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# Presence of isolated catatonic signs in chronic psychosis: is chronic catatonia under-recognised? A case series

## Introduction

Catatonia is a complex syndrome of specific motor abnormalities associated with various psychiatric disorders. Historically, more than 50 clinical signs have been described in catatonia, however, it is now confined to the 23 signs mentioned in the Bush-Francis Catatonia Rating Scale [1]. In clinical practice we are apt to recognise catatonia in its stuporous form presenting in emergency with risks due to compromised food and water intake and immobility. Excited catatonia is often missed or diagnosed in hindsight when it presents with manic excitement [2]. In this case series we want to highlight that the presence of a few catatonic signs may often be missed as has been pointed out earlier [3]. This under-recognition may account for the discrepancy between findings in literature [4]. In the International Pilot Study of Schizophrenia (IPSS) though catatonic signs were noted in 96 patients only a few among them were diagnosed as catatonic schizophrenia. Conversely, most of the 55 patients diagnosed as having catatonic schizophrenia did not have catatonic symptoms [5].

In this case series, we would like to present three patients with persistent catatonic symptoms occurring during their psychotic illnesses. The catatonic signs were recognized on clinical evaluation. The signs specifically responded to treatment with lorazepam and in two of the cases, drug default or attempts to taper the dose; led to resurgence of catatonic symptoms.

## Case series

1. A 23-year old male presented with a 1 year duration of illness with disorganized behaviour, apathy, alogia, asociality and persecutory delusion. He also had echolalia, echopraxia and sudden bursts of pacing behaviour during in-patient stay. A diagnosis of unspecified non-organic psychosis was made. We stabilized him on Tab. olanzapine 12.5 mg. He showed significant resolution of disorganized behaviour and was discharged. He continued to have echolalia, echopraxia and sudden unexplained pacing behaviour at follow-up. Initially thought to be part of psychotic excitement, these behaviours were now recognized as catatonic symptoms and a trial of lorazepam 4 mg was given. There was good response after 3 weeks. On two attempts to taper lorazepam catatonic symptoms recurred.
2. A 35-year-old male with 9 year duration of chronic psychosis characterized by predominant negative symptoms and auditory hallucination, was treated with risperidone 6 mg. Hallucinations were well controlled, but he had ambitendency, mutism and negativism for last 6 months. The symptoms had not worsened to catatonic stupor and he was otherwise able to perform his daily chores. He was started on 4 mg of lorazepam as an out-patient for these catatonic symptoms. He showed marked improvement after 3 weeks and is currently under follow up with the same dose of lorazepam.



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3. A 37-year-old male with chronic psychosis presented with a relapse of symptoms characterized by withdrawn behaviour, mannerisms, touching and tapping nearby objects. Patient was started on lorazepam 8 mg and risperidone 5 mg. He responded well to medications in 2 weeks. On tapering lorazepam below 4 mg in out-patient follow up after 4 weeks, mannerisms and tapping behaviour alone reappeared without any psychotic symptom. Presently, the patient is being continued on lorazepam 4 mg in view of the reemergence of catatonic signs on tapering lorazepam.

## Discussion

Catatonia is easily recognized when a patient presents with catatonic stupor. However, more subtle or persistent signs of catatonia are often missed. In this case series catatonic signs persisted during the maintenance phase in an otherwise chronic course of psychotic illness.

All three patients required and responded well to lorazepam trial. In all the patients, default of medications or attempts to taper lorazepam were met with re-emergence of catatonic signs. There have been previous reports of possible need for longer duration of lorazepam treatment in a subset of patients with catatonic stupor [6], though other trials have failed to show improvement of chronic catatonic symptoms with lorazepam [7]. In the present series, we are laying emphasis on subtle manifestations of catatonic signs that may present social and personal discomfort rather than with potential for medical complications seen due to catatonic stupor. Catatonia, as described or defined by Kahlbaum, Kraepelin, ICD-10 and Diagnostic and Statistical Manual of Mental Disorders, Fifth edition (DSM V) list 27, 23, 9 and 12 catatonic symptoms respectively. However, Leonhard's system operated with 57 signs and symptoms of catatonia. This decrease in the number of signs that are recognised as catatonic is due to the reduced emphasis on phenomenology and psychopathology in modern psychiatry in contrast to the meticulous description of the catatonic symptoms in the earlier literature [8]. This could have led to a slight delay in diagnosis.

In the three patients, the catatonic behaviour was persistent despite antipsychotic medications. On the other hand, one must be aware of the possibility of emergence or worsening of catatonic symptoms due to the use of antipsychotics. This phenomenon is especially marked with typical antipsychotics [9]. Patients whose psychotic symptoms such as hallucinations or delusions are in remission (as in the above three cases), we must attempt a reduction in antipsychotic dose and use lorazepam to treat catatonic symptoms. We must prefer atypical antipsychotics over typical antipsychotics. Moreover, the cases described above justify the current nosological status of catatonia as a distinct clinical entity rather than being a subtype of schizophrenia [10]. The patient's behaviour also caused significant social embarrassment to the family members requiring specific remedy. Thus, the use of lorazepam was justified as it helps to reduce stigma and relieve the patient of symptoms. Moreover, leaving catatonic symptoms untreated may also have the risk of worsening into a frank catatonic stupor in some cases and hence warrants specific treatment.

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