The Catatonia Foundation

How did lorazepam become the treatment of choice for catatonia?

Dr. Fricchione:
I wish I could take credit for that, but I'll tell you, it was more like picking something out of the air. And Andy, I remember telling Andy this because people give me far too much credit — this happened when I was a fellow. I had this brilliant mentor, and he was a famous psychiatrist at Mass General. He also was a Jesuit priest. So he was a brilliant guy.

One of my assignments as a fellow was to staff the cardiovascular intensive care unit where patients who are having high-end sort of cardiac surgery would go after their surgery. As you may know, many of those patients become acutely delirious and very, very agitated, which becomes an emergency because they've got all these tubes. They just come out of surgery and they're vented and all of this stuff.

In those days, they called us very often to see those patients. And the standard of treatment was to give haloperidol as a major tranquilizer when they were acutely agitated, which I did. And lo and behold, this patient became catatonic and the surgeons were mad at me because this was a VIP patient, like many of the patients at Mass General. Usually you could discharge a patient on post-op day seven or eight. And so he was a rich person from South America, and he was scheduled to go back to South America.

So I made the guy catatonic, and he was languishing in the cardiovascular intensive care unit. And I was trying to get him out of catatonia. I had stopped the haloperidol, but he was now in catatonic withdrawal, rigid and mute, and not eating, et cetera.

I was giving him an anticholinergic agent, antiparkinsonian agents, and he wasn't getting out of it. So I went to Dr. Cassem, and he was a busy man, and he said, “Okay, why don't we go back up there tonight?” So we went up there like at 8:30 at night, and we examined him and we went to the nurses station, and it was Dr. Cassem who chose the lorazepam. And he basically chose it because he was actually looking for diazepam/valium, which is this drug we give for muscle spasms, right? So he chose the lorazepam. And, so I spritzed the patient with two milligrams of lorazepam, which is what we would use for patients with an acute seizure or status epilepticus or something like that. And you know, in five minutes he came out of it and he started talking. So that was amazing to Dr. Cassem, and he whispered to me as we were leaving — and the nurses were just so amazed — he whispered to me, “We've gotta do that again.” So that's when we started using it.

The one thing I must take credit for was that in the discussion section of the original paper in 1983, because we did that in 1982, but in the discussion section of the paper in 1983, I had written that this worked so well for patients with medical catatonias. Like neuroleptic-induced catatonia or other catatonia.

We had one patient with a craniopharyngioma who we lysed catatonia with lorazepam. I wrote in the discussion section, “This works so well, it should be tried for patients with psychogenic catatonia, schizophrenia, bipolar illness, et cetera.” And the editor said, “You need to take that out because you have no evidence for that.” And my other mentor, George Murray, said, “No way, you're leaving that in the paper. You tell the editor you're leaving that in the paper.” He used a curse word when he was talking to me about that, and I told the editor, “No, we think it should be—” and he left it in and people started using it. And it works just as well, if not better, for patients with psychogenic catatonia.

So I learned a lot from that, but the credit for choosing lorazepam with that first patient goes to my mentor.