ISSN: 0975-833X

Available online at http://www.journalcra.com

International Journal of Current Research
Vol. 12, Issue, 05, pp.11479-11480, May, 2020

DOI: https://doi.org/10.24941/ijcr.38577.05.2020

INTERNATIONAL JOURNAL OF CURRENT RESEARCH

RESEARCH ARTICLE

MANAGEMENT OF PERIODIC CATATONIA BY RISPERIDONE

[1]Dr. Vipin Nain, [2,*]Dr. Anirudh Bhushan, [3]Dr. Priti Singh and [4]Dr. Rajiv Gupta

[1]Junior Resident, 3rd year, Dept. of Psychiatry, Pt B.D. Sharma PGIMS, Rohtak
[2]Junior Resident, 3rd year, Dept. of Psychiatry, Pt B.D. Sharma PGIMS, Rohtak
[3]Senior Professor, Dept. of Psychiatry, Pt B.D. Sharma PGIMS, Rohtak
[4]Senior Professor and Head of Department, Dept. of Psychiatry, Pt B.D. Sharma PGIMS, Rohtak

ARTICLE INFO

Article History:
Received 28th February, 2020
Received in revised form
14th March, 2020
Accepted 28th April, 2020
Published online 30th May, 2020

Key Words:
Ivory Coast, soybeans,
Lima Bean, Cowpea,
Pigeon Pea.

ABSTRACT

Catatonia is a syndrome having symptoms such as catalepsy, waxy flexibility, stupor, posturing, negativism, mutism and echolalia.1There are numerous causes of catatonia but patients with affective illness and schizophrenia, accounts for 25% of the catatonia population.2 An untreated and prolonged course of catatonic features may lead to life-threatening complications such as the development of pulmonary embolism or aspiration pneumonia, and significantly increased mortality and morbidity 3

Citation: ***Dr. Vipin Nain, Dr. Anirudh Bhushan, Dr. Priti Singh and Dr. Rajiv Gupta.*** **2020.** "Management of periodic catatonia by risperidone", *International Journal of Current Research*, 12, (5), 11479-11480.

INTRODUCTION

Catatonia is a syndrome having symptoms such as catalepsy, waxy flexibility, stupor, posturing, negativism, mutism and echolalia (Fink *et al*., 2001). There are numerous causes of catatonia but patients with affective illness and schizophrenia, accounts for 25% of the catatonia population (Abrams, 1976). An untreated and prolonged course of catatonic features may lead to life-threatening complications such as the development of pulmonary embolism or aspiration pneumonia, and significantly increased mortality and morbidity (Ignatowski, 2007). Kraepelin and two other lesser known Europeans, Gjessing and Leonhard, are associated with the concept of periodic catatonia.It is characterized by catatonic episodes occurring in a cyclical manner with clinical features of combined stupor and excitement, remissions to an interval state and an autosomal dominant pattern of transmission (Taylor, 2003). The pathogenesis of periodic catatonia is complex and poorly understood. It is reported that the average interval of recurrent catatonia is 10.7 months, varying from 4.5 to 20 months (Sienaert, 2014). Benzodiazepenes and ECT had been considered the first line treatments for catatonic symptoms (Cárdenas-Delgado, 2012).

Corresponding author: **Dr. Anirudh Bhushan,**
Junior Resident, 3rd year, Dept. of Psychiatry, Pt B.D. Sharma PGIMS, Rohtak.

Although acute catatonia has been shown to be responsive to benzodiazepines, they are generally not effective for chronic catatonia. A double-blind placebo-controlled study shows that lorazepam has no effect in chronic catatonia (Ungvari, 1999). There had been case reports suggesting role of antipsychotics in the management of periodic catatonia (Guzman, 2007; Chen, 2017). We present a case report of male patient who presented with recurrent catatonic symptoms and had shown improvement with risperidone and lorazepam combination.

CASE DESCRIPTION

A 25-year-old man educated up to class 10, unmarried from rural background was brought to the Psychiatry OPD by his mother having complaints of being non-responsive to commands, food refusal and lying still for most of the time for last 3 months. The symptoms had exacerbated in the last 2 weeks. There was no precipitating factor. The total duration of illness was 4 years and the patient had three prior episodes having similar symptoms lasting for 3 to 6 months which resolved with medication within 2 weeks. There was no history of trauma, substance use and medical disorder. The patient had positive family history with his mother having symptoms of psychotic illness. He was given INJ. LORAZEPAM 2 mg I/M along with fluids and subsequently admitted. On General Physical Examination the patient had tachycardia (P-110/min)

BP-100/70. On neurological examination the tone was increased in all the 4 limbs with rigidity more in lower limbs in comparison to upper limbs. On mental status examination, there was mutism, rigidity, negativism, posturing with staring look Routine blood tests, Liver function tests, Kidney function tests and serum electrolytes were within normal range except for hyponatremia. Thyroid function tests were within normal range. The patient was started on TAB RISPERIDONE 2 mg and TAB LORAZEPAM 2 mg 1-x-2 along with monitoring of vitals. The patient started interacting with family members the next day and within few days he was shifted to oral intake and his symptoms improved. On further exploration of history, it was found that the patient had shown response to RISPERIDONE and had poor treatment adherence. After a week the patient was discharged. Benzodiazepines were tapered off in subsequent visits and patient continued to maintain well on atypical antipsychotic (RISPERIDONE)

DISCUSSION

Periodic catatonia is an extremely rare type of catatonia, its diagnosis and management can be quite troublesome. There are no guidelines regarding management of periodic catatonia. Ever since Huang *et al*. reported the use of a lorazepam–diazepam protocol to relieve catatonic symptoms in schizophrenic patients, it has been proven to be an efficient treatment for acute catatonia (Huang, 2005). There are also case reports where atypical antipsychotics had role in management of periodic catatonia (Guzman *et al*., 2007; Chen, 2017). In our case, the patient had shown response to treatment by Risperidone.

The importance of drug compliance is also crucial in our case to prevent future relapses. The patient had positive family history and genetic predisposition is an important trigger of catatonic episodes.

REFERENCES

Abrams R, Taylor MA. 1976. Catatonia. A prospective clinical study. *Arch Gen Psychiatry*. 33(5):579–81.

Cárdenas-Delgado CL. 2012. Pharmacological treatment of acute catatonia. Vertex, 23(104):271-80.

Chen R., Huang T. 2017. Periodic catatonia with long term treatment:a case report. *BMC Psychiatry*., 17(1):1-5

Fink M, Taylor MA. 2001. The many varieties of catatonia. *Eur Arch Psychiatry Clin Neurosci.,* 251(Suppl.1):SI8-S13.

Guzman CS., Myung VHM., Wang YP. 2007. Treatment of periodic catatonia with olanzapine: a case report. *Rev Bras Psiquiatr*., 29(4):380.

Huang TL. 2005. Lorazepam and diazepam rapidly relieve catatonic signs in patients with schizophrenia. *Psychiatry Clin Neurosci*., 59(1):52–5.

Ignatowski M., Sidhu, S., Rueve, M. 2007. Pulmonary embolism as a complication of major depressive disorder with catatonic features: a case report. Psychiatry (Edgmont). 4(6):51–6.

Sienaert, P., Dhossche, D., Vancampfort D. *et al*., 2014. A clinical review of the treatment of catatonia. *Front Psychiatry*. 5:181.

Taylor MA., Fink M. 2003. Catatonia in psychiatric classification: a home of its own. *Am J Psychiatry*., 160(7):1233-41

Ungvari GS., Chiu HF., Lau BS., Tang WK. 1999. Lorazepam for chronic catatonia: a randomized, double-blind, placebo controlled cross-over study. Psychopharmacology (Berl) 142:393-98.

****