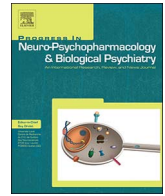




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Prevalence and characteristics of catatonia on admission to an acute geriatric psychiatry ward[☆]



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ABSTRACT

Background: This study aims to describe the prevalence of catatonia in a population of older acute psychiatric inpatients according to different diagnostic criteria. Secondary objectives are: to compare the catatonic symptom profile, prevalence, and severity, in respect to the underlying aetiology, and to evaluate the association between catatonic and somatic comorbidity.

Methods: The study included 106 patients admitted to an acute geriatric psychiatry ward. Catatonia was assessed using the Bush Francis Catatonia Rating Scale (BFCRS).

Results: Catatonia was highly prevalent ($n = 42$; 39.6%), even when using restrictive diagnostic criteria: Fink and Taylor ($n = 19$; 17.9%) and DSM 5 ($n = 22$; 20.8%). Depression was the most frequent psychiatric syndrome among catatonic patients ($n = 18$; 42.8%). Catatonia was more frequent in depression (48.6%) and delirium (66.7%). Affective disorders showed a higher risk than psychotic disorders to develop catatonia ($OR = 2.68$; 95% CI 1.09–6.61). This association was not statistically significant when controlling for dementia and geriatric syndromes. The most prevalent catatonic signs were excitement (64.3%), verbigeration (61.9%), negativism (59.5%), immobility/stupor (57.1%), and staring (52.4%).

Conclusions: Catatonia in older psychiatric inpatients was highly prevalent. Depression was the most common psychiatric syndrome among catatonic patients, and catatonia was more frequent in depression and mania, as well as in delirium. Affective disorders were associated with a higher risk of developing catatonia compared to psychotic disorders. Somatic and cognitive comorbidity played a crucial aetiological role in catatonia in this series.

1. Introduction

Catatonia is a complex neuropsychiatric syndrome which was first described by Karl Kahlbaum in 1874 (Kahlbaum, 1874). It comprises motor, behavioral and autonomic abnormalities that occur in the context of general medical, neurological, and psychiatric conditions as well as associated with medications and drugs of abuse. The role of antipsychotics is not well defined since some of the available literature suggests that they may induce or even worsen catatonia (Francis, 2010). The DSM 5 (American Psychiatric Association, 2013) has made changes to its diagnostic criteria from DSM-IV (American Psychiatric

Association, 1994), allowing the diagnosis of catatonia in all psychotic and major mood disorders, in the context of general medical conditions, or as a syndrome not otherwise specified (Grover et al., 2015; Walther and Strik, 2016). Nevertheless, it was not included as an independent diagnostic category, only as a transdiagnostic specifier (Hirjak et al., 2015).

Catatonia is a highly prevalent syndrome across psychiatric conditions, especially in acute psychiatric inpatients. Some studies have reported a prevalence ranging between 5% and 50.8% in acute psychiatric admissions (Chalasanani et al., 2005; Rosebush et al., 1990; Stuivenga and Morrens, 2014; van der Heijden et al., 2005), depending

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on the diagnostic system used. Even though catatonia has been traditionally linked to schizophrenia (Bartolommei et al., 2012), it is most commonly associated with mood disorders, particularly mania (Taylor and Fink, 2003). The prevalence of catatonia due to a general medical condition may also vary from 20% to 39% (Smith et al., 2012).

Whilst some studies include older patients in their samples (Sayegh and Reid, 2010), only a few reports specifically explore catatonia in this age group (Jaimes-Albornoz and Serra-Mestres, 2013; Kaelle et al., 2016). A potential limitation in the understanding of catatonia in older people may be the high prevalence of comorbid somatic and cognitive conditions in this age group, as they are also underlying causes of catatonia (Wijemanne and Jankovic, 2014). Furthermore, older patients present with a higher risk of somatic complications when catatonia is not detected or treated appropriately (Swartz and Galang, 2001). Another challenge in this age group is that the boundary between delirium and catatonia is often indistinct with catatonic features not uncommonly occurring in delirium (Oldham and Lee, 2015). In older patients with a history of depression or schizophrenia, clinicians may overlook comorbid medical conditions as a cause of catatonia because they may believe those previous psychiatric diagnoses to be the cause of the catatonic features (Takata et al., 2005).

In relation to these considerations, this study aims: 1. to describe the prevalence of catatonia in a population of older acute psychiatric inpatients according to different diagnostic criteria, 2. to compare the catatonic symptom profile, prevalence, and severity, in respect to the underlying aetiology, and 3. to evaluate the association between catatonic and somatic comorbidity.

2. Methods

2.1. Participants and setting

The present study was conducted at the acute psychiatric unit of Parc Sanitari Sant Joan de Déu (PSSJD, Sant Boi de Llobregat, Barcelona, Spain) a general multispecialty hospital affiliated to the University of Barcelona. At the time of the study, PSSJD's catchment area was of 640,572 adults distributed across eight community mental health areas in the South Barcelona health district, with a mean of 1350 adult discharges per year for the previous 10 years. The acute inpatient psychiatric unit at PSSJD consists of three wards with 69 beds, and are staffed by multidisciplinary teams of senior and junior psychiatrists, nurses, psychologists, and social workers. The unit provides multi-disciplinary acute specialist clinical care for patients admitted with serious mental illnesses, in the form of pharmacotherapy, psychotherapy, social work and occupational care, and a recovery program. There are also two clinical care programs: first-episode psychosis and geriatric psychiatry. Electro-convulsive therapy was not available when the study was carried out. Most of the patients (90–95%) are admitted from the emergency room. They usually suffer from severe primary psychiatric disorders with acute disturbances or risk of self-harm. The remaining of patients are referred from community mental health providers. For the purpose of this study, all consecutive admissions aged over 64 years between May 2013 and April 2014 were selected. The assessment of catatonia was conducted on the first 24 h of admission, when catatonic signs are more likely to appear. The other variables of this study were collected during period of hospitalisation. The only exclusion criterion was patients unable to communicate effectively due to a language barrier. A total of 106 patients were included.

Ethics approval was obtained from the Sant Joan de Déu Foundation Ethics Board. Patients (or legal guardians in the case of legally incapacitated patients) signed a written informed consent.

2.2. Study measures

2.2.1. Socio-demographic questionnaire and medication recording

A demographic questionnaire was used to collect data on the following variables: gender, age, place of birth, marital status, employment status, educational level and living situation. We also recorded antipsychotic (Chlorpromazine equivalent dose)(Gardner et al., 2010) and benzodiazepine (Lorazepam equivalent dose) (Ashton, 2005) treatment exposure prior to admission to hospital. If any information was not available medical records were reviewed.

2.2.2. Clinical information

In order to ascertain whether the psychiatric pathology was early-onset or late-onset, and the need to exclude the possibility of any acute medical pathology or drugs misuse being the cause of the current catatonia, the following information was collected: past medical, psychiatric, and drug history, findings of the clinical evaluation, and results of blood (blood count, biochemistry, serology) and urine investigations, and brain imaging (brain computed tomography (CT) or head MRI scan).

2.2.3. Evaluation of catatonia

Catatonic signs were evaluated by JCE and LB with the Bush Francis Catatonia Rating Scale (BFCRS) (Bush et al., 1996). The BFCRS is one of the most used rating scales in routine clinical practice, because of its reliability, validity, and ease of administration (Sienaert et al., 2011). It comprises 23 items. The first 14 items are used as a screening tool, constituting the Bush Francis Catatonia Screening Instrument (BFCSI). Presence of 2 or more BFCRSI items for > 24 h indicate current catatonia (Bush et al., 1996). The BFCRS comprises the 14 items of the BFCSI plus 9 other signs to reflect their severity, measured as the sum score of the 23 items (on a 0–3 point scale), with a maximum score of 69 and minimum of 0 points. The formal diagnosis of catatonia was then made using the DSM-5 diagnostic criteria (Tandon et al., 2013) and the diagnostic criteria proposed by Fink and Taylor (Taylor and Fink, 2003).

2.2.4. Assessment of psychiatric disorders

Psychiatric diagnoses were established at the end of hospitalisation by senior psychiatrists in charge of clinical care. Psychiatric disorders were also assessed by JC and LB with the Spanish version of the Mini International Neuropsychiatric Interview (MINI) in order to ensure good clinical diagnostic validation. MINI is a structured interview that generates diagnoses according to DSM-IV criteria (Sheehan et al., 1998). Dementia and Delirium were diagnosed according to DSM-IV criteria. Since DSM-IV does not allow to specify which sort of behavioral disturbances are present in dementia, we decided to consider dementia as a comorbid cognitive condition of a psychiatric disorder. In this way we were able to analyse the underlying psychological features of dementia syndrome involved in catatonia. We also recodified psychiatric diagnoses into psychiatric syndrome diagnoses in order to analyse their relationship with catatonia (Fig. 1).

2.2.5. Physical comorbidities

The number of comorbid medical conditions (NCM) and geriatric syndromes in the previous 6 months was assessed by medical interview (self-reported history and interview) and corroborated with the patients' problem-list in their General Practitioner's (GP) medical records. We selected from the literature a group of geriatric syndromes that had shown an influence on outcomes of hospitalisation (Anpalahan and Gibson, 2007; Bell et al., 2016): mobility, falls, incontinence, cognitive status, confusional state, infections, nutrition, hearing or sight impairment, constipation, depression, immune deficiency, iatrogenesis (polypharmacy or side effects from drugs) and sexual dysfunction. Items were given "yes/no" responses. The total score ranged from 0 points to 13 points.

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