Prevention of Catatonia With Olanzapine Long-Acting Injectable

Petru-Iulian Ifteni, MD, PhD1,2* and Andreea Teodorescu, MD, PhD2

Keywords: catatonia, prevention, olanzapine pamoate, second-generation long-acting injectable, schizophrenia

CLINICAL FEATURES

The patient was a 31-year-old divorced white woman living with her parents in an urban area. She was diagnosed with paranoid schizophrenia at the age of 22, before Graduation of the Faculty of Economics. After the first admission in the Psychiatry and Neurology Hospital of Brasov, Romania, she managed to complete her studies but soon relapsed with the second paranoid episode. As a particularity of the case, we noted the evolution with 3 paranoid episodes followed by the last 3 consecutive catatonic episodes between 2009 and 2011. The patient’s files and her family statements revealed that the side effects were the main reasons for the patient’s nonadherence to the antipsychotic treatment: haloperidol induced acute dystonia, risperidone induced akathisia, and amisulpride induced amenorrhea. The patient response was very good to olanzapine 10 mg/d, but the patient followed the treatment only for a short period (2–3 months) after discharge. The paranoid episodes consisted in auditory hallucinations, persecutory delusions, and aggressive behavior. Usually, she was admitted in the Acute Psychiatric Department involuntarily. After 4 years, she was medically retired, and she spent all day smoking and watching TV with minimal social interaction.

In August 2011, she suddenly became bizarre with refusal of meals and leaving her bed. After 2 days of mutism and total refusal of any food or water, she was admitted into an emergency psychiatric unit. The patient’s brother affirmed that he was pretty sure that a new catatonic episode occurred (similarity with the previous 2 catatonic episodes was striking), and he decided to ask for psychiatric help immediately. He also declared that 4 months ago, at the end of April 2011, the patient informed her family using the sentence: “I’m cured and the treatment is no longer needed.” Despite her family and the warnings of the psychiatrist, she refused to follow the antipsychotic treatment with oral olanzapine. During the medical examination, she showed passive resistance to any attempts to move her arms and legs with waxy flexibility. Routine complete blood count, electrolytes, creatinine, and liver function tests were normal as well as the electrocardiogram. Urine toxicology was negative. The patient had normal vital signs. The brain computed tomography with contrast substance was normal.

THERAPEUTIC CHALLENGE

Catatonia is a potentially life-threatening but treatable neuropsychiatric syndrome which has been associated with schizophrenia, but which may occur also in other psychiatric, metabolic, or neurologic conditions. The symptoms include rigidity, negativism, mutism, and waxy flexibility.

The most important differential diagnosis of catatonia is neuroleptic malignant syndrome (NMS) phenomenon.
known as catatonic dilemma. The literature does not disclose cases of catatonic prevention after starting long-acting injectables (LAIs) and, as far as we know, there are no articles published regarding this topic.

LAIs were developed after the second half of last century in the attempt to improve adherence in schizophrenia, but challenges of long-term treatment outcomes still remain. The pamoate salt of olanzapine is one of the second-generation antipsychotic depot formulations whose efficacy and safety in the treatment of schizophrenia has been previously documented.

The common recommendation is to avoid antipsychotics, at least during the early phases of catatonia treatment, to avoid antipsychotic-associated NMS, which has been believed to occur in up to 10% of the catatonic patients treated with antipsychotics.

We present the case of a young woman with previous catatonic relapses before starting the treatment with second-generation LAI (olanzapine pamoate). Informed consents for publication have been obtained from patients and are available for the editor.

SOLUTION

According to the clinical features, laboratory results, computed tomographic images, and absence of the antipsychotic treatment for more than 4 months, we excluded NMS, and the diagnosis was catatonic schizophrenia.

She was given oral lorazepam 3 mg/d (in the absence of intramuscular or intravenous formulations of lorazepam at site) and glucose 5% 1000 mL/d for hydration and olanzapine 10 mg/d intramuscular from the second day.

The patient was responsive, and after 3 days, she started to eat and drink. The treatment continued with oral olanzapine 10 mg/d and then 20 mg/d leading to improvement of her condition. After 2 weeks, she was given olanzapine LAI 300 mg/intramuscular with no sign of postinjection syndrome. She was discharged in highly improved condition after 4 weeks, with the recommendation of continuing treatment with olanzapine pamoate 300 mg/intramuscular at every 2 weeks.

After the last hospitalization, she had monthly appointments to a psychiatrist and continued the treatment with olanzapine pamoate 300 mg twice/mo for 3 years. In this period, she was in remission, she was part-time employed to a pizza house, and established a relationship. Her life became quite normal, and her family was satisfied and affirmed that they fully trust the efficacy of this treatment.

Since May 2014, she continued the treatment with olanzapine pamoate 300 mg once/month at the recommendation of her psychiatrist. A subsequent follow-up, after starting LAI, found her in remission with good social and professional functioning and no relapses, incomparable with the time before LAI.

Catatonia is a syndrome caused by a variety of brain diseases and continues to be a potentially lethal condition. We present a case of young woman with schizophrenia and previous relapses who started olanzapine LAI after her third consecutive catatonic episode. She has been in full remission for almost 5 years under treatment with olanzapine LAI which provide long-term efficacy and safety of this formulation.

Standard care of catatonia includes hydration, nutrition, cooling, prevention of aspiration, and thrombophlebitis. Benzodiazepines, especially lorazepam intravenously (2–5 mg), are widely recommended as a first choice of drugs for the treatment of catatonia. When benzodiazepine therapy fails, or the patient’s condition is severe, electroconvulsive therapy is the treatment of choice for this disorder.

Although the role of antipsychotics in treatment of catatonia is still controversial, because in some cases it has been shown to trigger catatonia, we successfully treated patients after exclusion of the NMS diagnosis.

We strongly remind that catatonia can occur in patients with schizophrenia anytime after they discontinue antipsychotic treatment even in the absence of previous catatonic episodes.

REFERENCES


www.americantherapeutics.com

