute neutrophils of 16.8, and absolute band of 8.6. A rapid clinical assessment revealed that the patient was in a state of medical emergency. We referred her to the emergency room (ER) of the local general hospital, where further testing revealed an elevated sodium of 164 mmol/L, blood urea nitrogen of 15.7 mmol/L, and raised liver function tests. She was admitted to the hospital and treated aggressively for dehydration and lithium toxicity. Lithium was discontinued, and intravenous fluids were administered, along with supportive care. Her hospitalization lasted for 9 days, and she fully recovered.

## Discussion

We describe this case to increase physicians' awareness of a common cause of lithium toxicity; specifically, gastrointestinal disturbance in which fluid intake is limited by illness. Initial concern led to the request to monitor her serum lithium level and complete blood count; it would have been prudent to withhold lithium treatment until the blood levels were obtained and her condition stabilized. The clinical deterioration of this patient, who became dehydrated and comatose, suggested an urgent need to acquire her blood chemistry, which should have led to urgent and appropriate referral. The finding of abnormal blood results should also have alerted the lab to report the results by telephone to her treating physician. We present this case to enhance physicians' awareness of the possible effects of nausea, vomiting, and diarrhea on lithium excretion and to remind physicians to be

vigilant when fluid intake is limited by supervening illness. Severe lithium toxicity can result, especially in the elderly and medically compromised patients (3). In such cases, lithium should be withheld, an urgent lithium level report obtained, rehydration with supportive care initiated, and the patient transferred to the ER if lithium level is elevated.

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## SARS or Not SARS: Outbreak of Fever in a State Mental Institute in Singapore

*Dear Editor:*

In mid-March 2003, Singapore reported its first cases of severe acute respiratory syndrome (SARS). By mid-July, the disease had claimed 32 lives, 206 people had been diagnosed with SARS, and 722 suspect cases had been reported. The outbreak in Singapore was characterized by the rapidity of nosocomial transmission, concentration in health care settings, and the large number of health care workers (HCWs) infected in several general hospitals.

Woodbridge Hospital is the only state mental institution in Singapore. It has 1900 beds, more than one-half of which are taken up by long-stay residents. A surveillance system was implemented following the SARS outbreak; it included monitoring the body temperature of all patients and staff 3 times daily, restricting movement of patients and visitors, and keeping track of staff movement to high-risk areas. On 8 May, 3 cases of fever were reported in 1 long-stay psychogeriatric ward; by 13 May, 34 patients and 14 HCWs developed fever. After consulting with the Ministry

of Health, hospital administrators decided that the prudent course was to assume a SARS outbreak until proven otherwise. A "no-movement" order was imposed; that is, there were no admissions or discharges during this period. Further, the entire hospital staff—more than 1300 individuals—voluntarily quarantined themselves in specific facilities.

After investigations, the final diagnoses showed considerable heterogeneity: viral fever (60.4%), respiratory tract infection (22.9%), urinary tract infection (6.3%), soft tissue infection (2.1%), and fever of undetermined origin (8.3%). For all patients, polymerase chain reaction serology was negative for SARS-associated corona virus (SAR-CoV). Six out of 9 individuals tested positive for influenza B virus antigen on enzyme-linked immunosorbent assay. The quarantine was subsequently lifted, and normal services were restored in the hospital.

The high index of suspicion and lowered threshold for defining fever, coupled with the rigorous monitoring measures, resulted in the identification of a large number of febrile cases that might have been routinely missed. Fever is a cardinal sign of SARS (1); however, in long-stay facilities, a wide range of illnesses can cause the initial SARS-like symptoms of fever, myalgia, and dry cough. In countries affected by SARS, an outbreak of fever in a long-stay facility can create a dilemma concerning the appropriate course of action. To err on the side of caution by assuming SARS entails expending more resources, disrupting normal services, and creating emotional stress for all concerned. Conversely, erroneously assuming that an outbreak is not SARS would have dire consequences.

Surveillance of nosocomial infections is the cornerstone of all infection-control programs; it provides facility-endemic infection rates that help with tracking the time and place of infection trends (2). Another effective strategy is vaccination against influenza. The vaccine is cheap, has few side effects (3), and is recommended for preventing influenza (4). In SARS-affected regions, vaccination against influenza would also lessen the "background noise" in the crucial initial

stages of deciding on the etiology of an outbreak of fever in long-stay facilities.

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## Conversion Disorder in a Patient With Diffuse Axonal Injury

*Dear Editor:*

Diffuse axonal injury (DAI) results from traumatic brain injury (TBI) and particularly from head acceleration or rotational force (1). Magnetic resonance imaging, single photon emission computed tomography, and positron emission tomography are more sensitive for DAI than CT scan, but they are generally not available for diagnosis of acute TBI. Thus, DAI is largely a clinical diagnosis in patients presenting with such an injury. These patients demonstrate cognitive and behavioural symptoms of frontal lobe pathology, such as reduced attention, emotional distance, psychomotor slowing, disinhibition, aggressivity, unrealistic judgment, communication disorder, and impaired executive functioning (1). We describe a case of conversion disorder in a patient with DAI.

Mr A, aged 29 years, presented with a closed head injury following motor vehicle accident. On scene, the patient had a Glasgow Coma Scale score of 3 that rapidly improved to 15. Nonetheless, he continued to have paucity of speech, to respond inappropriately, and to

perseverate. He demonstrated spontaneous movement in all limbs but was unable to sit up or walk.

Neurological testing was inconsistent. Mr A showed a protective response on provocative testing, pointing away from an organic cause. However, pain testing failed to elicit a response, and he had a left-facial paralysis. Investigations, including 2 head CT scans, were apparently normal.

The team diagnosed mild DAI on the basis of the frontal lobe pathology demonstrated by the patient's reduced attention and communication deficits. Treatment comprised seizure and anticoagulation prophylaxis with dilantin and heparin, respectively. The patient received physiotherapy and speech-language therapy.

However, the extent of the patient's cognitive and motor dysfunction could not be explained by mild DAI alone and suggested psychiatric comorbidity. Information obtained from his brother was remarkable for significant psychosocial stressors. A refugee for 1 year, the patient had left his birth country because of threats to his safety. He was recently divorced, and he was under financial pressure.

The psychiatric functional inquiry was negative for substance or alcohol abuse, suicidal and homicidal ideation, mood and anxiety disorders, psychosis, delirium, and dementia. Mr A had suffered what appeared to be a dissociative episode 10 years earlier. There were no apparent medical, personal psychiatric, or family psychiatric histories. There was no obvious motivation for malingering.

The team ultimately concluded that Mr A met DSM-IV criteria for conversion disorder. He had multiple and significant stressors in his life over the course of 1 year and subsequently presented to us with vague neurologic findings that affected both motor and sensory function. The neurosurgical team could not offer a diagnosis to explain all his symptoms.

At 3-week follow-up, he showed minimal improvement. His behaviour was child-like and largely nonverbal, and he was not walking. The persistence and severity of these symptoms indicates that the underlying DAI pathology is more severe than once thought. This case

demonstrates the difficulty encountered in diagnosing conversion disorder in the context of pathology that is not detectable with imaging, such as DAI.

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## A Case of Erotic Violence Syndrome

*Dear Editor:*

Langevin and others (1) identified an erotic violence syndrome (EVS) in male rapists characterized by the following: 1) sexual arousal or climax to controlling, terrorizing, humiliating, injuring and (or) destroying another person (sadism); 2) a history of rape and indecent assault; 3) feminine gender identity or gender ambivalence–indifference; 4) right temporal lobe abnormalities, both structural and functional; 5) hormone abnormalities in some cases; 6) impotence or retarded ejaculation; and 7) some orgasmic cross-dressing not exclusive to the syndrome (that is, occurring in non-EVS rapists as well). I describe a case of EVS in a single man who was examined, observed, and treated within Ontario's forensic hospital system over a period of approximately 14 years.

## Case Report

This single man entered the Ontario provincial forensic system after being found “not guilty by reason of insanity” (now termed “not criminally responsible on account of mental disorder”) on several charges involving a violent and extremely sadistic sexual assault on an 83-year-old man. However, no signs or symptoms of any form of major mental illness were ever uncovered throughout his lengthy period of hospitalization.

The patient was reportedly a full-term infant who had a normal birth. However, he experienced a series of convulsions during the first 5 days of birth, when the temporal lobes of the cerebrum are particularly vulnerable to hypoxic brain damage. Between the ages of 2 and 18 years, he was placed in at least 18 foster homes wherein he was physically and emotionally abused. He also evinced a childhood and adolescent history of substantial physical violence against others, including criminal behaviours comprising nonviolent (for example, auto theft and forgery), violent (for example, physical assault), and sexually violent (for example, sexual assaults of women) offences, one of which was an attempted sexual homicide of an adult woman who turned down his sexual advances. He commenced the use of alcohol at age 18 years and became a heavy drinker, which was reportedly associated with aggressive behaviour and difficulty maintaining control. He was functionally illiterate and worked at several unskilled labour jobs, none of which lasted more than a few weeks or months. Eventually, he received a disability pension because of his inability to hold consistent, responsible employment.

Over the years, many psychological, neuropsychological, and psychosexual (including phallometry) examinations were conducted. As well, actuarial risk

of recidivism measures, such as the Violence Risk Appraisal Guide (VRAG), documented a 100% probability that he would reoffend violently following his release to the community.

Neuropsychological investigation uncovered a right temporal lobe profusion deficit (that is, mesial temporal sclerosis) that allegedly stemmed from his history of neonatal convulsions.

Assessment with instruments such as the Psychopathy Checklist-Revised (PCL-R) revealed that the patient was a prototypical psychopath with a high potential for violent recidivism.

Phallometric examinations espied sexual sadism with an unremitting sexual preference for rape and an inability to discriminate between consenting and nonconsenting sexual stimuli; they also uncovered a preference for indiscriminate, nonconsenting, aggressive, and sadistic sexual activity. A police report documented the following statement: "I told you I wear girl's clothes and I have problems with things like that. Every time I come to town I get these feelings that I want to rape someone or something like that." A psychological examination at one point uncovered the patient's belief that he was feminine in both appearance and personality. While hospitalized, he continued to sexually harass, stalk, and target vulnerable female patients for sexual purposes.

Despite an extensive period of cognitive-behavioural treatment interventions, relapse prevention treatment (for sexual offending), and behavioural, electrical, and olfactory aversion therapies, no change was noted.

After being given extended community privileges, he shortly thereafter brutally raped a young female in the community, threatening to kill her should she report him to the police (which she did, nevertheless).

This case exemplifies all the exclusive criteria and one of the nonexclusive criteria (that is, cross-dressing) of this extremely dangerous subgroup of male rapists. Individuals with this syndrome are among the most dangerous to society, and it is therefore vital that clinicians be fully aware of and not miss this differential diagnosis—especially in light of the apparently very tenebrous prognosis for the syndrome.

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