The Medicine-Psychiatry Unit: After Dualism, Considering Catatonia from an Integrated Framework

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Background

In the acute medical-surgical setting, >50% of catatonia stems from medical etiology (Oldham, 2018). We present a case illustrating how the medicine-psychiatry unit (MPU) created the integrative environment necessary to uncover the medical etiology of one patient's malignant catatonia: neuropsychiatric lupus (NPSLE).

Case Summary

MZ is a 66-year-old woman with schizophrenia (treated by Haldol 5 mg qhs), hypertension, hyperlipidemia, diabetes, osteoporosis, tuberous sclerosis and seizure disorder, who first presented with altered mental status, fever, and new oxygen requirement. Broad-spectrum antibiotics for lobar pneumonia initially yielded clinical improvement, but 21 days into her community hospitalization she developed fever, autonomic instability, hyperreflexia, and dystonic posturing. MZ was then transferred to our MPU for further evaluation of neuroleptic malignant syndrome (NMS) versus malignant catatonia. Collaboration between many subspecialties provided the integrated care necessary to untangle the cause of MZ's malignant catatonia.

Subspecialty Consults

- **Infectious Disease:** rule out occult infection, given recurrent fevers, hypotension, and leukopenia despite broad-spectrum antibiotic treatment
- **OBGYN:** rule out occult pelvic infection, given the above, and patient's history of inserting foreign objects in the vagina while psychotic
- **Neurology:** rule out neurological etiology, given seizure history, absence of AED treatment, and the statistic that 70% of medical catatonia is secondary to CNS disease (Rogers, 2019)
- **Hematology:** rule out hematological causes of progressively worsening leukopenia or ongoing infection
- **Rheumatology:** rule out lupus cerebritis, given elevated ANA
- **Dermatology:** evaluate herpetic rash after steroid initiation and recommend treatment
- **Psychiatry:** rule out serotonin syndrome, given rigidity and hyperreflexia

DDx of Psychomotor Symptoms

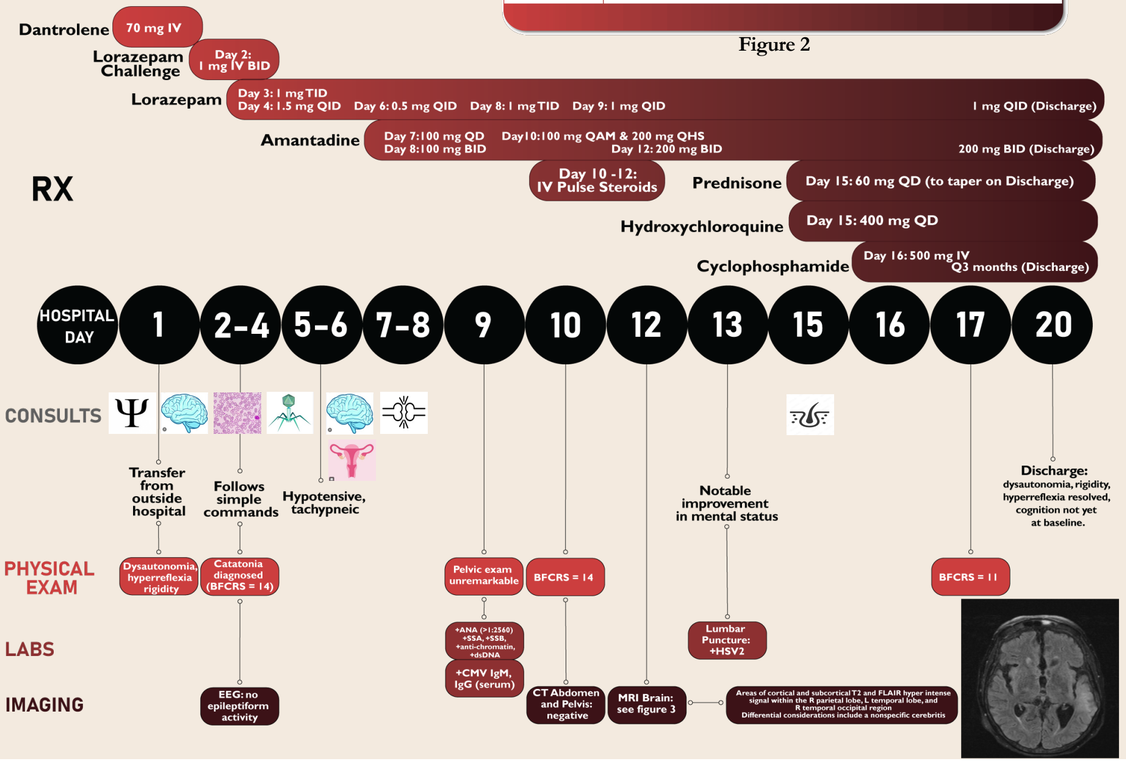
Catatonia	Medical / Psychiatric
Malignant Catatonia	
Neuroleptic Malignant Syndrome	
Serotonin Syndrome	
Delirium	

Figure 1

DDx of Catatonia Etiology in This Case

Psychiatric	History of schizophrenia
Infectious	1. Occult infection (recurrent fevers, hypotension, and leukopenia despite broad-spectrum antibiotic treatment and negative blood cultures; patient also had a history of inserting foreign objects in the vagina while psychotic); ruled out with abdominal CT and pelvic exam 2. CMV (+IgM in CSF); ruled out as relevant by ID 3. Herpes encephalitis (+HSV2 in CSF); treated with IV acyclovir
Neurologic	Seizure/status epilepticus (history of seizure disorder without current anti-epileptic treatment); ruled out with EEG
Autoimmune	NPSLE (+ANA (high titer), subsequently +SSA, +SSB, +antichromatin, +dsDNA; suggestive MRI brain findings)

Figure 2



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Disclosures
We have no financial or other disclosures. This case report was reviewed by the UH IRB and approval is not required - IRB Number: STUDY20231124. The patient's guardian provided informed consent.

Discussion

Delayed identification of MZ's neuropsychiatric lupus exemplifies the conundrum of the psychiatric patient, whose medical problems are often inappropriately attributed to psychiatric illness (Reeves, 2010). Factors that likely contributed to the initially narrow diagnostic framework include:

- **Anchoring bias**: initial misattribution of illness to one early hypothesis, with subsequent reluctance to broaden the differential.
- **Intersection of marginalized identities**: a Hispanic woman older than 65, diagnosed with schizophrenia, and disabled to an extent that precluded communication or self-advocacy.
- **Historical misconception:** relegating catatonia exclusively to the house of psychiatry.

Strategies to Promote Whole Health

- **Medical Psychiatric Unit** frames patients with psychiatric conditions as full people requiring comprehensive medical workup and ongoing access to subspecialty consults with a primary medical team.
- **CL psychiatrists can mitigate anchoring bias** by drawing attention to clues pointing towards an unidentified medical etiology; in this case, the failure of scheduled lorazepam and amantadine to improve malignant catatonia.
- **Emphasize prevalence of medical catatonia** advocating for consideration of NMDA-receptor encephalitis and NPSLE, the two most common autoimmune neurologic conditions associated with catatonia.

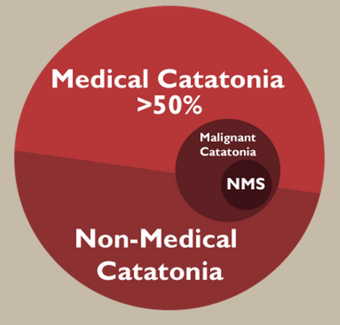

Figure 3

Conclusion

Minoritized people are more likely to be diagnosed with psychiatric conditions before ruling out possible explanatory medical conditions (like NPSLE). Premature and inappropriate psychiatric diagnoses– like MZ's highly questionable diagnosis of schizophrenia— detract from subsequent medical workups. Ageism, ableism, and the communication challenges of catatonia further conspire to divorce patients from structural power. Consult liaison psychiatrists are uniquely equipped to advocate for a thorough medical evaluation of catatonia in the general hospital. The MPU environment offers the integrated care across subspecialties that complex cases like this one require.