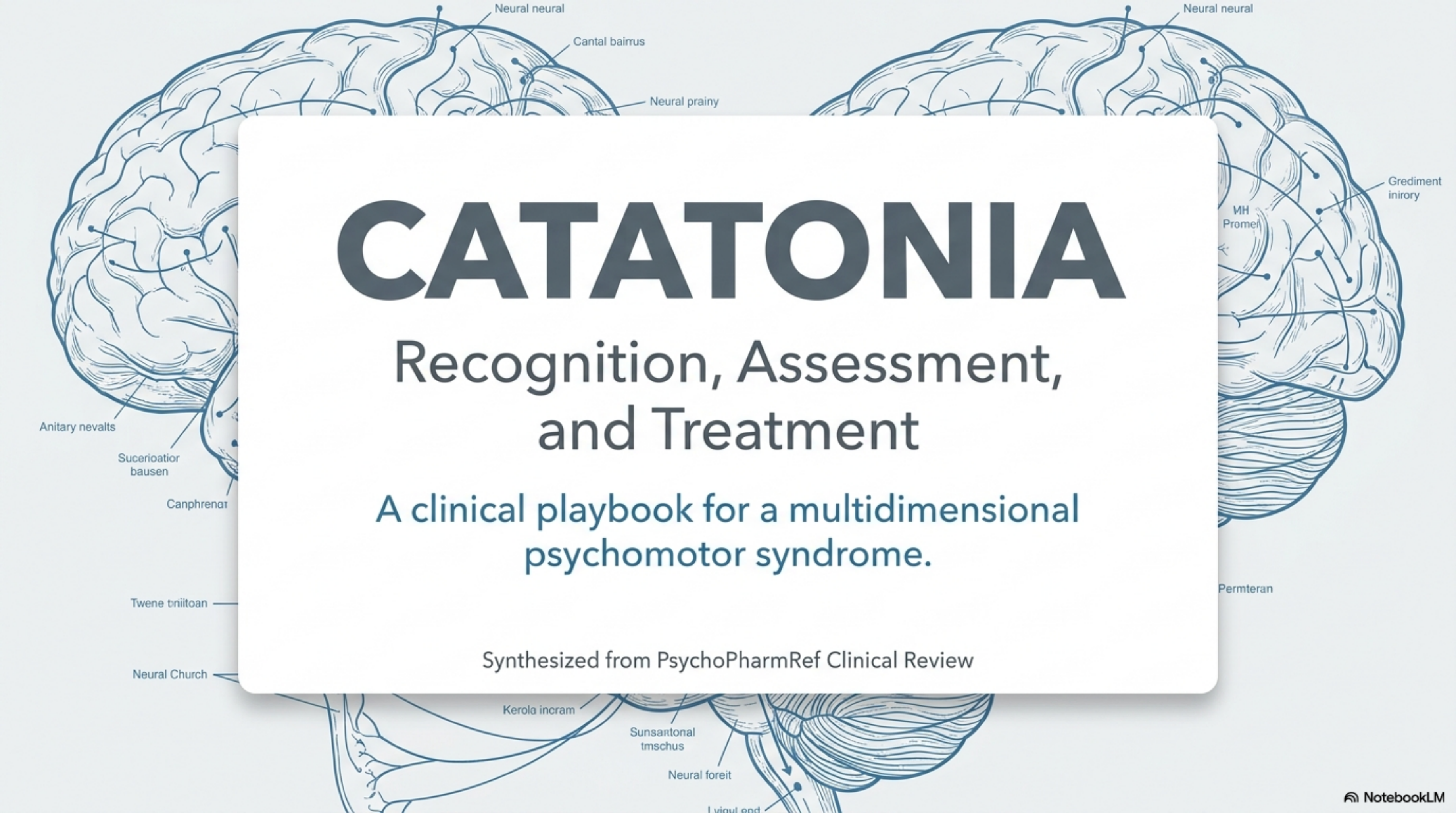




CATATONIA

Recognition, Assessment, and Treatment

A clinical playbook for a multidimensional
psychomotor syndrome.

Synthesized from PsychoPharmRef Clinical Review

The Hidden Psychiatric Emergency

0.5–1%

Of all acute psychiatric admissions present with catatonia.

2–6 Weeks

The average diagnostic delay from symptom onset, leading to prolonged suffering and risk.

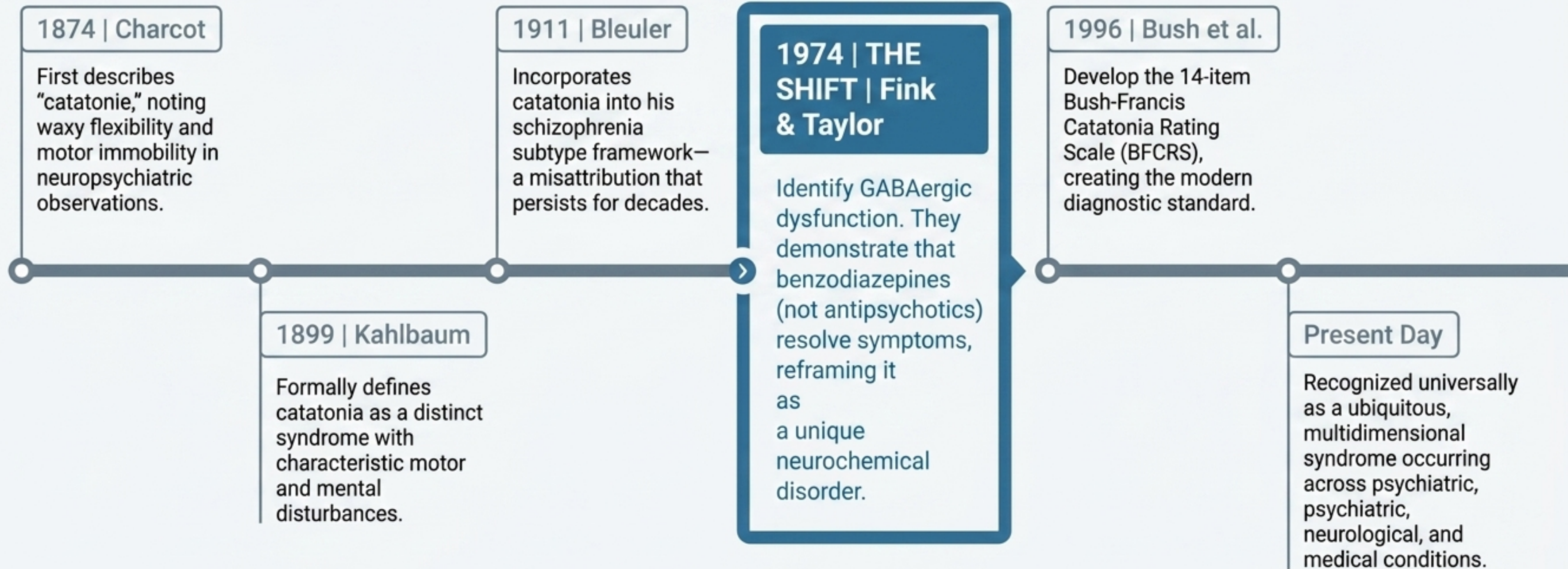
10–52%

Cases driven by primary medical or neurological etiologies, not primary psychiatric illness.

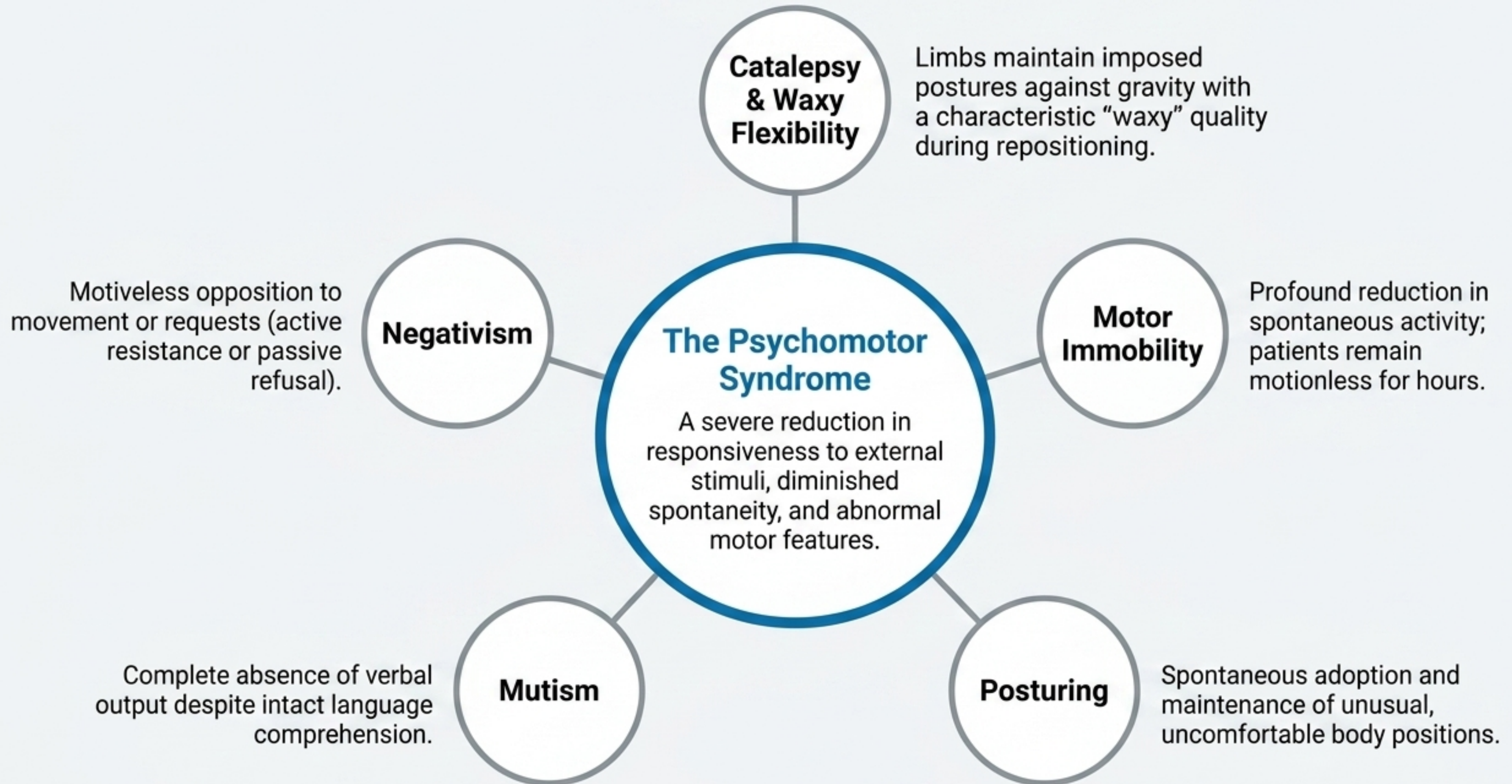
40% Mortality

The historical death rate for untreated Malignant Catatonia (reduced to <5% with modern, rapid intervention).

Breaking Free From the Schizophrenia Umbrella



The Core Phenomenological Signature



The Three Clinical Presentations

Retarded (Most Common, ~70%)

Profile:

Stupor, motor immobility, waxy flexibility.

Key Features:

Mutism, posturing, negativism, preserved reflexes but reduced spontaneity.

Excited (Often Misdiagnosed)

Profile:

Hyperactivity, agitation, purposeless movement.

Key Features:

Impulsivity, forced speech, echolalia/echokinesis, potential aggression. Often confused with severe mania.

Malignant (Medical Emergency)

Profile:

Autonomic dysregulation.

Key Features:

Hyperthermia ($>38.5^{\circ}\text{C}$), lead-pipe rigidity, tachycardia/hypertension, altered consciousness, elevated CK. High mortality risk.

Beyond Psychiatry: The Etiological Landscape

Psychiatric (48-90%)

Schizophrenia, bipolar, major depression, conversion.

Clues: Mood/psychotic features predominate; highly responsive to benzodiazepines.

Neurological (10-30%)

Anti-NMDA/GABA encephalitis, epilepsy, stroke.

Clues: Abnormal CSF/imaging, oncologic history; may not respond to lorazepam; often requires immunotherapy.

Medical/Systemic (10-40%)

Infection/sepsis, metabolic (hyponatremia), autoimmune (SLE).

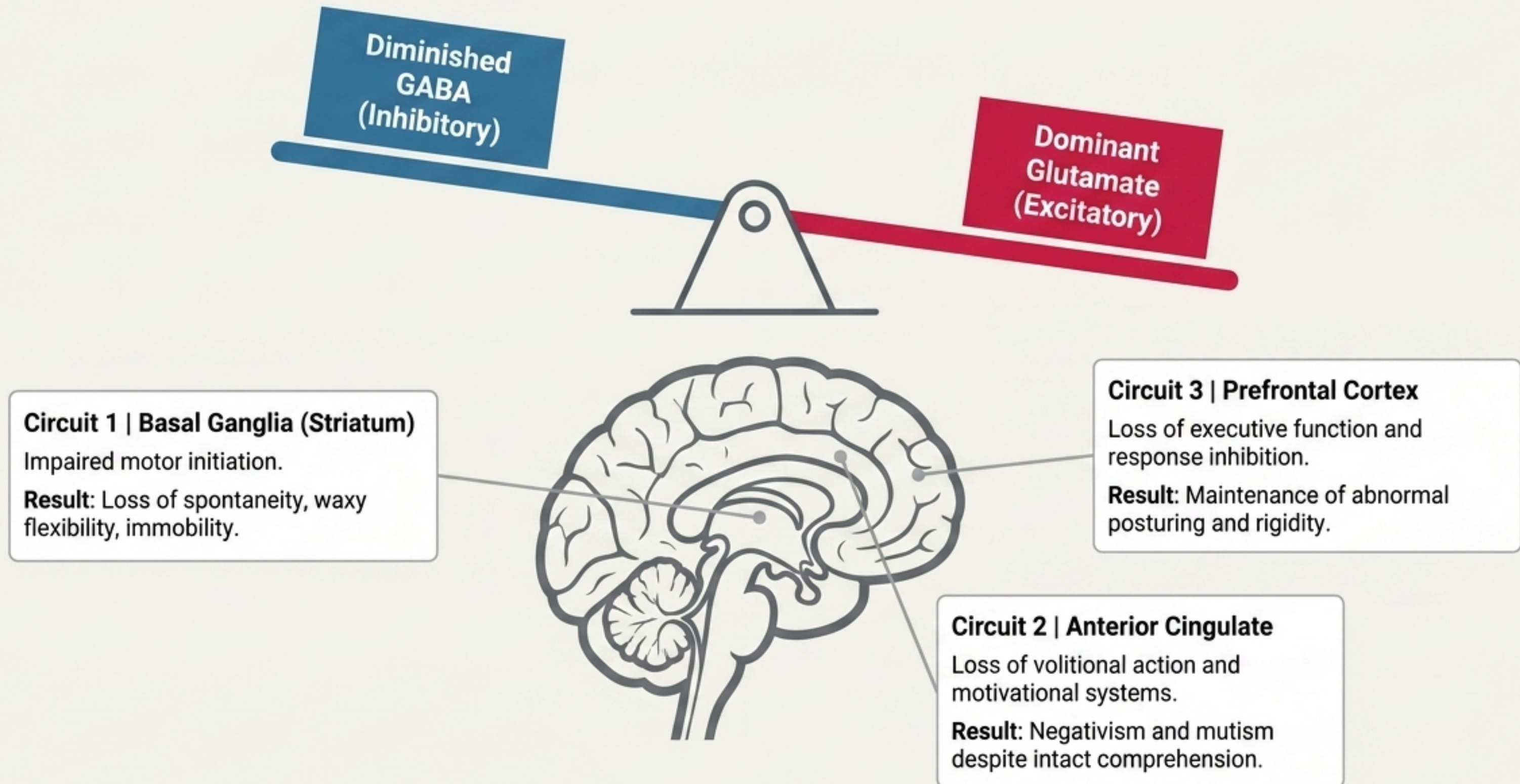
Clues: Abnormal lab values; resolving the underlying condition reverses the catatonia.

Medication-Induced (5-15%)

Antipsychotics, stimulants, BZD withdrawal.

Clues: Critical temporal relationship to med change; avoiding antipsychotics is paramount.

The Neurochemical Seesaw: GABA vs. Glutamate



The Gold Standard: Bush-Francis Catatonia Rating Scale

Motor Deficits

Immobility/Stupor
Waxy Flexibility
Posturing
Rigidity
Grimacing
Stereotypy
Reflex Abnormalities

Verbal Abnormalities

Mutism
Verbigeration
Echolalia

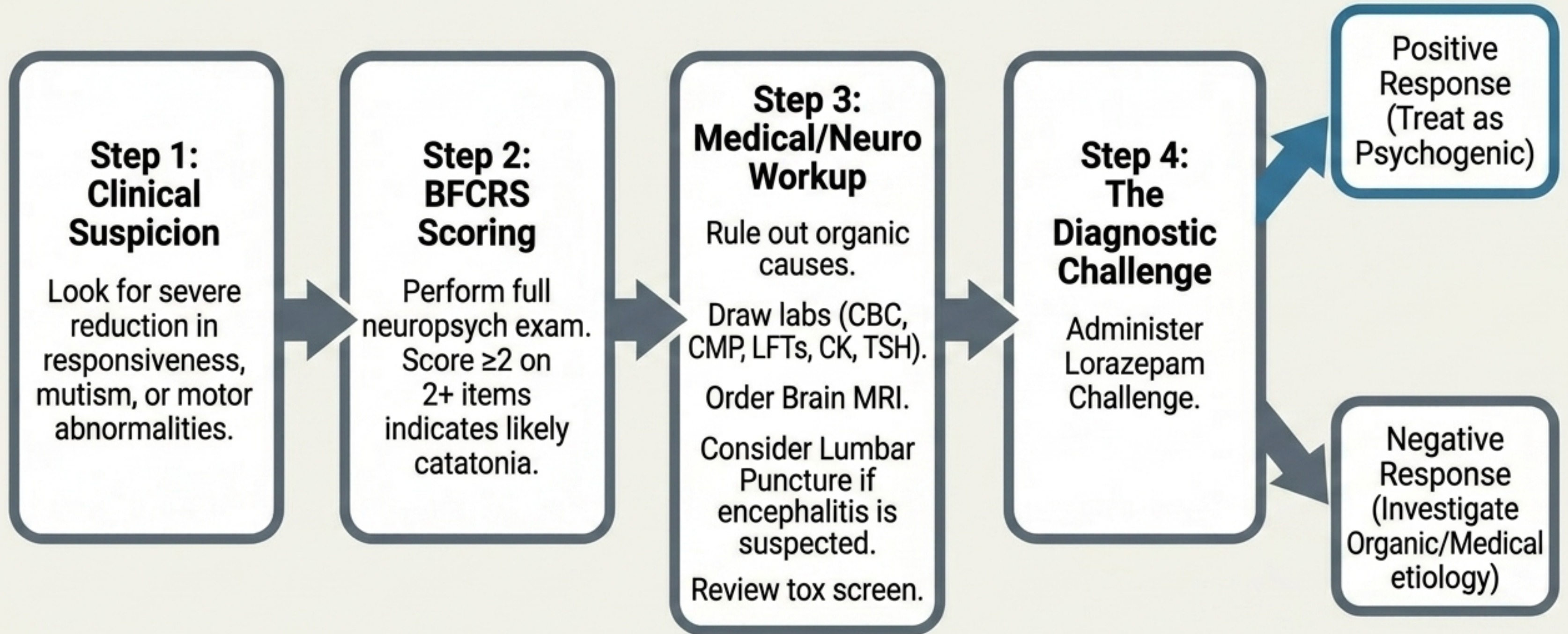
Behavioral Resistance

Negativism
Excitement
Echokinesis
Combateness

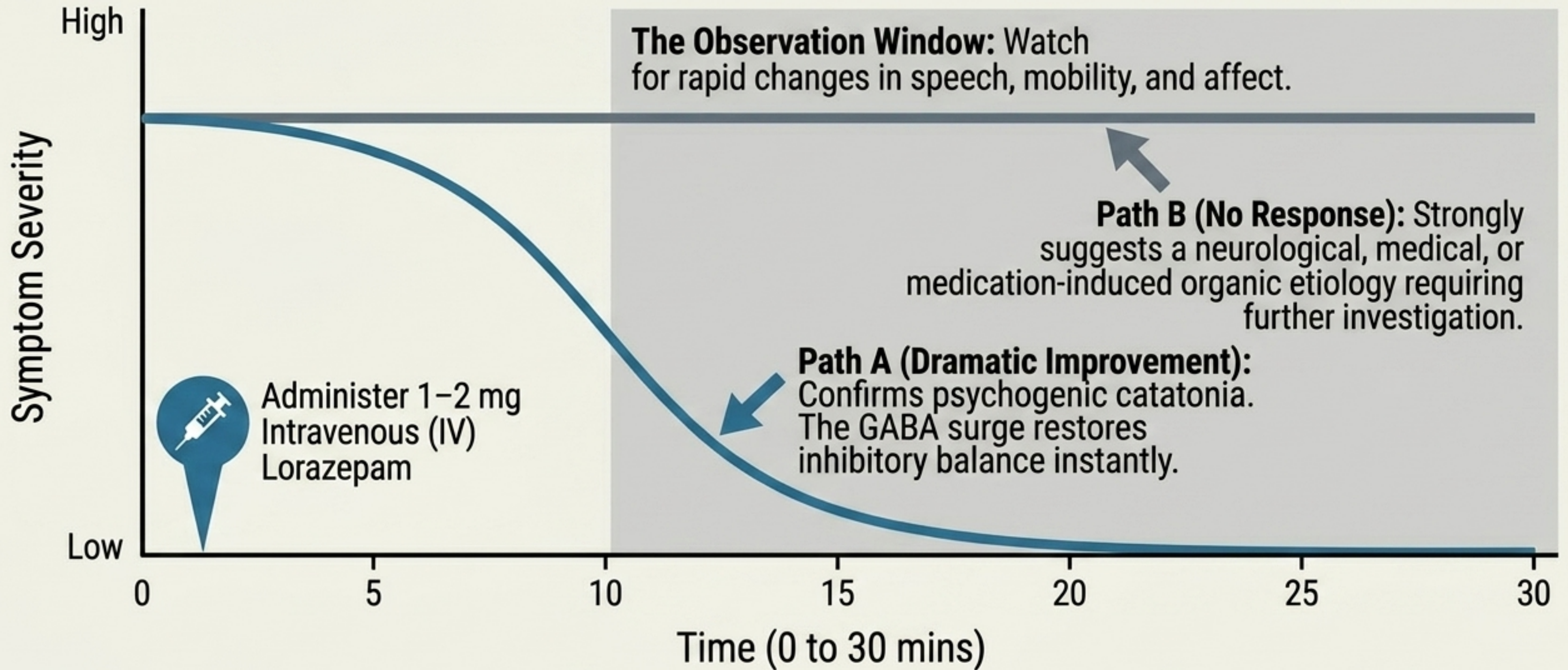
Diagnostic Threshold Panel

Each item scored 0-3. A score of **≥ 2 on ANY** item suggests presence.
A total score **≥ 5 (or ≥ 2 on two items)** signals **probable catatonia**.

The Standardized Diagnostic Workup



The Lorazepam Challenge: Test and Treatment



CLINICAL ALERT: Recognizing Malignant Progression

The Context: Untreated, benign catatonia can rapidly progress to malignant status, carrying a **40% historical mortality rate** due to rhabdomyolysis and AKI.

TEMP Hyperthermia >38.5°C	HEART/BP Tachycardia (>120 bpm) & Hypertension (>180/120)
MUSCULATURE Lead-pipe rigidity	LABS Elevated Creatine Kinase (CK >1000 IU/L)

ACTION: Constitutes an ICU-level medical emergency requiring immediate high-dose IV benzodiazepines and possible ECT.

First-Line Intervention: Restoring GABAergic Tone

Efficacy: 70-90% of patients show dramatic response to Benzodiazepines.

Tier 2: Maintenance Phase (Weeks 2-4)

- **Protocol:** Transition to oral dosing (**6-30 mg/day** divided **BID-TID**).
- **Tapering Rules:** Gradual taper only. Reduce by 25% every 3-7 days. Restart immediately if symptoms recur.

Tier 1: Acute Phase (Days 1-7)

- **Protocol:** **1-2 mg IV Lorazepam** (or **5-10mg IV Diazepam**) every 4-6 hours.
- **Dosing:** Typically requires **10-40 mg/day** Lorazepam equivalent.
- **Rule:** Do NOT begin tapering until the patient is 48-72 hours **completely symptom-free**. Monitor respiration.

Second-Line & Adjunctive Strategies

Electroconvulsive Therapy (ECT)

The most effective intervention (>90% success) for Benzodiazepine-resistant cases.

Deployment Criteria: Malignant catatonia, severe danger to self/others, underlying severe psychiatric illness, or failed Lorazepam challenge.

Adjunctive Protocols

For Psychiatric:

Add antipsychotics/antidepressants ONLY after the acute catatonic state is resolved (avoiding worsening of symptoms).

For Neurological:

Immunotherapy (plasmapheresis/IVIG) alongside benzodiazepines for autoimmune encephalitis.

Supportive:

Nutrition (PEG tube if swallowing impaired), DVT prophylaxis for immobile patients.

Sites of Care: Matching Setting to Severity

Intensive Care Unit (ICU)



For Malignant features (Temp $>39^{\circ}\text{C}$, CK $>10,000$, dysautonomia) requiring continuous monitoring and respiratory support.

Acute Psychiatric Hospital



Primary setting for stable, psychogenic cases requiring intensive Benzodiazepine schedules and ECT capability.

Neurological Unit



For suspected encephalitic etiologies requiring neuroradiology, lumbar punctures, and complex immunology consultations.

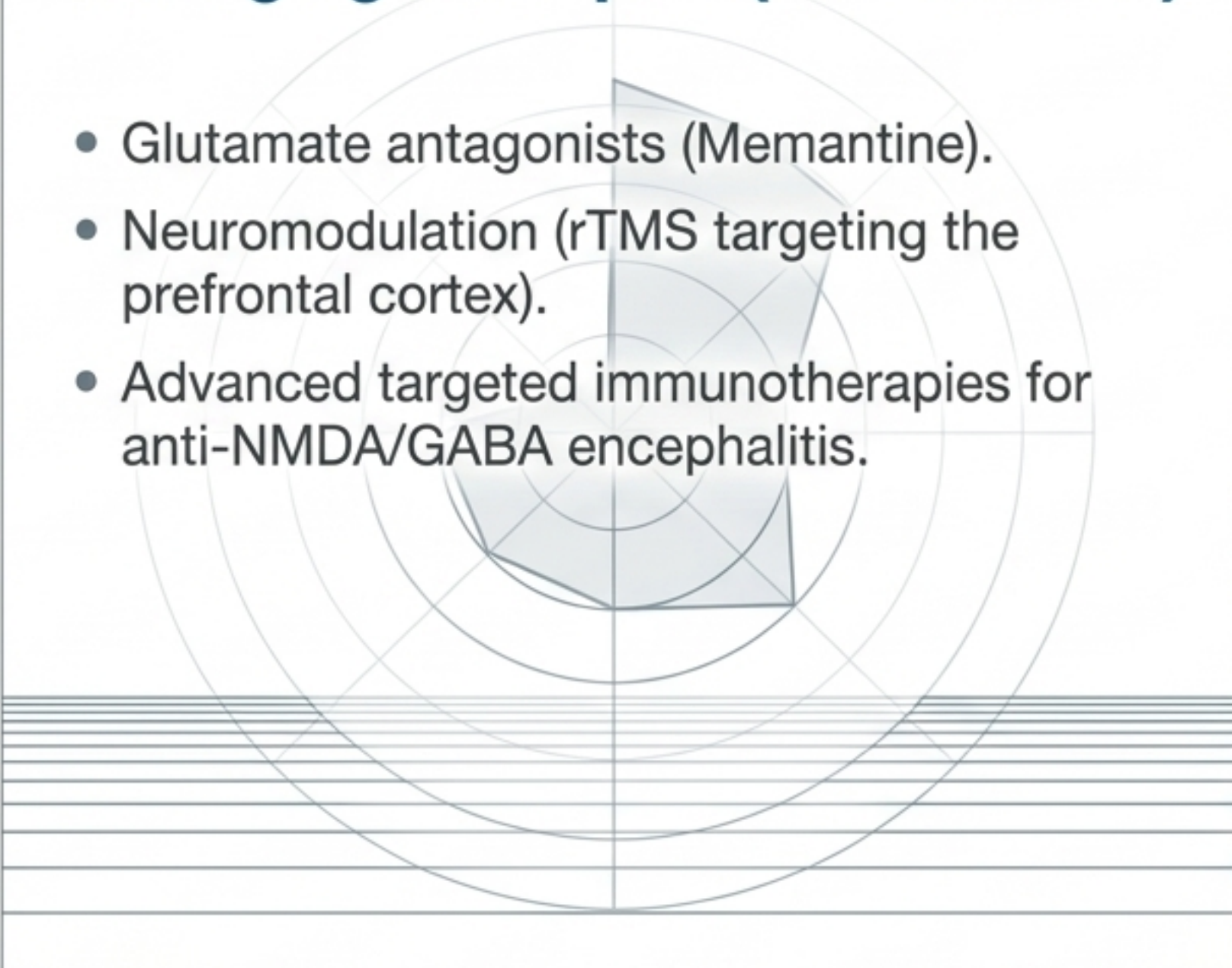
General Medical Floor



For stable cases driven by underlying medical etiologies (e.g., active sepsis management) with psychiatric consultation.

Clinical Synthesis & The Modern Frontier

Emerging Therapies (The Horizon)

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- Glutamate antagonists (Memantine).
 - Neuromodulation (rTMS targeting the prefrontal cortex).
 - Advanced targeted immunotherapies for anti-NMDA/GABA encephalitis.

The 5 Golden Rules of Catatonia Management

1. Maintain high clinical suspicion for mutism and motor anomalies.
2. Always utilize the 14-item BFCRS for standardized tracking.
3. Rule out organic/medical causes before assuming psychiatric origin (10-52% are organic).
4. Use the Lorazepam Challenge as both the definitive test and immediate intervention.
5. Treat Malignant Catatonia as a high-mortality, ICU-level emergency.