The catatonia syndrome: forgotten but not gone – a case report

Blerta Cenko[1]* and Spiro Milic[2]

[1]Barnet, Enfield and Haringey Mental Health Trust and [2]Barnet Enfield and Haringey MH NHS Trust
*Corresponding author.

doi: 10.1192/bjo.2021.370

Aims. To highlight the presentation and treatment of catatonia in a patient with Schizophrenia.
Background. Catatonia is a syndrome of altered motor behaviour accompanying many general and neurological disorders. It frequently goes unrecognized, leading to the erroneous conclusion that it is rare. Signs and symptoms of catatonia are commonly relieved by the intravenous (IV) administration of a barbiturate or benzodiazepine. If the patient does not fully respond to the sedative drug, ECT becomes the default.
Result. A 61-year Caucasian male with a diagnosis of Paranoid Schizophrenia had been stable for 17 years on Clozapine. He was monitored by his GP. He resided in supported accommodation for 19 years and he was rehoused in a new borough. He was unable to obtain new prescription for Clozapine from his new GP and suffered a psychotic relapse following a period with no Clozapine and admitted under section 2 of the MHA. Clozapine was not restarted due to concerns of prolonged QTc and ectopics. Aripiprazol 15 mg and promethazine were prescribed. He was transferred to a medical ward three weeks later presenting as rigid with abnormal posturing on his bed, febrile, tachycardic and mute. He was confused, withdrawn and not responding to questions. In the medical ward he was bedbound, had high spiking temperatures, raised CK, ongoing fever.He was agitated , restless and confused with dystonic movements of arms and legs and echolalia. He developed an oral thrush, fecal impaction and was catheterised, had mittens put on due to pulling his iv cannulas. Clonazepam 2 mg QDS was prescribed, antipsychotic stopped and rehydrated. After two weeks in hospital clozapine was reintroduced and titrated accordingly. After 8 weeks Lorazepam was introduced as 1 mg QDS and he discharged to psychiatry unit on Lorazepam 1.5 mg QDS after 82 days in medical ward. He continued to be rigid and psychotic. Treatment continued with lorazepam increased up to 16 mg daily and 8 session of ECT were prescribed. Following ECT his mental state improved significantly and there was no rigidity or abnormal movements.
Conclusion. Catatonia is better regarded as a movement and behavioral syndrome with particular attributes and diverse antecedents. First line of treatment is high dose of Lorazepam and second line ECT. Catatonia is a diagnosable and treatable entity.More education is needed to reinforce this message for physicians, especially in emergency departments and psychiatric facilities.

A literature review for the introduction of psychiatric simulation to University of Liverpool Medical School

Alexander Challinor[1]* and Declan Hyland[2]

[1]School of Medicine at the University of Liverpool, Cheshire and Wirral Partnership NHS Foundation Trust and [2]School of Medicine at the University of Liverpool, Mersey Care NHS Foundation Trust
*Corresponding author.

doi: 10.1192/bjo.2021.371

Aims. The aim of this review is to systematically investigate simulation in psychiatry to enable the evidence based introduction of psychiatry simulation into the undergraduate curriculum at the University of Liverpool.
Background. Transformations in the structure of psychiatric delivery and reductions in funding to mental health care have limited the availability of direct patient clinical experiences for medical students. Experiential learning through simulation can be utilised as a powerful pedagogical tool and provide exposure to a broad range of psychopathology.

Although psychiatric skills and knowledge are gained from the current University of Liverpool undergraduate curriculum, there is no specific well-designed psychiatry simulation.
Method. The author searched MEDLINE, EMBASE and PsycINFO databases for studies that met the inclusion criteria. Search terms included 'simulation (psychiatry or 'mental health'). Studies were also searched using snowballing via citation tracking within the databases.

Inclusion criteria comprised studies of an educational intervention that involved simulation. The intervention had to be utilised within the field of psychiatric teaching.
Result. The literature review illustrated the dearth of studies analysing role-playing (RP) and/or simulated patients (SP) in psychiatry with it typically encountered as part of the more general communication skills curriculum. Studies analysing SP and RPs demonstrate how they build on the social context of learning alongside drawing on a range of educational theories, including experiential learning. However, studies show that well-designed simulation training should encompass more facets of learning to be transformative, specifically reflecting upon ones experiences alongside understanding and interpreting this new knowledge, allowing it to guide future actions and change practice.

Studies analysing virtual-reality in psychiatry are limited but demonstrate significant improvements in students' acquisition of key psychiatric skills and exposure to psychopathology. More studies are needed to evaluate the efficiency and cost-effectiveness of virtual-reality over more traditional methods.

Despite the increase in simulation teaching within psychiatry, and the expansion of innovative simulation approaches in other specialties, there was limited use of novel approaches found within the studies analysing psychiatric simulation. There were studies evaluating novel approaches to psychiatry simulation outside of the undergraduate curriculum.
Conclusion. Whilst there are barriers to overcome in simulation training, these are primarily logistical and are clearly outweighed by the educational gain demonstrated throughout this review. Simulation training in psychiatry has often remained limited to traditional communication-oriented scenarios using RP or SP. A greater emphasis on furthering the advancement and integration of more innovative approaches into psychiatric undergraduate teaching is needed.

The long and short of it!

Sidra Chaudhry[1]* and Adwaita Ghosh[2]

[1]Sheffield Health and Social Care NHS Foundation Trust and [2]Rotherham Doncaster and South Humber NHS Foundation Trust
*Corresponding author.

doi: 10.1192/bjo.2021.372

Aims. The aim of this study was to conduct a literature search on long and short QTc and its implications on prescribing medications.

We also intended to assess the knowledge of psychiatry core trainees in the South Yorkshire region regarding QTc and its implications on prescribing for patients.