

Successful Management of Recurrent Acute and Transient Psychotic Disorder with Catatonic Features with Fluphenazine Depot Injection

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1. INTRODUCTION

Catatonia a psychomotor syndrome usually associated with psychiatric illnesses such as schizophrenia, mood disorders or organic syndrome. Although the introduction of antipsychotics has reduced the incidence of catatonia, it is still not uncommon (prevalence of 10% among psychiatric inpatients) ^{1,2}. Catatonia requires treatment in its own right, independent of any underlying disorder. Benzodiazepines are the drugs of choice. Patients who are unresponsive or partially responsive to benzodiazepines need electroconvulsive therapy (ECT). Antipsychotics are generally not recommended during a catatonic phase even if there is an underlying psychotic illness as the risk of precipitating neuroleptic malignant syndrome (NMS) is considerably increased. But in schizophrenia or recurrent acute and transient psychotic disorder (ATP) with catatonic features the use of antipsychotic is essential when the catatonic phase is over. We present a case of recurrent acute and transient psychotic disorder with catatonic features with history of noncompliance to medications, who was successfully managed with fluphenazine depot injection.

2. CASE HISTORY

Mr. A., 45-year-old male without family history of neurological and psychiatric illness presented with an acute onset illness without an identifiable precipitating factor characterized initially by fearfulness, suspiciousness and muttering to self for initial 2 days followed by mutism, posturing, rigidity, negativism, decreased sleep and poor self-care for last 2 weeks. Past history of the patient revealed similar episodes of illness at an interval of 9-12 months during last 5 years. During these episodes no mood symptom or psychomotor excitement was observed. Past treatment records showed that he was hospitalised in our institution every time for his episodic illness and treated with injection lorazepam followed by ECT. On an average he received 4-6 ECTs each time and improved completely within 3-4 weeks. He was prescribed olanzapine tablet 5-10 mg/ d after being discharged from the hospital. But the patient used to stop medication after 1-2 months due to financial problems and relapse after 9-12 months. There was complete interepisodic recovery. Currently blood investigations, CT scan head and EEG were within normal limits. As there is history of unresponsiveness to lorazepam and good response to ECT, so he was given 5 ECTs and he improved completely. Considering the history of noncompliance and relapse each time it was planned to start fluphenazine decanoate (25mg/ml) long-acting injection intramuscularly every 1 monthly. The patient and his family members were psychoeducated about the illness and need for compliance to treatment. The patient is currently continuing same long acting injection every 1 monthly for last 2 years and there is no relapse.

3. DISCUSSION

Our patient is a case of recurrent acute and transient psychotic disorder (ATP) with catatonic features. In each episode the patient has initial psychotic features followed by catatonia. Probably the main cause of relapse was noncompliance to antipsychotic medication. The patient always came for treatment in catatonic state. In each episode treatment with lorazepam injection (upto 16mg/d) was

ineffective, but ECT was effective. So in the current episode it was planned to increase the compliance of the patient and target the psychotic features as catatonia is always preceded by psychotic features. So monthly fluphenazine decanoate (25mg/ml) long-acting injection was started. Though antipsychotics with more “typical” D2 antagonism are best avoided in catatonia³, but in our case fluphenazine long acting injection was cheap and more convenient option of treatment for the patient. As we have not given the medication in catatonic phase, so the risk of developing NMS is minimal. With the use of long acting injection we avoided repetitive use of ECT (which may have deleterious effect on memory and cognition) and also there is no relapse for last 2 years. Our patient is not a case of periodic catatonia (as there is no cyclical pattern of catatonic episodes with features of combined stupor and excitement), where use of lithium and carbamazepine has been documented.⁴ So we advocate the more use of long acting first generation antipsychotic injections in schizophrenia and recurrent ATP with catatonic features.

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