Commentary on "Catatonia and Competency to Stand Trial With Unique Response to Haloperidol"

Letter to the Editor: I read with great interest the case report by Gill et al, which underscores the intricate clinical management of a patient dealing with catatonia in the context of a legal issue related to competency for trial.[1] As the authors rightly emphasize, restoring capacity in catatonia patients is crucial from both clinical and legal perspectives. Clinically, when a patient does not respond adequately to lorazepam, the next treatment option, electroconvulsive therapy (ECT), can only be administered with the informed consent of the patient, especially in many US states.[2] A rights-based approach in psychiatric care requires informed consent from the patient, consent from a nominated representative if available, or a determination of incompetency by a court.[2]

Bostwick and Chozinski[2] reported a case with an ethical dilemma wherein a catatonia patient resistant to lorazepam treatment could not undergo ECT because no information about the patient's relatives was available in the file. Similar situations are likely to be common in forensic settings, as described in the case report. A practical step would be to explore a patient's treatment preferences, including ECT, when they respond positively to lorazepam challenge tests and are temporarily of sound mind. These preferences should be thoroughly documented and considered in future treatment planning. This pragmatic approach to restoring capacity before making clinical decisions can create ethical opportunities to preserve the patient's autonomy.[2]

It is important to note that many catatonia signs, such as stupor, mutism, negativism, or withdrawal, may complicate the evaluation of a patient's capacity to consent, as it can be challenging to differentiate from voluntary refusal of treatment.[3] However, serial evaluations of a catatonia patient, especially after a lorazepam challenge test, can provide valuable clinical insights to distinguish catatonic signs from a volitional refusal of treatment. This is particularly crucial, as data indicate that catatonia patients often comprehend what others are saying and can vividly recall their experiences while in a catatonic state.[3]

Fortunately, in this case, the patient provided consent for ECT, but did not respond to either lorazepam or ECT and subsequently responded to haloperidol. However, it is worth mentioning that the use of antipsychotics is a highly debated aspect of catatonia management. Research suggests that antipsychotics can induce catatonia and increase the risk of neuroleptic malignant syndrome, and some studies show poor outcomes associated with their use.[3]

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Dr Gill was shown the letter and declined to comment.

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