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Childhood Catatonia

Catatonia is a syndrome of motor dysregulation that is rarely recognized in pediatric age group with an estimated incidence of 0.16 million per year [1,2]. In any patient presenting with catatonia, neurological or other general medical conditions, neuroleptic induced side effects, substance intoxication or withdrawal should be ruled out before considering psychiatric etiology [3]. We report a rare case of childhood catatonia due to psychosis.

Master A, 11-year-old male, a fourth standard student, presented with abrupt onset and gradually progressive course of decreased interpersonal interaction and decreased self care for 3 months. He was evaluated in pediatrics, pediatric neurology and endocrinology OPD. Personal and developmental history was uneventful. There was no history of seizure, fever, drug use preceding onset of illness. Apart from BMI of 28, physical examination did not reveal any abnormality. Slit lamp examination did not reveal K-F ring. Hemogram, renal function tests, liver function tests, MRI brain, thyroid profile, serum insulin, fasting blood glucose, post-prandial blood glucose and serum cortisol did not reveal any abnormality. As no organic cause was found, he was referred to child and adolescent psychiatry OPD.

On mental state examination, patient fulfilled syndromal diagnosis of catatonia and had psychotic signs. He was not clinically depressed. He was diagnosed to have psychosis unspecified (F 29) and treated with risperidone (upto 4 mg/day) and lorazepam (upto 4 mg/day). He gradually improved over 8 weeks. Lorazepam was tapered and stopped. He was discharged on risperidone 4 mg/day. At 3 months follow up, he was mildly inactive as compared to his usual self but was doing well otherwise.

Dysregulation of γ-aminobutyric acid (GABA)-A, glutamate, and dopamine systems are hypothesized to be involved in catatonia [4]. Deprivation, abuse and trauma can precipitate catatonia in paediatric patients without clear medical cause [5]. Acute management of catatonia involves lorazepam challenge test, identifying and correcting underlying medical cause, maintaining adequate nutrition, fluid and electrolyte balance, and avoiding postural immobility which may lead to complications like bed sores or muscle contracture [4]. Electroconvulsive treatment (ECT) is considered as the last choice [4]. As our patient responded well to pharmacotherapy, ECT was not necessitated.

Catatonia is poorly recognized in children and adolescents due to overshadowing by medical or neurological or pervasive developmental disorders [5]. Accurate diagnosis is important because catatonia responds readily to benzodiazepines and electro-convulsive therapy.

ROSHAN BHAD AND RAJESH SAGAR
Department of Psychiatry and National Drug Dependence Treatment Centre,
All India Institute of Medical Sciences, New Delhi 110 029, India.
drroshansindia@gmail.com

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