Coprophagia as an Unusual Presentation of Catatonia

Rachel Varadarajulu, MBBS,[a] and Yassir Mahgoub, MD[b,*]

Catatonia is a complex psychomotor dysregulation seen concurrently in a number of psychiatric illnesses, with up to 10% of the inpatient population having catatonic signs.[1] A feature of catatonia that is often missed is mannerism, which is odd and idiosyncratic methods of performing a task. The abnormality is inherent in the act itself, such as hopping or walking tip toe or saluting passersby.[2,3] We report the case of a patient who presented with repetitive odd behavior, eating of feces, and thought perseveration that did not respond to adequate doses of 3 antipsychotics but responded to the addition of lorazepam when catatonia was considered.

Case Report

Ms A, a 21-year-old Asian woman with no significant medical history but with reported history of depression, was admitted to the inpatient psychiatric unit due to aggression at home. A few weeks preceding her admission, she was reported to be spending hours in the bathroom, and when her father asked her to come out, she became violent, which ultimately resulted in hospitalization. She reportedly had significant decline in her educational, interpersonal, and occupational functioning for over a span of 1 year prior to admission. She revealed that she stayed in the bathroom to eat her feces and drink urine. Ms A was unable to reason her behavior, which was ego syntonic and was not preceded by anxiety. However, she endorsed extreme anger toward her father when she was asked to come out of the bathroom. She appeared to be disheveled and oddly related. While walking, she was noted to take 1 step forward followed by a step backward. Her speech was repetitive (repeated her own and interviewers' sentences, reframing them multiple times, fixating on 1 or 2 topics) with loosening of associations. She was diagnosed with schizophrenia, and her behavior was initially categorized as obsessive psychosis.

Olanzapine was initiated and titrated to 35 mg but was switched to risperidone because of lack and improvement. Risperidone was titrated to 8 mg with no improvement and subsequently was switched to aripiprazole, and the dose was titrated to 20 mg daily with no improvement. Her diagnosis was revisited, and catatonia was considered. Lorazepam 1 mg was added to aripiprazole. Within 3 days, Ms A's presentation improved, including the coprophagia, and she was discharged on aripiprazole 20 mg and lorazepam 1 mg daily. She was lost to follow-up following discharge.

Discussion

In retrospective evaluation, our patient demonstrated multiple catatonic signs. According to the Bush-Francis Catatonia Scale,[3] she exhibited (1) combativeness (unprovoked bouts of anger toward her father), (2) mannerism (repeated coprophagia), (3) ambitendency (walking forward and then backward with indecisiveness), (4) thought perseveration, and (5) verbigeration (repetition of phrases or sentences).

Initially, she was diagnosed with schizophrenia due to disorganized thoughts and behavior. Engagement in repeated, ritualistic behavior raised suspicion for obsessive-compulsive disorder (OCD). However, OCD is usually associated with experiencing unpleasant urges that are relieved when the compulsive action is performed[4] and is not characteristically treated with lorazepam. Mannerism behaviors are highly heterogeneous and may be verbal or nonverbal, fine or gross motor oriented, or simple or complex and may involve complex behaviors.

McDaniel and Spiegel[5] describe a case of abnormal ingestion of metal associated with other catatonic signs, wherein the catatonia and the abnormal ingestion abated after treatment with lorazepam, and suggested that the metal ingestion was a form of mannerism. They also described 3 other cases of polydipsia in which the excessive water drinking was associated with catatonia and stopped following treatment with lorazepam. Laux and Mahgoub[6] described 2 cases of patients with catatonia who presented with polydipsia, and both catatonia and polydipsia resolved after treatment with lorazepam. Both McDaniel and Spiegel[5] and Laux and Mahgoub[6] considered the polydipsia a form of stereotype, as the problem was the frequency of the action and not the inherent act itself such as coprophagia.

Our case highlights the importance of revisiting diagnosis and management when a patient does not respond to conventional treatment and the need to consider complex catatonic presentation as a differential in treatment-resistant patients.

[a]Department of Psychiatry, Maimonides Medical Center, Brooklyn, New York

[b]Department of Psychiatry and Behavioral Health, Penn State College of Medicine, Hershey, Pennsylvania

*Corresponding author: Yassir Mahgoub, MD, Department of Psychiatry and Behavioral Health, Penn State College of Medicine, 500 University Dr, Hershey, PA 17033 (ymahogub@pennstatehealth.psu.edu).

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