

LETTER TO EDITOR**Deep Vein Thrombosis with First Episode Catatonia: A Case Report***Sunilkumar¹, Chaukimath S.P^{1*}, Prabhumallikarjun Patil²*

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Abstract:

Catatonia is a medical emergency condition with varied causative factors. Medical complications of catatonia put the patient to high risk of morbidity and mortality. Earlier studies show mortality rates up to 50% without proper and timely intervention. Deep Vein Thrombosis (DVT) is one such life threatening complication which can be prevented with proper management and care. A case of acute onset catatonia with a left leg DVT in a 21 yr old young single male is discussed here.

Keywords: Catatonia, Deep Vein Thrombosis

Introduction:

Catatonia is a complex neuropsychiatric syndrome characterized by reduced or sometimes increased psychomotor activity, mutism, posturing, waxy flexibility, hypertonia etc. Catatonia can be seen as a part of general medical conditions like stroke, infective causes, and multiple sclerosis. In psychiatric conditions it is seen in mood disorders and schizophrenia [1].

Significantly reduced psychomotor activity, reduced intake of fluids and calories puts catatonic patient at greater risk of developing malnutrition, electrolyte disturbances, decubitus ulcers, muscle contractures, UTI, deep vein thrombosis and sometimes risk of pulmonary thromboembolism [2]. A life-threatening condition, Pulmonary

embolism (PE) most often arises from deep vein thrombosis (DVT) of the lower extremities, 80% of these distal DVTs resolve spontaneously. However, once DVTs reach a proximal vein (i.e., popliteal vein or higher), chances of developing PE goes up to 50% of patients [3].

Case Report:

A 21 year old graduate student was admitted to our Psychiatry ward with an illness of 20 days duration which began with persecutory and self referral ideas in the initial days followed by reduced psychomotor activity, mutism, posturing and negativism. He refused food and fluids for 4-5 days before admission. There was no history of any physical illness or any other significant mood symptoms and stressful events. Two days before admission the family members had noticed swollen left lower limb.

On evaluation patient had a Bush-Francis Catatonia Rating Scale (BFCRS) score of 10 with tachycardia and normal blood pressure. Systemic and CNS examination was within normal limit. There was pedal edema on left side. Blood investigations that included hemogram, liver function test, renal function test, serum electrolytes and platelet count were normal. Doppler USG showed acute DVT of left popliteal

vein and superficial femoral vein. Plain CT head was also normal. The case was referred for surgical and medical opinion and management of DVT. Patient was treated with anticoagulants, subcutaneous warfarin and parental Lorazepam 2 mg. He showed excellent response to Lorazepam with improved psychomotor activity within two days. His DVT symptoms were also reduced. Two weeks later after significant improvement both in his psychological as well as physical condition, he was discharged with Olanzapine 10mg/day and oral anticoagulants.

Discussion:

This young man with no risk factors for DVT with a short duration of first episode of psychiatric illness went on to develop DVT possibly due to reduced motor activity, decreased fluid and calorie intake. Up to 40% of hospitalized patients with a physical morbidity are reported to

develop DVTs [4] and around 70% of them are asymptomatic [5]. There has been no systematic survey on the incidence of DVTs in psychiatric settings. It is possibly high in them, given their physical inactivity and the sedative effects of psychotropics [6]. Deep venous thrombosis and pulmonary embolism are serious, life-threatening events which are often ignored in psychiatric settings. Once DVTs reach a proximal vein (i.e. popliteal vein or higher), PE reportedly occurs in up to 50% of patients [7].

There have been guidelines for prophylactic interventions for the prevention of DVTs for hospitalized patients [7] which has not yet been addressed in psychiatric settings. This case presenting with first episode of psychiatric illness of short duration, developing DVT with no risk factors calls for regular clinical screening for DVT in all catatonic patients.

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