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**Case Report**

# Missing Features of Catatonia in Major Depressive Disorder: A Case Study

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## ABSTRACT

*Catatonia is a complex disease that is commonly seen in patients suffering from acute neuropsychiatric disorders. With respect to Major Depressive Disorder (MDD), in particular, catatonic features are frequently disregarded. In this condition once neuropsychiatric examination is done catatonia features should be evaluated and if left untreated; it can have life-threatening effects. Here, we describe a case of a 25-year-old woman who presented with diagnostic dilemma of having the MDD with the features of catatonia. However, she received psychiatric treatment for MDD only. On 3rd day patient was brought to emergency and after the comprehensive evaluation, the patient was finally diagnosed with MDD with catatonic characteristics. Subsequently, she was given pharmacological treatment of Inj. lorazepam, 1-2 mg/day intramuscular, and improvement was noticed within the first ten minutes. We believe that adding benzodiazepines (BZDs) to a psychotropic regimen would be beneficial to treat mixed features of catatonia and depression that is required to continue for a period of three to six months in order to prevent relapses.*

**KEYWORDS:** Depression, Negativism, Stupor, Catatonia

## BACKGROUND

Approximately 14% of people with severe psychiatric problems have been found to have catatonia, a complicated psychomotor illness[1]. The two varieties of catatonia are retarded and stimulated, respectively, and are distinguished by their lack of movement, retreat and reluctance to eat, posturing, negativism, stereotypy, automatic obedience, etc.

Depression is often discovered to have a known history in catatonia cases, especially in middle age patients[2].

Catatonia is a marked disturbance in the voluntary control of movements including extreme slowing or absence of motor activity, mutism, purposeless motor activity unrelated to external stimuli, assumption and maintenance of rigid, unusual or bizarre postures, resistance to instructions or attempts to be moved, or automatic

compliance with instructions[3]. This is due to the fact that there are no particular confirmatory tests for this illness[4].

It involves 5–18% of patients in psychiatric inpatient facilities, 12% of patients with first-episode psychosis who have never taken drugs, and 8.9% of older patients with psychiatric illness[5].

However, catatonia is frequently misdiagnosed in severe cases of psychiatric disorders when the presenting symptoms may overlap with those of the condition, which may be fatal[6].

There are few studies on catatonia and its treatment in MDD patients from India, despite the fact that it is a common symptom among MDD patients. An intriguing example of a young female patient with MDD and sudden catatonia is presented here.

## CASE DESCRIPTION

In January, a 30-year-old woman complained of having less sleep, difficulty in speaking, a stern expression, a low mood, a lack of interest in activities she used to enjoy; decreased energy, fewer social interactions, a lack of appetite, and a lack of self-care. She had previously seen numerous psychiatrists for her MDD, for which she was treated with mirtazapine 15 mg/day with no appreciable improvement. The results of a general examination revealed no anomalies in vital signs, orientation, or consciousness. She was asked to come in for a follow-up appointment the following week after being moved on to paroxetine 12.5 mg/day therapy.

The patient was taken to the emergency room 2 days after, in February due to concerns of diminished interaction, a refusal to eat, a lack of sleep, and a failure to obey orders from the previous two days. The regular biochemical tests she underwent after being admitted to the psychiatry ward — the thyroid function test, full blood count, liver function test, kidney function test, and serum electrolytes — all came normal. The patient was interviewed that day in her room since she wouldn't get out of bed. She didn't say much verbally and shown negativity by declining to work with the therapy team.

The first day of catatonia according to the Bush Francis rating scale has a score of 30 for mutism, stiffness, negativism, abnormal posturing, stupor, withdrawal, and gazing. Given these results, her diagnosis was changed to MDD with catatonic aspects, and she began receiving injectable lorazepam 1 mg twice day as well as a 25 mg/day increase in paroxetine right away. The patient was out of bed and interacting with the family members in less than two hours. Within two hours of lorazepam medication, the catatonia score on the Bush Francis rating scale significantly decreased.

The following day, she started interacting with the staff, consuming meals, and taking her oral drugs on a regular basis. Her quality of sleep and self-care also enhanced. The symptoms of depression significantly improved, and she was discharged on day 10 while taking oral tablets containing paroxetine 25 mg/day and lorazepam 2 mg/day. Following a 10-day check-up, the patient denied having symptoms of depression, but the medication she was taking was kept the same.

## DISCUSSION

The present case study serves as a reminder of the significance of thoroughly evaluating catatonia in MDD patients, who are frequently treated ineffectively for their catatonic symptoms while being mistakenly classified as having an acute episode of the primary disease. Furthermore, the likelihood that catatonia may go untreated may be increased by the similarity between the psychomotor slowness in MDD and the non-responsiveness found in catatonia. In our patient, the presence of posturing and negativism strongly suggested catatonia, which is consistent with previously described cases of MDD with catatonia, particularly in grown up female patients[7,8]. Catatonia is treated differently from other forms of MDD. The addition of a BZD has been demonstrated to reduce relapses and recurrences while also improving catatonia and depression. For catatonic MDD, lorazepam is the drug of choice because it has a proven 80% remission rate[9]. The starting dose, which is 1-2 mg given intravenously every 4–12 hours, provides immediate relief in catatonic symptoms as demonstrated in our patient and in other cases of similar nature[6,7]. The decrease or inhibition of the gamma amino butyric acid (GABA) receptors that link the basal ganglia with the cortex and thalamus in the right orbitofrontal lobe may be one explanation for the role of a BZD in catatonia. It's interesting to note that only the right orbitofrontal activity is claimed to be decreased in catatonic patients, whereas the left orbitofrontal lobe activity is believed to be unaffected[10]. Electroconvulsive therapy (ECT) or a combination of BZD and ECT may be suggested for patients who do not react to BZD[11]. Given the lack of published information on the treatment of catatonia in MDD from the North Indian region, this case report would be a crucial record for building a body of evidence for treating this difficult condition.

## CLINICAL SIGNIFICANCE

The avoidance of any long-term morbidity depends on the early diagnosis and treatment of catatonia. The signs of catatonia in MDD patients may be disregarded as psychomotor retardation, which makes a diagnosis more challenging and calls for a high degree of suspicion. Hence, treating catatonia acutely, lorazepam as alternative can be considered as a drug of choice that has shown efficacy in these complex syndromes.

**CONFLICT OF INTEREST:** None

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