



# the columns

## correspondence

### Catatonia made complex

Sir: Catatonia has been a poorly understood syndrome since psychodynamic theory struggled to explain its symptoms in the first half of the past century. The persistence of the nosologic confusion surrounding catatonia, malignant catatonia and neuroleptic malignant syndrome (NMS) is well illustrated by Carey *et al*'s confused and uncertain case study (*Psychiatric Bulletin*, February 2002, **26**, 68–70).

Did their patient have 'no history of catatonia' or did he suffer from 'persistent stereotypies, mannerisms . . . dyskinesia and . . . dystonia'? Both statements cannot be true! It is unsurprising that in such a patient, with a possible history of encephalitis, the administration of high dose, high potency neuroleptics precipitated the malignant syndrome. This is a well-recognised clinical scenario. The association of catatonia with general medical conditions was emphasised by Kahlbaum in 1874 and has been reviewed in detail more recently (Philbrick & Rummans, 1994; Clark & Rickards, 1999).

The important points to remember are:

- (a) catatonia may be simple (motor symptoms only) or malignant (motor symptoms together with hyperthermia or autonomic instability)
- (b) neuroleptic (and some other) medications may exacerbate simple catatonia and precipitate malignant catatonia, in which case it may be termed the NMS
- (c) the most effective treatments for the catatonic syndrome are benzodiazepines or electroconvulsive therapy.

A fuller, clinically orientated review, including a suggested management plan, has been provided by Clark and Rickards (1999), while other authors have usefully considered the nosologic and dimensional status of the syndrome (for example, Mann *et al*, 1986; Singerman & Raheja, 1994; Fink, 1996). It is unfortunate that Carey *et al*'s discussion fails to aid understanding of a condition that is often iatrogenic and, as they point out, occasionally fatal.

CLARK, T. & RICKARDS, H. (1999) Catatonia 2: diagnosis, management and prognosis. *Hospital Medicine*, **60**(11), 812–814.

FINK, M. (1996) Neuroleptic malignant syndrome and catatonia: one syndrome or two? *Biological Psychiatry*, **39**, 1–4.

MANN, S. C., CAROFF, S. F., BLEIER, H. R., *et al* (1986) Lethal catatonia. *American Journal of Psychiatry*, **143**, 1374–1381.

PHILBRICK, K. L. & RUMMANS, T. A. (1994) Malignant catatonia. *Journal of Neuropsychiatry*, **6**(1), 1–13.

SINGERMAN, B. & RAHEJA, R. (1994) Malignant catatonia – a continuing reality. *Annals of Clinical Psychiatry*, **6**, 259–266.

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**Authors' reply:** It is agreed with your correspondent that certainty may often be preferred to confusion. We plead guilty to one nosological omission: the patient described had no history of classical catatonia (akinesia, mutism and waxy flexibility). Your correspondent's own cited review from 1999 (Clark & Rickards) admits there were no randomised controlled trials of treatment in catatonia. It is to be hoped that our article will have refreshed clinicians' awareness of this condition, as it is indeed often iatrogenic.

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### Missed-fit ECT audit

Sir: We read with interest the article by Davies and Wilson (*Psychiatric Bulletin*, June 2001, **25**, 215–216) on the rate of missed-fits during electroconvulsive therapy (ECT). We have recently completed a retrospective survey of the missed-fit rate in our hospital's ECT department. Of the 70 patients who received ECT between January and December 2001, case notes were obtained for 68. Eighty per cent of the patients were on antidepressants, 47% on antipsychotics, 19% on benzodiazepines and 3% on antiepileptic drugs, and no medication was recorded for one patient.

The total number of ECT treatments given was 481. Of these, only five resulted in missed-fits. These patients were not on

benzodiazepines or antiepileptic drugs. The stimulus dose applied in all five cases was appropriate to the patients' age and gender. All of them went on to fit successfully later in the course. In addition, different junior doctors were involved in the administration of ECT on the above occasions.

The rate of missed-fits in our survey was very low, 1.04%, which is comparable with the rate reported by the authors (1.8%) in their third audit-year. Our ECT department is consultant-led, with theoretical teaching and clinical supervision, as well as random checks to ensure that correct procedures are followed. A stimulus-dosing protocol is strictly adhered to.

As a result of this survey, restimulation guidelines are being drafted and will be included in ECT dosing policy. It is also proposed that this survey will become an annual event in our department.

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### Poetry and psychiatry

Sir: Holmes' carefully-reasoned evaluation of the relationship between poetry and psychotherapy (*Psychiatric Bulletin*, April 2002, **26**, 138–140) lends further support to the argument that the arts essentially complement our work in psychiatry and that a special interest group could be established by the College to promote this perspective, for the benefit of clinicians and patients alike.

The psychiatrist who is afraid of getting 'wet' (or appearing to be) is perhaps afraid of the uncertainty that all difficult endeavours, including scientific explorations, may reveal. The purpose of a special interest group in the arts would be to share versions of such uncertainty that psychiatric science may be less aware of and would hopefully serve to reduce the polarisation of psychiatric approach to the experience of mental illness, which Holmes has described.

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