CASE REPORT

Unnoticed Catatonia in Major Depressive Disorder: A Case Report

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Abstract

Catatonia is a complex syndrome frequently reported in patients with acute neuropsychiatric illnesses. It is often overlooked, especially among patients with major depressive disorder (MDD) owing to the commonality between the clinical features of these conditions. If remained unaddressed, catatonia can lead to life threatening consequences and hence, requires prompt evaluation through physical and mental status examinations. Here, we report a case of a 62-year-old female who was incorrectly diagnosed with and treated for MDD. On the subsequent emergency visit, the patient was found to have MDD with catatonic features and was started with lorazepam 1–2 mg/day and improvement was seen within the first ten minutes. We believe the addition of a benzodiazepine (BZD) in a psychotropic regimen could improve both catatonia and depression, and should be continued for 3–6 months to prevent relapses.

Keywords: Benzodiazepine, Catatonia, Clinical improvement, Depression, Lorazepam, Major depressive disorder.

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Background

Catatonia, a complex psychomotor syndrome, is reported in ~17% of patients with acute psychiatric conditions. Characteristically, catatonia is divided in two subtypes: Retarted (involving paucity of movement, withdrawal and refusal to eat, posturing, negativism, stereotypy, automatic obedience, etc.) and excited (severe psychomotor agitation).[1] In most cases of catatonia, depression is found to be a known history, especially among older patients.[2] Owing to the absence of specific confirmatory tests, the diagnosis relies on clinical examination, i.e., presence of three or more of the following symptoms: Stupor, waxy flexibility, catalepsy, mutism, posturing, negativism, stereotypes, mannerisms, grimacing, agitation, echopraxia, and echolalia.[3] It prevails in 5–18% patients in psychiatry inpatient units, in 12% drug naïve patients with first episode psychosis and in 8.9% of elderly patients with psychiatric illness.[4] However, in acute cases of psychiatric illnesses, wherein the presenting symptoms could overlap with that of catatonia, the latter is often missed to be diagnosed and may be life-threatening.[5] Despite being a common entity among patients with MDD, there is scarcity of data on catatonia and its management in Indian patients with MDD. Here an interesting case of elderly female patient with acute presentation of catatonia with MDD.

Case Description

A 62-year-old female presented to psychiatry outpatient department on 20th April 2022 with complaints of low mood, decreased interest in activities she previously enjoyed, decreased energy, reduced frequency of interaction, lack of appetite, not taking self-care, and decreased sleep. She was a known case of MDD since 2019, for which she had consulted many psychiatrists earlier and was being treated with mirtazapine 15 mg/day with no meaningful improvement. General examination revealed no abnormalities of vital functions, orientation and consciousness. She was switched to paroxetine 12.5 mg/day therapy and was asked to come for follow-up visit the next week.

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On 23rd April 2022, the patient was brought to the emergency department with complaints of decreased interaction, refusing to eat, lack of sleep, and not following any commands from the past 2 days. She was admitted to the psychiatry ward and was investigated for the following routine biochemical tests: Thyroid function test, complete blood count, liver function test, kidney function test, and serum electrolytes, which were all found to be normal. That day, the patient was interviewed in her room as she refused to get out of her bed. She had a minimal verbal response and also showed negativism by refusing to participate with the treatment team. Bush Francis rating scale of catatonia revealed a score of more than or 2 for mutism, rigidity, negativism, abnormal posturing, stupor, withdrawal, and staring. Considering these findings, her diagnosis was revised to MDD with catatonic features and she was immediately started on intramuscular lorazepam 1 mg twice daily and the dose of paroxetine was increased to 25 mg/day. Within 2 hours, the patient was out of bed and interacting with the staff. Bush Francis rating scale of catatonia score markedly decreased within 2 hours of lorazepam therapy. The next day, she started interacting with family members, taking food and to take her oral medications regularly. Her sleep and self-care also showed improvement. Her

depressive features showed marked reduction and the patient discharged on day 10 on oral tablet, paroxetine, 25 mg/day and tablet, lorazepam, 2 mg/day. At the next follow-up after 10 days, the patient denied of depressive symptoms; she was continued on the same medications.

Discussion

The current case highlights the importance of thorough evaluation of catatonia in MDD patients, who are often misdiagnosed to have acute episode of the primary disease and remain untreated for their catatonic features. Moreover, the overlap between psychomotor retardation in MDD and non-responsiveness seen in catatonia may also enhance the chances of catatonia remaining unaddressed. Presence of posturing and negativism clearly indicated of catatonia in our patient, which is in line with the previously published cases of MDD with catatonia, especially among elderly female patients.[6,7]

Treatment of MDD subtype catatonia differs from that of MDD. Addition of a BZD has shown to improve both catatonia and depression while also preventing relapses and recurrences. Lorazepam is a preferred choice for catatonic MDD and has demonstrated remission rate of 80% in this condition.[8] The recommended starting dose is 1–2-mg administered intravenously for every 4–12 hours and shows prompt benefits in catatonic symptoms as seen in our patient as well as in similar cases reported earlier.[6,7]

A possible explanation for the role of a BZD in catatonia could be the reduction or inhibition of the gamma amino butyric acid (GABA) receptors that connect the basal ganglia with the cortex and thalamus in the right orbitofrontal lobe. Interestingly, in catatonic patients, only the right orbitofrontal activity is reported to be reduced with the left orbitofrontal lobe activity remaining unchanged.[9] For patients who do not respond to BZD, electroconvulsive therapy (ECT) or a combination of BZD and ECT can be recommended.[10]

Considering the dearth of published data on management of catatonia in MDD from Northeast Indian region, this case report would serve as an important record for creating evidence base for managing this complex condition.

Clinical Significance

Timely identification and treatment of catatonia is crucial for the prevention of any long-term morbidities. In patients with MDD, the symptoms of catatonia could be overlooked as psychomotor retardation of MDD adding to the difficulty in diagnosis and necessitate a high level of suspicion. Lorazepam is a valuable option for acute management of catatonia with proven effectiveness.

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