Catatonia: Closer Than We Think

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Aims: This is a comparative study between two unusual and distinct cases of catatonia, managed by the Liaison psychiatry team that helped us to broaden our thinking and explore variable differential diagnoses for patients' management.
Methods: Case1: Mr.P is a 74-year-old male who was admitted following unusual behaviour, including shouting with slurred speech outside his house. During his admission, he was non-verbal, non-compliant with oral intake including medication and demonstrated bradykinesia and stiff joints. His initial investigations were unremarkable.

Mr. P has a background history of Paranoid Schizophrenia and been treated with Aripiprazole 30mg. Four months prior, he had a lengthy hospital admission with a similar presentation, and he was conservatively managed for hypoactive delirium.

Our differential diagnoses included hypoactive delirium, catatonia, CNS infection and NMS. When the physical health issues were ruled out, a Lorazepam challenge test was initiated; this was effective and made a significant change in his presentation. Thus, we diagnosed him with Catatonia and treated him with high dose of Lorazepam according to the policy. At discharge he had returned to his baseline.
Results: Case2: Mrs.Q is a 78-year-old female who was admitted to hospital after concerns of self-neglect and confusion. Her initial investigations showed an AKI and raised inflammatory markers. Thus, she was treated with IV fluid and antibiotics. Collateral from daughter suggested that Mrs. Q had a rapid decline in her presentation prior to the hospital admission.

Mrs.Q has a background history of depression and been treated with Mirtazapine 15mg.

Despite optimisation in her physical health, Mrs. Q did not show significant improvements. She had minimal engagement, minimal oral intake, very slow movements, and significant thought block. Initially, it was presumed that Mrs.Q had a slowly resolving delirium, however as she was not improving as expected so a Lorazepam challenge test was trialled. Mrs Q responded well to the lorazepam challenge, thus, she was diagnosed with catatonia and treated accordingly.
Conclusion: Catatonia is a neuro-psychiatric condition characterised by marked changes in muscle tone or activity that may alternate between extremes of movement deficits (stupor) and excessive movement (excitement). According to DSM-5 and ICD-11, a diagnosis requires the presence of three or more of the 12 clinical features.It can be validated through BFCRS or KCRS. Catatonia is not a disease, but a syndrome associated with various conditions.Its management includes Benzodiazepams, and/or ECT and supportive care.

Abstracts were reviewed by the RCPsych Academic Faculty rather than by the standard *BJPsych Open* peer review process and should not be quoted as peer-reviewed by *BJPsych Open* in any subsequent publication.

Case Report: Management of Delusional Parasitosis With Parkinsonism

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Aims: The co-occurrence of delusional parasitosis (primary Ekbom syndrome) with idiopathic Parkinson's disease is considered rare. Most literature consists of individual case reports or small series, indicating it is an uncommon but recognised clinical phenomenon. The rarity is compounded by the therapeutic challenge it presents.
Methods: A 74-year-old gentleman of Caribbean origin, with a longstanding diagnosis of persistent delusional disorder (delusional parasitosis, F22.0), was admitted under Section 3 of the Mental Health Act. He had a history of non-concordance with olanzapine for three years, resulting in significant clinical deterioration. Comorbidities included idiopathic Parkinson's disease (also non-concordant with medication) and prostate cancer in remission.

On presentation, he exhibited classic Ekbom syndrome: believing bugs infested his body, he applied yoghurt to his skin and stored debris. Profound self-neglect, hoarding of soiled items and out-of-date food, and environmental squalor were noted. Significant weight loss, worsening mobility, and cognitive decline were reported.
Results: Management was complicated by the contraindication of many antipsychotics in Parkinsonism, where they exacerbate motor symptoms. Olanzapine was briefly restarted but poorly tolerated. Aripiprazole was initiated cautiously at a low dose (max 25mg daily) with monitoring for akathisia. Procyclidine effectively managed resultant hypersalivation. His Parkinson's medications were recommenced.

Pharmacological guidance, per Maudsley's guidelines, restricts options. Risperidone and typical antipsychotics like flupentixol are contraindicated due to high extra-pyramidal side effect risk. While quetiapine has marginal efficacy, it is often trialled before clozapine. In this case, aripiprazole was selected as a potentially safer atypical agent.
Conclusion: This case illustrates the complex interplay between psychotic illness and neurodegenerative disease, highlighting the severely limited and high-risk antipsychotic options available. Multidisciplinary management, including SALT input (showing dietary improvement), remains essential for this vulnerable patient with concurrent severe mental illness, physical comorbidity, and challenging medication non-adherence.

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A Case Report of a Child With Attention Deficit and Hyperactivity Disorder With Persistent Acral Swelling and Desquamation Following Methylphenidate

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Aims: Methylphenidate is a relatively safe medication used frequently in ADHD with only a few dermatological side effects reported up-to-date. While direct relation between the medication and the dermatologic side effects on children are discussed and supported by the disappearance of reactions after medication withdrawal, other confounding factors such as parental stress and coping mechanisms, were indeed observed to have a direct impact on children's wellbeing. The higher the maternal anxiety was related to the worse outcome in children with stress. This fact could explain recently emerged or prolonged skin reactions especially during the pandemic, as it provokes health-related anxiety, especially in vulnerable people.