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Diferencijalno dijagnostički i terapijski izazov kod katatonije u starije bolesnice sa somatskim komorbiditetima

/ *Differential Diagnostic and Therapeutic Challenges of Catatonia in an Older Woman With Somatic Comorbidities*

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Uvod: Katatonija je bihevioralni sindrom obilježen nemogućnošću izvođenja normalnih pokreta, usprkos punom fizičkom kapacitetu za to. Sindrom se može pojaviti u brojnim psihičkim i somatskim poremećajima koje viđamo u jedinicama objedinjenog hitnog bolničkog prijema. Prikaz pacijenta: Pacijentica u dobi od 88 godina upućena je na konzilijarni pregled pod dijagnoznom katatonije u sklopu demencije. Dovezena je iz umirovljeničkog doma jer je posljednja dva dana bila bez kontakta. Dva dana ranije pregledana je nakon što je navodno pala i udarila glavom, nakon čega je postala nekontaktibilna. Ranije bolesti: Demencija, fibrilacija atrija, prije 3 godine preboljela moždani udar.

Introduction: Catatonia is a behavioral syndrome characterized by an inability to perform normal movements despite full physical capacity to do so. The syndrome can occur in numerous psychiatric and somatic disorders that we encounter in emergency hospital admission units. Case presentation: An 88-year-old female patient was referred for a consultative examination with a diagnosis of catatonia in the context of dementia. She was brought in from a nursing home because she had been unresponsive for the previous two days. Two days earlier, she had been examined after allegedly falling and hitting her head, after which she became non-responsive. Past medical history: Dementia, atrial fibrillation, and an isch-

Godinu dana ranije hospitalizirana je zbog sinkope, kada ju je medicinski tehničar zatekao klonute glave, nije mogla samostalno sjediti ni govoriti. Dan prije konzilijarnog pregleda psihijatra pregledana je neurološki jer je bila bez kontakta, gledala je uprazno i nije odgovarala na pitanja. Zbog sumnje na katatoniju ordiniran je diazepam 1/2 ampule, 10 mg iv. Pacijentica nakon dva sata postaje kontaktibilna. Sljedećeg dana konzilijarni psihijatar zbog moguće psihotične podloge uvodi antipsihotik (olanzapin 5 mg uvečer, uz oksazepam) nakon čega ponovno dolazi do pogoršanja stanja svijesti. Sljedeći konzilijarni psihijatar za dva dana ukida antipsihotik, postavlja sumnju na maligni neuroleptički sindrom koji se laboratorijskim nalazima i daljnjom opservacijom te pregledom neurologa isključuje, kao i moguće infektološko zbivanje. Uvodi lorazepam u dozi od 3 x 2,5 mg, koji se modificira na dozu 1, 1, 2,5 mg, s tim da je pacijentica adekvatnog kontakta. Zaključak: Unatoč teškom prepoznavanju i nizu diferencijalnodijagnostičkih dilema važno je pravodobno dijagnosticiranje i liječenje benzodiazepinima i/ili elektrokonvulzivnom terapijom uz liječenje medicinskih stanja koja su u podlozi katatonije, s obzirom na to da katatonija može biti životno ugrožavajuće stanje.

emic stroke three years earlier. One year before the current episode, she had been hospitalized for syncope, when a nurse found her with her head slumped, unable to sit up or speak on her own. The day before the psychiatric consultation, she had been examined by a neurologist because she was unresponsive, staring blankly, and not answering questions. Due to suspected catatonia, diazepam 1/2 ampoule 10 mg IV was administered. Two hours later, the patient became responsive. The following day, a consultative psychiatrist, suspecting a possible psychotic basis, started an antipsychotic (olanzapine 5 mg in the evening, with oxazepam), after which there was a renewed deterioration in consciousness. Two days later, a subsequent consultative psychiatrist discontinued the antipsychotic and raised suspicion of neuroleptic malignant syndrome, which was ruled out by laboratory findings, further observation, and neurologic examination, as was a possible infectious process. Lorazepam was introduced at a dose of 3 × 2.5 mg, later adjusted to 1, 1, and 2.5 mg, with the patient maintaining adequate contact. Conclusion: Despite the difficulty of recognition and the numerous differential diagnostic dilemmas, timely diagnosis and treatment with benzodiazepines and/or electroconvulsive therapy, alongside management of the underlying medical conditions causing catatonia, are crucial, given that catatonia can be a life-threatening condition.