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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

From Assessment to Management: Tackling Catatonia in Schizophrenic Patients

Ashley Baker:
Welcome to *NeuroFrontiers* on ReachMD. I'm psychiatric nurse practitioner Ashley Baker, and I'm speaking with Dr. Stanley Caroff, who is an Emeritus Professor of Psychiatry at the University of Pennsylvania Perelman School of Medicine and the VA Medical Center in Philadelphia. Today we'll be discussing his research on the treatment of schizophrenia with catatonic symptoms.

Dr. Caroff, thanks for being here today.

Dr. Caroff:
Thank you, Ashley.

Ashley Baker:
So to start us off, why is it important to know about schizophrenia with catatonic symptoms?

Dr. Caroff:
Well, it's an auspicious time to be talking about this. This is actually the 150-year anniversary of a famous textbook written by Karl Kahlbaum in Germany in which he first talked about and described catatonia as an independent disorder. But unfortunately, subsequently and throughout the 20th century, catatonia became connected mostly with schizophrenia as if it were a type of schizophrenia, virtually synonymous with schizophrenia, so unfortunately, people who had catatonia were assumed to have schizophrenia and were treated with antipsychotic drugs. But people didn't realize that antipsychotic drugs can themselves cause or even worsen catatonia, so many people were harmed. But fortunately, today it's recognized and accepted that catatonia itself is a neuropsychiatric syndrome that can be caused by many different kinds of brain disorders, and it's not specifically related to schizophrenia alone, and that's been codified in DSM and so forth.

Ashley Baker:
So with that being said, can you explain in a little bit more detail the typical presentation and what we would see with someone with schizophrenia with catatonic symptoms and how specifically it differs from schizophrenia without catatonia?

Dr. Caroff:
Well, that's a really very important question. In a sense, we don't really know whether in a patient with schizophrenia if they have catatonia that's different in any way from people with schizophrenia who don't have catatonia. So for example, is catatonia just a state-related epiphenomena of being psychotic, or is it somehow a core dimension of having schizophrenia itself?

But to get to your question, the presentation of catatonia in schizophrenia really covers the whole gamut of what we know of as catatonic symptoms, a full range of things. So it could be somebody presenting with hypokinetic withdrawal and immobility or stupor, or it could even be someone with schizophrenia who's excited and agitated. But apart from those quantitative changes in motor activity, whether they're withdrawn or they have too much activity, they are also peculiar qualitative motor symptoms of catatonia like waxy flexibility and posturing, stereotypes, and mannerisms as well. Catatonia can also manifest in peculiar speech changes or echophenomena, or people with catatonia can show changes in their voluntary control of their behavior, so they can be extremely negativistic, or they can have what we call automatic obedience. So there's a wide range of peculiar psychomotor disorders that characterize catatonia in general that also can be seen in schizophrenia.

What's also important is to take note of whether catatonia in a patient with schizophrenia is an acute sudden episode if it occurs periodically throughout their disorder or if it's a chronic aspect or presentation of their schizophrenia. These patients with chronic

catatonic symptoms may actually have a worse prognosis and not as responsive to treatment.

Ashley Baker:
So if a patient presents, we know that they have schizophrenia, and now they're presenting catatonic, what is the standard treatment?

Dr. Caroff:
Well I think in general, you could say that the treatment of catatonia in schizophrenia is the same as the treatment of catatonia in any condition. So what you want to do if you have a patient who presents with catatonia is first, recognize the symptoms of catatonia, which are often missed, and then perform a differential diagnosis because as we said, catatonia is a neuropsychiatric syndrome that can present in many kinds of brain disorders. So the first thing to do would be to rule out some sort of organic brain disease, especially encephalitis, which is becoming a condition of interest recently.

Once you rule out medical, neurological, and organic causes of catatonia, you have to consider mood disorder, especially bipolar disorder, because catatonic symptoms are very common in people with bipolar disorder. But finally, when you rule those out—and the patient may have schizophrenia—but nevertheless, if the patient presents with a catatonic picture and if they're stuporous and mute, the first-line treatments would include lorazepam or a benzodiazepine. If that fails or if they're in critical condition because they're not eating and taking care of themselves, ECT continues to be probably the most effective treatment for an acute episode of catatonia.

Now if lorazepam and ECT fail in a small minority of patients, there are other drugs that have been looked at, like so-called NMDA antagonists like amantadine or memantine, and there are others as well. As for antipsychotics, the patient has schizophrenia, but if they're presenting with acute catatonia or a stuporous mute state, then you really should treat the catatonia first with lorazepam or ECT, and once that resolves, then you can consider antipsychotics for the underlying schizophrenia.

Ashley Baker:
Was there anything further that you wanted to touch on that you feel is important to our audience to know about second-generation antipsychotics and ECT?

Dr. Caroff:
That's an unfortunate question because of misunderstandings and misconceptions about the modern practice of ECT, but in fact, especially for a catatonic patient who's stuporous and mute, catatonia can be life-threatening, and that's especially true if it becomes a more malignant form of catatonia. But even in simple benign catatonia itself—people are not eating, they're not moving, and they're not taking care of themselves—so there's a very high incidence of malnutrition and phlebitis leading to pulmonary emboli, infections, aspiration pneumonia, and even death. So it's not a benign situation, and in those situations, something like ECT, which can be very quickly effective in relieving the catatonic stupor, can be lifesaving. So we would just try to present the facts to a patient or family about the real strong evidence of efficacy; it's tolerated well if it's done properly and the consequences if it is not done and try to answer their questions as best we could.

So it really is the treatment of choice in catatonia that's not responsive to medications and goes on for a period of time, especially if it takes a malignant form. There are older studies, actually, that looked at the effectiveness of antipsychotics in people with schizophrenia who also have catatonic symptoms, and they seem to show that people with chronic schizophrenia who also had chronic catatonic symptoms really weren't helped very much by the older first-generation agents. But the newer agents that are less likely to cause neurologic complications are probably effective and the drugs of choice in people who have schizophrenia once the catatonic symptoms have been effectively treated and resolved by lorazepam or ECT.

So SGAs, second-generation agents, and maybe especially clozapine, which of course has other side effects to consider, are probably the drugs to choose if you have a patient with schizophrenia who had catatonic symptoms in the past, spontaneously or as a side effect of previous antipsychotics, or if they continue to have what we call parakinetic symptoms of catatonia. So the second-generation agents, and clozapine in particular, are probably good choices in people who have chronic schizophrenia once any stupor, mutism, or acute catatonic symptoms have been removed.

Ashley Baker:
For those just tuning in, you're listening to *NeuroFrontiers* on ReachMD. I'm Psychiatric Nurse Practitioner Ashley Baker, and I'm speaking with Dr. Stanley Caroff about his research on the treatment of schizophrenia with catatonic symptoms.

So given everything that we've discussed so far, Dr. Caroff, what does all of this mean for the treatment in the clinical practice setting? And what types of settings may we see this? Is it mostly the emergency room? inpatient? Could we possibly see this in our offices?

Dr. Caroff:
Well, catatonia is probably more prevalent than people realize, and I think if we learn to recognize catatonic symptoms, they're quite

common, especially in people with schizophrenia. It certainly can be seen in the emergency room where a person presents with mutism and stupor and they're not responsive or certainly in a psychiatric unit, also in medical and surgical settings. Sometimes they're brought in because failure to thrive. They're not eating, not taking care of themselves, and they seem confused. They wind up in a medical ward, and they're found to have catatonic symptoms. That's not uncommon.

If they present in the office, while the acute stuporous mute person may present initially, but obviously has to be referred to the hospital. But you may have people with chronic schizophrenia who you're treating who don't have an acute stupor or urgent presentation, but they may have ongoing peculiar psychomotor behavior or delay in responding, things like that, that suggests they also have catatonia.

There are other forms of catatonia that may present that you may see. There's so-called catatonic excitement, which is the opposite of the immobile withdrawn patient, and that may actually—well, more often than not—is a sign of severe or delirious manias. You have to consider that as the underlying diagnosis.

Ashley Baker:
What remains some of the challenges, if any, in standardizing the treatment of catatonic symptoms in schizophrenia? And if there are still residual challenges here, how would you suggest that we overcome them clinically?

Dr. Caroff:
Well, the challenges are just getting the word out to increase awareness and education and recognition of what catatonic symptoms are and the simple paradigm for treating them. And then in reality, as often the case, we really don't have very much controlled evidence on how best to treat someone with schizophrenia who also has catatonic symptoms. Most of what we're talking about today are based on clinical observational studies and clinical experience, so it would be great to have more controlled studies and trials of what are the special needs of someone or treatments of someone who has both schizophrenia and catatonic symptoms. So we need more awareness and more research.

Ashley Baker:
Before we close, are there any final thoughts that you would like to share with our audience that you find to be key takeaways here?

Dr. Caroff:
There is good news that we've made a lot of progress in the last few decades in recognizing and understanding catatonia as an independent neuropsychiatric syndrome. It does occur in schizophrenia, but it's not restricted to schizophrenia. We've advanced in accepting that really good treatment of catatonia per se with lorazepam and ECT, but there is still the challenge, as we've talked about today, in treating catatonia and in relation to schizophrenia because antipsychotics, while very effective for schizophrenia, have a downside and can be poorly tolerated by people with catatonia. So the takeaway is sequential. When you have a patient with schizophrenia and catatonia, you sort of treat sequentially. First, address and treat the catatonia, try to resolve that with lorazepam or ECT, but then SGAs or clozapine are very effective for those people as they are for other people with schizophrenia. And finally, there's a need for greater awareness and more data on this entire subject.

Ashley Baker:
So this has been a very insightful discussion about the treatment of schizophrenia with catatonic symptoms, and I'd like to thank my guest, Dr. Stanley Caroff, for sharing his insights. Dr. Caroff, it was wonderful speaking with you today, and thank you for all of the information that you shared with us.

Dr. Caroff:
Thank you as well.

Ashley Baker:
For ReachMD, I'm Ashley Baker. To access this and other episodes in our series, visit *NeuroFrontiers* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening.