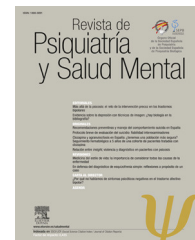




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LETTERS TO THE EDITOR

Delirium in the Spanish version of the DSM-5: More confusion?*



Delirium en la versión en español del DSM-5: ¿más confusión?

Dear Editor:

In May 2013 the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) was published, involving changes in some diagnostic criteria with respect to the previous edition, some more profound than others.¹ The most important modifications in relation to delirium were the following:

- Focusing Criterion A on attention/awareness, which is the most important core characteristic of the disorder according to empirical data.² For this purpose, the complex term “consciousness” used in Criterion A in the DSM-IV-TR was abandoned.
- Including a specific criterion on differential diagnosis with other neurocognitive disorders such as Alzheimer’s or with a state of severely reduced level of arousal (e.g., coma).

Experts in America and Europe received these changes positively, especially those related to Criterion A.³ The other 3 criteria, which involve the presence of alterations in other cognitive functions (e.g., in memory), the acute-fluctuating onset of symptoms and the need to identify possible aetiologies, were only slightly modified.

In the Spanish version of these new criteria for the diagnosis of delirium (2014),⁴ the word “awareness” (present in the new Criterion A) is translated as «conciencia» [consciousness/awareness/conscience]; this word had been translated as «atención al entorno» [attention to the surroundings] in previous versions of the manual, thus preserving the authors’ intention. The erroneous use of the complex and operationally weak term «conciencia» for “awareness” in the main item of the new criteria could reduce concordance between examiners and hinder therapeutic decisions.

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In addition, it may reduce the international validity of studies carried out using the Spanish version of the DSM-5.

The DSM-5 in Spanish also disconcerts by calling the disorder «síndrome confusional» [confusional syndrome]. This designation is related to the 19th-century French concept, *Confusion Mentale Primitive* (which had to do with the consolidation of the current construct of the syndrome).⁵ However, most Spanish speakers prefer the term delirium.⁶ This expression was salvaged from the first specific operative criteria published in the DSM-III, looking to preserve historical coherence with the term introduced by Celsus (c. 25 BCE–c. 50 CE).⁷ Delirium is also the designation used in the other current Spanish classification, the 10th version of the International Classification of Diseases. Such lack of consensus in the name used for a disorder involving professionals from various areas makes communication more difficult. It could also lead to situations in which the different specialists think that they are facing various diagnoses instead of only one.

The editors of the REVISTA DE PSIQUIATRÍA Y SALUD MENTAL informed us that the DSM-5 translation team received a glossary of terms in Spanish from the American Psychiatric Association that they were to use. This instruction meant that the version of several diagnostic criteria in our language is not as well adapted to the linguistic characteristics as the team would have wished. Consequently, refining these criteria in a new revision is of great interest.

Reed and Ayuso-Mateos,⁸ in reference to the forthcoming 11th edition of the International Classification of Diseases, argue that during the development of any diagnostic classification, the characteristics of the different languages in which the classification is to be published should be considered, to optimize its usefulness. Along these lines, Tohen⁹ indicates that every effort must be made so that the language, as the backbone of psychiatry, facilitates collaboration among Spanish-speaking professionals.

In our opinion, when the DSM-5 in Spanish is used to diagnose delirium, it should be remembered that Criterion A of the original in English refers to alterations in attention.³ Another point is that delirium is the current designation and the one most accepted everywhere for the syndrome in question.⁶ That is why we advocate its use instead of other expressions that proliferate among diverse specialists.

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Psychosis, an unusual presentation of Hashimoto's thyroiditis[☆]



La psicosis, una presentación inusual de la tiroiditis de Hashimoto

Dear Editor:

Hashimoto's thyroiditis is an entity described by Hashimoto in 1912. It is characterised by high titres of antithyroid antibodies and lymphocytic inflammation of the thyroid gland. In 1966, Brain et al.¹ linked Hashimoto's thyroiditis and Hashimoto's encephalopathy. In this case, onset is gradual, the condition is recurrent and antibody titres are high.²

Its prevalence is 2.1/100,000, and is much more common in women (5:1). Approximately 20–44% of cases present before the patient is 18 years old.³ Of unknown aetiology, it is classified in the group of autoimmune disorders and associated with entities such as lupus erythematosus, Sjögren's syndrome and diabetes mellitus type 1.³ Its pathogenesis is also unknown, because there is no direct relationship between thyroid disease and encephalitis. Thyroid function is preserved in most cases; in others, the condition progresses with hyperthyroidism and, rarely, it presents with hypothyroidism. All Hashimoto's encephalitis cases present clinical signs and symptoms of acute or subacute encephalopathy that can progress with neuropsychiatric symptoms.⁴ Its most common evolution is with relapses and remissions (50%), and gradual and insidious (40%).⁵

Complementary tests are insignificant. Analytical results are generally normal; the exception is cases of associated Hashimoto's thyroiditis and Hashimoto's encephalopathy,

detected by autoimmune disease markers. Among the antithyroid antibodies, the antimicrosomal and antiperoxidase antibodies at titres more than 100 times normal levels are the most specific and are present in 100% of cases⁶; antithyroglobulin antibodies appear in 70% of these cases.³ The most frequent electroencephalogram (EEG) pattern is slow waves, triphasic waves or epileptic disorders.⁷ Neuroimaging tests are non-specific. Diagnosis is reached by exclusion, once the most frequent causes of encephalopathy are ruled out and antithyroid antibodies are detected.

Treatment consists of intravenous and oral corticoids for 4–6 weeks until improvement appears; after that, a descending series is given until the corticoids are withdrawn.^{6,8} Symptomatic treatment with hydration measures, analgesics and antipsychotic and antiepileptic drugs is also necessary.

We present the case of a 44-year-old male, single, with good social and occupational support. The patient had no psychiatric antecedents. The physical history consisted of hyperthyroid clinical symptoms of 4 months' evolution, with manifest anxiety, insomnia and a weight loss of 23 kg. Toxic habits included long-standing alcohol abuse, sporadic cocaine use and excessive tobacco consumption.

The clinical picture was characterised by psychomotor excitation, behavioural disorganisation, perplexity, delusions of paranoid, religious and megalomaniac type with fluctuating subject matter depending on the affective state. At the onset of the condition, there were associated seizures in which the patient suffered cranioencephalic trauma.

The physical exam revealed that the patient was haemodynamically stable, without alcohol on the breath. In the neurological exam, we found bradypsychia, daytime sleepiness and intention tremor of the upper limbs. General analytical test results were normal and negative for toxic substances. Complementary testing revealed elevated thyroid hormones (T3: 0.51 ng/dl; T4: 1.94 ng/dl), as well as elevation of microsomal (159.8 UI/ml) and antithyroglobulin antibodies (420.7 UI/ml). The computed axial tomography (CAT) scan showed an image suggestive of thymic hyperplasia. The thyroid gland presented a diffuse

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