What Internists and Neurologists Know and Think About Catatonia:

Reply to Espinoza and Kellner

To the Editor: We appreciate the response from Drs Espinoza and Kellner and thank them for their thoughtful engagement with our recent publication.[1] We fully agree with the importance of electroconvulsive therapy (ECT) as a treatment option for catatonia, particularly as second-line treatment in patients for whom benzodiazepines are no more than partially effective or a first-line consideration for those with severe manifestations, especially malignant catatonia. The American Psychiatric Association's recently published resource document on catatonia also recommends starting ECT as soon as possible for the above cases (ie, limited response to benzodiazepines and severe cases of catatonia).[2]

We acknowledge our oversight in not surveying participants on their knowledge of ECT as a treatment for catatonia. We envisioned this project as a first step toward generating awareness of catatonia among internists and neurologists. Our intention was not to provide an exhaustive assessment of diagnostic and therapeutic approaches, but rather to initiate awareness and identify opportunities for further education among 2 groups of clinicians who are often the first to encounter catatonia in acute care settings. Put differently, we sought to provide internists and neurologists with the equivalent of "basic cardiopulmonary resuscitation" catatonia training. Just as a hospitalist's role is to identify cardiac arrest, begin first-line treatment, and consult emergency services and cardiology for advanced management, we regard a similar first-line role of internists and neurologists for catatonia, including diagnosis and initiating first-line treatment (ie, benzodiazepines) while consulting psychiatry for further evaluation and management. We would typically expect a psychiatric clinician to determine whether other pharmacotherapeutic approaches, such as mood stabilizers or *N*-methyl-D-aspartate receptor antagonists,[3] or initiating ECT are indicated.

Our findings are preliminary and should be interpreted with caution in the setting of the study's limitations. The Catatonia Experience, Impressions, and Applications survey (see Supplementary Material) was developed by our research team and piloted internally with faculty, residents, and medical students at our institution. As with many early-stage instruments, the questionnaire would benefit from further refinement, specifically incorporating feedback and insights gained from this initial study. Due to differences in design and methodology, our results are not directly comparable to those of Cooper and Roig Llesuy[4]; however, they, too, identified differences in knowledge about catatonia among medical specialties and highlighted areas for continued education among internal medicine and psychiatric clinicians. We also acknowledge as limitations our study's modest sample size, high attrition rate, and potential selection bias—namely, that those who participated may have had a greater interest in and knowledge of catatonia than the general population of acute care practitioners.

Our overarching goal with this study is to raise awareness of catatonia among acute care practitioners, so we are grateful for the opportunity afforded by this letter to reinforce the importance of early catatonia recognition and effective management. Continued research and educational efforts across specialties are essential to ensuring prompt recognition and treatment of catatonia, including consideration of ECT, which can prove lifesaving.

References

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Supplementary Material

Article Title: What Internists and Neurologists Know and Think About Catatonia: Reply to Espinoza and Kellner

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LIST OF SUPPLEMENTARY MATERIAL FOR THE ARTICLE

1. Pre-Survey: Experience, Impressions, and Applications

DISCLAIMER

Pre-survey: Experience, Impressions, and Applications[a]

Please complete the survey below.

Thank you!

Which of the following best describes catatonia?	◯ Catatonia is a state of akinetic mutism. ◯ Catatonia is a reaction to trauma characterized by loss of touch with reality. ◯ Catatonia is a subtype of schizophrenia. ◯ Catatonia is a psychomotor syndrome with hypo-, hyper-, and parakinetic types.
Have you ever diagnosed catatonia?	◯ Yes ◯ No
Have you done so in the past 3 months?	◯ Yes ◯ No
Have you ever managed a patient with catatonia?	◯ Yes ◯ No
Have you done so in the past 3 months?	◯ Yes ◯ No

To what degree do you agree with the following statements?

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
It is important for practitioners in my specialty to know about catatonia.	◯	◯	◯	◯	◯
I am confident in my ability to diagnose catatonia.	◯	◯	◯	◯	◯
I am confident in my ability to manage catatonia.	◯	◯	◯	◯	◯
It would be beneficial for my practice to receive more training on catatonia.	◯	◯	◯	◯	◯

Clinical Application

Are the following statements correct or Incorrect?

	Correct	Incorrect
Catatonia can be complicated by autonomic instability and prove fatal.	◯	◯
Catatonia should be treated only in psychiatric settings.	◯	◯

Secondary causes of catatonia should be considered when catatonia is diagnosed.	◯	◯

Based on published data, what proportion of catatonia has a secondary (medical or neurological) cause?	◯ 0% ◯ 20% ◯ 65% ◯ 90%
What proportion of secondary catatonia is due to a condition that directly affects the CNS (e.g., seizures, encephalitis, structural damage)?	◯ 0% ◯ 20% ◯ 65% ◯ 90%
Which of the following are potential complications of catatonia? SELECT ALL THAT APPLY	☐ Pulmonary embolism ☐ Contractures ☐ Aspiration pneumonia ☐ Autonomic instability ☐ Malnutrition and dehydration ☐ Pressure ulcers
What is the first-line treatment for catatonia?	◯ Selective serotonin reuptake inhibitor (SSRI) ◯ Benzodiazepine ◯ Atypical antipsychotic ◯ Lithium
OPTIONAL: We welcome any comments you might have about the items above.	_____

[a]The authors retain copyright of this survey.