Childhood Catatonia Commonly Missed, Badly Managed

Daniel M. Keller, PhD | Apr 09, 2013

NICE, France — Catatonic syndrome is a common child and adolescent psychotic disorder that responds well to benzodiazepines, with the addition of electroconvulsive therapy (ECT) if there is insufficient response to benzodiazepines.

However, a retrospective study suggests the condition is frequently missed, that these specific interventions are underused, and that the inappropriate use of neuroleptic drugs can precipitate clinical worsening.

Speaking here at EPA 2013: 21st European Congress of Psychiatry, Michal Goetz, MD, head of the Diagnostic Unit and assistant professor in the Faculty of Medicine at Charles University in Prague, Czech Republic, said that catatonia symptoms are often overlooked or misinterpreted because of the misperception that these symptoms are rare in children.

To avoid overdiagnosis, Dr. Goetz and coinvestigator Dirk Dhossche, MD, PhD, professor of psychiatry and director of the Child Psychiatric Unit at the University of Mississippi Medical Center in Jackson, Mississippi, used stringent criteria requiring 4 positive symptoms from among the first 14 items on the 23-item Bush-Francis Catatonia Rating Scale (BFCRS).

Of the 69 admissions (mean age, 15.8 years), 25 patients (36.2%) had a diagnosis of catatonia; this is twice the incidence found in 2 previous studies by other investigators in the at-risk population of young patients with psychosis, mood disorders, or pervasive developmental disorders.

Among the 25 catatonic patients, the number of symptoms on the BFCRS screen ranged from 4 to 14, with mutism, staring, immobility/stupor, excitement, impulsivity, perseveration, negativism, withdrawal, and stereotypy each affecting more than half the group.

An acute stressor preceded the psychosis in 76% of the catatonic patients vs 31.8% of the others ($P = .001$). Aggression and the use of bed restraints were more frequent among the group with catatonia than among patients with other diagnoses (56% vs 18.2%, $P = .003$; 40% vs 2.3%, $P < .001$; respectively).

Hazards of Antipsychotics

The recommended first-line treatments for catatonia were grossly underused. Only one quarter of these patients received benzodiazepines, and only 2 patients received ECT. Acute extrapyramidal crises occurred in 36% of the catatonic patients compared with 6.8% of the noncatatonic patients ($P = .006$).

"The use of antipsychotics complicated getting to the remission," Dr. Goetz told Medscape Medical News. "It's important to have in mind the possibility of catatonia and diagnose it routinely and then to start with proper first-line treatment, like using benzodiazepines before you will use the antipsychotics. Some of them...can really worsen the catatonia.... Diagnosing catatonia is a safety issue."

Very large doses of benzodiazepines, most commonly lorazepam, may be required. Dr. Goetz said that in his practice, he usually sees improvement within several days.

Similarly, "it usually takes more ECT sessions than in the treatment of depression, such as the possibility of daily bilateral ECT for a dozen sessions."
Nurses play a key role in helping to make the diagnosis, and they should be aware of risk groups, such as psychotic patients and patients with mood disorders or autism. Dr. Goetz advises physicians "to use the [rating] scales and to train nurses to be aware of catatonic symptoms and to be able to describe them clearly in charts."

Dr. Dhossche added that the upcoming *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) should facilitate better diagnosis and, therefore, better treatment because catatonia will have a separate code and will not require another underlying condition.

"That is very important because we do have the acute treatments that work in most patients." He noted that up to 80% of patients improve on benzodiazepines alone and that about 95% of cases resolve with the addition of ECT.

**Catatonia, Not Schizophrenia**

Session cochair Lee Wachtel, MD, medical director of the Neurobehavioral Unit at the Kennedy Krieger Institute and associate professor of psychiatry at Johns Hopkins Medical Institution in Baltimore, Maryland, who was not involved in the study, commented to *Medscape Medical News* that not a lot of work is being done on catatonia in the adolescent population.

"This is a diagnosis that's often missed, with a very negative consequence for the patients, particularly as [Dr. Goetz] pointed out in terms of safety" if antipsychotic drugs are used, she said.

"So bringing the idea of catatonia to the child psychiatrist, which is somewhat new, also for psychiatry in general...not only can it save lives but also reduce patient suffering and get them better and get them out of the hospital quickly," Dr. Wachtel added.

She advised "looking for that constellation of motor, focal, and behavioral symptoms and not to make the pitfall of assuming that it has to be psychosis, because catatonia doesn't equal schizophrenia, and if you go down that pathway, you may do more harm than good."

Patients do not need to have symptoms of waxy flexibility and posturing, as commonly thought, but may also be highly agitated, possibly with self-injurious behaviors. Patients with either presentation respond well to benzodiazepines.

*Dr. Goetz is on the advisory board and has received travel support from Eli Lilly and Company. He is a member of the speakers' bureaus of Eli Lilly and Janssen-Cilag. Dr. Wachtel and Dr. Dhossche reported no relevant financial relationships.*


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Cite this article: Childhood Catatonia Commonly Missed, Badly Managed. *Medscape*. Apr 09, 2013.