What role do you think other medical diagnoses may play in catatonia?

Dr. Beach:
As a consult psychiatrist, one of the things that's really interesting for me is that I have a little bit of a skewed sample, but I would say at least 50 percent of the cases of catatonia that I see have a primary neurological or medical etiology underlying them. And again, that's because I'm mostly seeing patients on the medical and surgical floors.

One of the things that's been remarkable to watch during my career—when I was a resident, the very first case of NMDA receptor antibody encephalitis was described in a case report. And now that's a diagnosis that we make very commonly on the neurology floors. And it's a diagnosis that's highly associated with catatonia—probably more highly associated with catatonia than any other single neurologic illness or medical illness. So if I think about medical causes or neurological causes of catatonia, that's the first one that I always think about. And we've seen a lot of cases of NMDA receptor antibody encephalitis, also a lot of cases of other forms of autoimmune encephalitis—or even what's now known as seronegative autoimmune encephalitis, where patients don't actually have a confirmed antibody that they're positive to—causing catatonia. So we see a lot of that on neurology services.

The other thing that I would highlight, especially for other physicians—one of the unfortunate things about the DSM-5 text revision, when it comes to catatonia, is it has this exclusion for delirium. So according to the DSM, you can't diagnose catatonia in the setting of delirium, and we know that's not true. In fact, catatonia and delirium are highly comorbid. Studies suggest that up to 30 percent of patients with delirium, especially hypoactive delirium, have features of catatonia. And probably more than 30 percent of patients with catatonia, if you did an EEG, you would find them to be encephalopathic or to have an EEG that's consistent with delirium. So those two co-occur very commonly. And I think one of the things I would emphasize for psychiatrists and other physicians is to really think about catatonia in patients presenting with delirium and really look for signs of catatonia in your delirious patients. Doesn't mean you always have to treat that. And that's a little bit different than with other forms of catatonia, because if catatonia is occurring in the setting of delirium, the catatonia may actually resolve just as you resolve the underlying medical issue like the delirium does. But you do want to recognize the catatonia and make sure that it's not worsening. Make sure that patients aren't developing malignant features that might put them at risk for other things.