BACKGROUND

The DSM-V describes catatonia as a "marked decrease in reactivity to the environment" [1]. A defining aspect is psychomotor abnormality, which can vary from retardation to agitation, and may be associated with a broad spectrum of psychiatric and medical illness. Per DSM-V, to diagnose catatonia, one needs three or more of twelve symptoms outlined in Table 1 [1].

INTRODUCTION

To date, few reports explore the presentation and treatment of catatonia in pediatric populations. Further, catatonic excitement is clinically rare and scarce in literature, especially in pediatric literature. Adult patients are treated with benzodiazepines, typical antipsychotics and electroconvulsive therapy ECT early to reduce morbidity and mortality before diagnosing an underlying condition [2]. Underdiagnosed and undertreated catatonia is particularly problematic in the pediatric population [3]. We present a 14-year-old female with symptoms consistent with catatonic excitement and psychosis, who was treated with a combination of Haldol, Ativan and Ramelteon. Like most cases, we treated her symptoms before identifying an underlying diagnosis to reduce morbidity.

CASE PRESENTATION

- Patient is a 14-year-old African-American female presenting to emergency department (ED) following two episodes of new onset seizure-activity. Prior to arrival patient demonstrated: poor sleeping pattern, extreme disinhibition in the milieu, and highly impulsive behavior at home for 1 week. Past psychiatric History: No hx of hospitalizations, substance use or trauma. PMH: Reproductive history significant for menstrual abnormality and transition from injectable contraceptive to oral contraceptive pills (OCPs). Patient then had menorrhagia for two weeks. While in ED, patient had no additional seizure activity. Patient admitted to general inpatient pediatric hospital service for resolution of metabolic disturbance as primary cause altered mental status. Elevated ammonia, hypokalemia, elevated magnesium and lactic acidosis were corrected. Imaging studies including EEG, non-contrast head CT and MRI, revealed no abnormalities.

On admission:
- Patient showed persistent disinorganization in thought, speech with paranoia, and pressured speech on psychiatric evaluation.
- With parental consent, started Zyprexa to target psychosis.

CASE PRESENTATION (cont.)

- Additional labs to rule out NMDA encephalitis (NMDA Antibody, (AMPA) R., (CASP2R) = negative)
- Patient continued to demonstrate impulsiveness, behavioral disinhibition, along with symptoms of perseverations, echolalia, repetitive speech, psychomotor behaviors.

Catatonia added to differential:
- Bush-Francis Catatonia Rating Scale (BFCRS): scored 21, due to: excitement, echolalia, stereotypic behavior, verberigation (repeating “shut up”), impulsivity, automatic obedience (exaggerated cooperation during evaluation), and perseveration.
- Following available guidelines for treating catatonia, even before an underlying diagnosis, patient started on Ativan and Zyprexa to target her most disruptive symptoms.

Optimizing medication:
- Ativan 0.5 mg TID, titrated down over 10 days following noticeable improvement in disinhibition.
- Zyprexa was increased to 12.5 mg/day, but discontinued due to persisting perseveratory delusions, internal preoccupation, agitation.
- For more potent D2 blockade, started Haldol 5 mg BID with Cogentin 1 mg BID for EPS prophylaxis.
- Ramelteon added to assist regulation of circadian rhythm.
- After 20 days, patient participated in group activities, with less restlessness. Thought process was linear with fewer episodes of derailment. Thoughts and speech were also less disorganized.
- BFCRS score on discharge = 3; she continued to display stereotypic behavior, automatic obedience and perseveration. Ativan titrated down to 0.25 mg HS.

REFERENCES