

Urinary Retention in Depression with Catatonia

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ABSTRACT

Catatonia can have a mosaic of clinical presentations ranging from behavioural disturbances to neurological signs. Here we describe a case of depression presenting with catatonic signs and urinary retention. Challenges in the diagnosis and treatment have been discussed.

Keywords: Urinary Retention, Depression, Catatonia.

1. BACKGROUND :

The neuropsychiatric syndrome of catatonia can be seen in neurological, metabolic and psychiatric conditions [1]. This syndrome of abnormalities in mood, behaviour or thought [2] is prevalent among all age groups in both sexes [3]. In India nearly 40% of inpatients having mood or psychotic disorders had catatonic presentation in them [4], with an incidence of 13.5% in admitted patients [5]. Catatonia can have a varied presentation with commonest signs being mutism, posturing, rigidity and negativism [6]. Here we describe a case of catatonia having depression presenting with mutism, negativism and urinary retention.

2. CASE REPORT :

Mrs Y, 36 years old married graduate homemaker, coming from a lower socio-economic status, resides with her 2 children and mother. She was brought to emergency following an alleged history of consumption of rat poison at her residence. Her vitals of blood pressure, pulse rate, temperature and SpO₂ (room air) were within normal limits. Patient was conscious with GCS (Glasgow Coma Scale) score of 15/15, her oral intake was poor, distended bladder with urinary retention was evident. Her systemic examination of other systems revealed no significant abnormality. Gastric lavage was done, medico-legal case

registered and referred to on-call physician.

Physician admitted the patient and relevant investigations of complete blood count, blood urea-creatinine, liver function tests, PT INR, serum electrolytes, urine routine and microscopy were done which were within normal limits. Her urine pregnancy test was found to be negative. Ryle's tube was inserted for feeding and catheterised with a Foley's catheter for urinary retention. Symptomatic treatment with antiemetics, antacids, laxatives were given. On repetitive examinations, physicians noticed that the patient appeared perplexed with decreased speech output during interviews. Psychiatrist reference was given for alleged consumption of rat poison and for her behavioural abnormalities.

On psychiatric interviewing with the mother and sister of the patient, 1 month history of low mood, decreased interactions, occasional crying spells, disturbed sleep with decreased functioning was evident. These features had aggravated since 3 days with marked reduction in her food intake and irregularities in her bladder habits. On further clarification; apart from the mother being hospitalised 1 month back for cardiac complications with guarded prognosis, no other stressors were evident. On mental status examination of the patient she did appear perplexed, intermittently mute, negativism and blank staring was seen. On

Bush Francis Catatonia Rating Scale (BFCRS) she received a score of 15. Lorazepam challenge test with Inj. Lorazepam 2mgIM (intramuscular) was given and patient was observed after approx. 90 minutes. Her catatonic signs showed improvement with BFCRS score reduced to 7. She received a diagnosis of severe depressive episode without psychotic symptoms (F32.2) intentional self-poisoning (X68) as per ICD-10-Classification of Mental and Behavioural Disorders [7].

Patient was started on Tab Lorazepam 2mg 1-1-1, Tab Sertraline 50mg 0-0-1 and Tab Olanzapine 5 mg 0-0-1. Over next 6-7 days her catatonia had improved along with subsidence in her urinary retention and Foley's catheter was removed. Patient was discharged with tapering doses of lorazepam, sertraline optimised to 100mg and olanzapine was stopped. Patient had come for follow up with improvement in her mood symptoms with no catatonic or suicidal ideations at 1 week and 3 week intervals post-discharge.

3. DISCUSSION :

Clinically over 40 signs have been described in patients presenting with catatonia [6]. Roughly these signs of catatonia can manifest either in a retarded-stuporous variety or excited-delirious variety [3]. As per few Indian studies on phenomenology, retarded-stuporous variety amounted to 12.5% [15] with mutism amounting to 87.5% [8] of all catatonic signs. Urinary retention in catatonia is usually seen in malignant/lethal catatonia [9] or in patients with schizophrenia [10], hence making this case of urinary retention in depression with catatonia a unique one.

In ICD-10 no separate diagnostic entity for catatonia in depression is seen and only catatonic stuporous patients having severe depression are coded as 'severe depressive episode with psychotic symptoms' (F32.3) [11]. Diagnosis of catatonia can be confirmed by symptomatic improvement in clinical signs after administration of challenge dose of lorazepam [12] as seen in this case. Benzodiazepines like lorazepam in dosages of 1-2mg oral/parenterally have shown to resolve catatonia [13]. Olanzapine was used as atypical antipsychotics are known to be beneficial in non-malignant catatonia [14]. Sertraline was used as the monotherapeutic

agent for her mood symptoms which helped in resolution of her mood symptoms and catatonic signs in follow-up [15].

4. CONCLUSION :

Amongst the myriad presentations of catatonia in depression, urinary retention is an uncommon presentation. Identification and prompt referral form important cornerstones in consultation-liasion psychiatry as seen in this case. Simultaneous management of catatonia and mood symptoms helped in remission of psychopathology and urinary retention in the patient.

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