CATATONIA AND CANCER CARE: NOT JUST A PSYCHIATRIC DIAGNOSIS
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BACKGROUND
Catatonia is potentially reversible syndrome that results in an acute change to one’s mentation, physical, and autonomic presentation that can frequently be misdiagnosed as a medical emergency. Once thought to be only psychiatric in nature, research now identifies 20-40% prevalence in those with ongoing medical populations, occurring in 10% of the population.

Given the complexity of not only identifying catatonia swiftly, but treatment, medical catatonia is frequently a missed diagnosis, and can comorbidity exist with a delirium, making treatment challenging. A cascade of contributing factors (infection, brain injury, medications, organic) should be considered to be contributory to the suspected dysregulation of neurotransmitters (dopamine, GABA, NAAA, Glutamate) that result in the 3 predominant medical catasotnia characterized as hypokinetic, hyperkinetic, and malignant catatonia.

A standardized scale assessment (Bush-Francis Catatonia Scale) is a 23-point screening tool that is used to identify and score severity, and efficacy of treatment. Scheduled Lorazepam was prescribed; the initial diagnosis of catatonia, amantadine was added and titrated up to 100 mg twice daily. Lorazepam was weaned off over 10 days, tapering, while adding bid amantadine (12/20 – current) up to 100mg twice daily. Lorazepam was weaned off over 10 days, tapering, while adding bid amantadine (12/20 – current) up to 100mg

CASE #1
The patient is a 66 female with a history of bipolar two disorder that had been stable. Bush-Francis catatonia scale (+ catatonia). All vital signs were within normal limits, with no signs of hypothyroidism or norepinephrine. The patient was started on amantadine.

The patient was readmitted for evaluation – 3 weeks later (10/25) with AHS and sleep disorders; a sleep disordered breathing and hypothyroidism. She was admitted to the hospital for a sleep study and was found to have a period of sleep apnea.

The patient was discharged home; however, the husband reported that the patient was not getting any sleep.

The patient was transferred to ICU on 11/22 and was intubated. She was noted to experience intermittent delirium with hallucinations and agitation requiring some use of antipsychotic medication for behavioral management. Attempts were made to wean down lorazepam without consistent success as patient continued to be intermittently delirious and catatonic. Mood became more depressed, and duloxetine was increased. Three weeks after intubation, the patient became autonomically unstable, with concern for malignant catatonia. The patient received 100mg amantadine twice daily with improvement. Her recovery was slow and her cognitive status began to improve. She was eventually transferred to a skilled nursing facility for further rehabilitation. The patient was discharged with amantadine 100 mg twice daily, duloxetine 20 mg daily, and quetiapine 150 mg daily. A trial of Depakote was prescribed; the patient eventually achieved complete resolution of her catatonic symptoms and was weaned off lorazepam without consistent success as patient continued to be intermittently delirious and catatonic. Mood became more depressed, and duloxetine was increased. Three weeks after intubation, the patient became autonomically unstable, with concern for malignant catatonia. The patient received 100mg amantadine twice daily with improvement. Her recovery was slow and her cognitive status began to improve. She was eventually transferred to a skilled nursing facility for further rehabilitation. The patient was discharged with amantadine 100 mg twice daily, duloxetine 20 mg daily, and quetiapine 150 mg daily.

CASE #2
The patient is a 46-y/o female with a history of tumerous calcinosis and lymphedema. She presented with complaints of fatigue, weight loss, and dyspnea. The patient was started on amantadine.

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LESSONS LEARNED
Early detection, assessment and implementation of catatonia in our fragile oncology population can lead to more positive outcomes and improve the recovery of those identified with a medical catatonia, increasing a clinician’s awareness of medical catatonia can lead to earlier detection and decrease in morbidity.

REFERENCES


