Sometimes There's No Place Like Home: An Illustrative Case for the Outpatient Management of Catatonia

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Introduction

Catatonia is traditionally considered a disorder primarily of inpatient management. The significant associated morbidity and mortality and need for close monitoring of treatment response often favor management in acute care medical or psychiatric units.

However, identifying and treating catatonia in ambulatory settings may carry significant benefits, including diagnosis earlier in the illness course and circumvention of access barriers to inpatient treatment. An outpatient approach to treatment optimizes patient autonomy, minimizing unintended trauma that can result from hospitalization [1,2].

Little has been published regarding the outpatient diagnosis and treatment of catatonia [1,3]. We present the case of a 50 yo patient illustrating best practices for ambulatory catatonia treatment, as well as potential pitfalls.

Case Presentation

Mr. L is a 50 yo male with schizoaffective disorder, bipolar type and suspected neurodevelopmental disorder who presented to our outpatient clinic to reestablish psychiatric care. He lived with his mother, who was highly invested in his care and accompanied him to each visit.

- Several months into treatment Mr. L's mother reported that he had become mute, was staring into space, and had significant decline in oral intake.
- Mr. L was scheduled for urgent outpatient follow-up and diagnosed with catatonia, scoring 11 on the Bush-Francis Catatonia Rating Scale (BFCRS).
- Both Mr. L and his mother were hesitant about hospitalization. After extensive psychoeducation and discussion of ED return precautions, he was sent home with a prescription for 2 mg of oral lorazepam and instructions for mother to call his psychiatrist shortly after administration.

Case Presentation, Continued

- After receiving lorazepam, mother described Mr L as more interactive and eating. A prescription for lorazepam 1 mg twice daily was sent and close follow-up scheduled with plan for further titration over future visits.
- At his next follow-up, oral intake and withdrawal continued to improve (BFCRS 5).
- Upon subsequent follow-up visits Mr. L's BFCRS improved to 0 and catatonia symptoms remained in remission on this dose for 12 months.
- One year later, Mr. L's mother was hospitalized for an illness, soon after which he became nonadherent to medications and was later admitted to inpatient psychiatry for re-emergent catatonia symptoms.

Figure 1: Case Timeline

A Suggested Approach to Outpatient Catatonia Management

Recognition

Early recognition and treatment initiation are of particular importance if catatonia is to be safely and effectively managed outpatient; consider **active screening for symptoms in high-risk groups**

Diagnosis

Assess symptoms using validated rating scale, e.g. BFCRS

- Physical examination
-Vital Signs
-Labs, medical consultation

- Mental Status Exam
- Thorough medical & psychiatric history

Conduct a lorazepam challenge:
- Give lorazepam 1-2mg oral in-office, reassess symptoms in 30 mins
- A modified, remote challenge may be an option in select cases

Treatment Planning

Determine candidacy for outpatient management:
- Symptom severity
- Medical/psychiatric comorbidity
- Psychosocial support

Psychoeducation for patient & caregivers:
- Instruction in use of a symptom monitoring tool[#]
- Symptoms warranting escalation of care

Treatment

Frequent follow-up and **caregiver contact** to monitor symptoms and treatment response

Gradual titration of benzodiazepine: will likely require increases between visits in collaboration with caregivers, especially early in treatment

Continuous re-evaluation of need for escalation in level of care at each visit

Contraindications to outpatient catatonia management:
- High-risk underlying medical conditions or comorbidities (e.g. autoimmune encephalitis)
- Autonomic/thermoregulatory instability (e.g. malignant catatonia, neuroleptic malignant syndrome)
- Other need for close medical monitoring, IV fluids, etc
- High-risk acute psychiatric pathology (psychosis, mania, severe depression, suicidal ideation, delirium)
- Dehydration, severe malnutrition
- Inadequate or unreliable caregiver/family support
- Inability to attend frequent follow-up appointments (telepsychiatry may be an option in select cases)

[#]Daily Catatonia Report (DCR) [1]
- Qualitative symptom report measure for families and caregivers
- 18 items based on BFCRS
- Has not been clinically validated

Conclusions

Despite potential benefits in early symptom recognition, care access, and avoidance of destabilizing disruption in routine or iatrogenic trauma, the existing literature regarding the management of catatonia on an outpatient basis is limited.

As with its inpatient management, standard practice in the outpatient treatment of catatonia should include:

- Timely recognition of symptoms
- Workup to identify and address any underlying medical causes or complications
- Trial benzodiazepine challenge to confirm the diagnosis and initiate treatment
- Frequent reassessment of symptoms with validated rating scales (e.g. BFCRS)

Mr. L's case illustrates the close caregiver support and communication, alliance with patients/families, and frequent follow-up with attention to indications for escalation of care essential for catatonia to be safely and effectively managed as an outpatient [1,4].

Given the experience of many C-L psychiatrists in managing catatonia and liaising with medical colleagues, those working in outpatient or integrated care settings may be ideally positioned to recognize catatonia early, determine its appropriate treatment setting, and provide high-quality care to candidates for outpatient treatment.

References

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