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Letter to Editor

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Catatonia: extinct, lost, or forgotten?

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Dear Editor

Catatonia is a neuropsychiatric syndrome that occurs in some primary psychiatric disorders (e.g., schizophrenia, mood disorders), or due to general medical conditions (e.g., neurological disorders, drug poisoning, metabolic disorders) (1). Although it is uncommon, but if it goes unrecognized in medical and surgical units (2), it can increase morbidity and mortality. Moreover, making a connection between signs observed across different systems (the motor, somatic, and psychiatric symptoms) could lead to misdiagnosis and a delay in treatment (3).

Our patient was a 48-year-old widow with a high school diploma, unemployed, and was from one of the northern cities of Iran. She had refused to talk and eat for the last 2 months prior to admission. She was brought to a psychiatric hospital by family members in September 2014. She complained about her weight loss, poor health, and inappropriate physical condition. In the referral letter, the psychiatry resident had noted that the patient was unconscious and did not make eye contact or verbal communication. Therefore, she was referred to the university general hospital for an investigation of her loss of consciousness. Following admission, patient's family left the hospital without notice or explanation. She was visited by emergency residents and physicians and was described as having loss of consciousness as well as lacking in verbal communication during physical examination. After initial laboratory tests, she underwent consultations with infectious diseases, internal medicine, and neurological specialists in order to understand the decreased level of consciousness. The results of the initial tests were as follows (Table 1):

The neurologist had noted that the patient had a history of major depressive disorders and was currently not conscious; she had rigidity in all limbs with the contraction lining of the bedridden. Rigidity was not reliable in the

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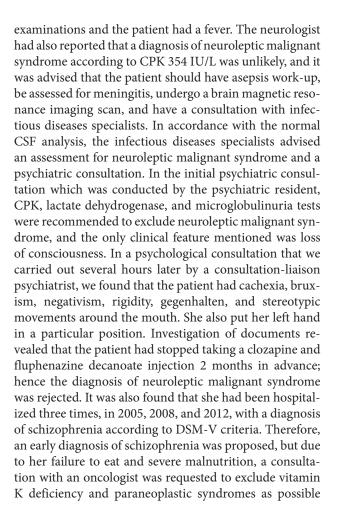


Table 1. The results of the initial tests

		Unit
White blood cell count	11.1	10^3/uL
Hemoglobin	12/4	mg/dL
Platelets	228	10^3/uL
Glucose	96	mg/dL
Creatinine	1.3	mg/dL
Urea	104	mg/dL
Alkaline phosphatase	133	U/L
СРК	354	IU/L
Serum glutamic oxaloacetic transaminase	130	U/L
Serum glutamic pyruvic transaminase	78	U/L
CSF	Normal	

Abbreviations: CPK, creatinine phosphokinase; CSF, cerebrospinal fluid analysis.



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causes of her catatonia. The patient was transferred to the psychosomatic ward and after the rejection of medical causes as being responsible for catatonia; the patient received electroconvulsive therapy (ECT), with the written consent of her father, along with supportive therapy, such as total parenteral nutrition. The patient showed a favorable response to ECT and came out of catatonia after six sessions.

The described patient was brought into the hospital as having catatonic signs arising from a primary psychiatric disorder. The patient was examined by four physicians specializing in other medical disciplines as well as six residents in emergency medicine, neurology, internal medicine, infectious diseases, anesthesia, and psychiatry before being visited by a consultation-liaison psychiatrist. The diagnostic and therapeutic approach to the patient was such as a comatose patient. Catatonia is diagnosed using motor signs including negativism, immobility, stupor, posturing, waxy flexibility, mutism, abnormal movements, echopraxia, echolalia, and stereotypic movements (3). It appears that a large number of physicians do not have the experience required to identify and apply the terminology describing catatonia (4), and some even believe that catatonia no longer exists. Subsequently, these physicians do not recognize and treat this syndrome (5). If physicians rely on a large number of abbreviations according to the definitions in the references, detection of catatonia will improve (6). Undiagnosed catatonia can increase morbidity and mortality which demonstrates the need for effective screening of patients for its presence. Diagnosis can be reduced due to the lack of familiarity with catatonia in modern medicine. It is recommended that catatonia be included as an important and indispensable aspect of training for psychiatry and emergency medicine residents in Iran. There is also a need for training in other medical fields including internal medicine, neurology and infectious diseases. In addition, the presence of consultationliaison psychiatrists in general hospitals may aid in the correct handling of catatonia.

Ethical issues

Not applicable.

Author's contribution

FE is the single author of the manuscript.

References

- 1. Fink M, Taylor MA. Catatonia: subtype or syndrome in DSM? Am J Psychiatry 2006; 163(11): 1875-76.
- Carroll BT, Spetie L. Catatonia on the Catatonia on the consultation-liaison service: a replication study. Int J Psychiatry Med 1994; 24(4): 329-37.
- Sadock BJ, Sadock VA, Ruiz P. Kaplan and Sadock's Synopsis of Psychiatry: Behavioral Sciences/Clinical Psychiatry. 11th ed. LWW; 2015. p. 343-6.
- Kirkhart R, Ahuja N, Lee JW, Ramirez J, Talbert R, Faiz K, et al. The Detection and Measurement of Catatonia. Psychiatry (Edgmont) 2007; 4(9): 52-6.
- van der Heijden FM, Tuinier S, Arts NJ, Hoogendoorn ML, Kahn RS, Verhoeven WM. Catatonia: disappeared or under-diagnosed? Psychopathology 2005; 38(1): 3-8.
- 6. Stompe T, Ritter K, Schanda H. Catatonia as a subtype of schizophrenia. Psychiatr Ann 2007; 37(1): 31-6.