COCHRANE CORNER

Benzodiazepines for catatonia in people with schizophrenia or other serious mental illnesses: a Cochrane Review†

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† This review is the abstract of a Cochrane Review previously published in the *Cochrane Database of Systematic Reviews*, 2019, Issue 8. Art. No.: CD006570, doi: 10.1002/14651858.CD006570.pub3 (see www.cochranelibrary.com for information). Cochrane Reviews are regularly updated as new evidence emerges and in response to feedback, and the *Cochrane Database of Systematic Reviews* should be consulted for the most recent version of the review.

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See commentary in this issue.

Background

Catatonia is a debilitating disorder of movement and volition associated with schizophrenia and some other mental illnesses. People with catatonia are more likely to require hospitalisation and highly supervised care than those without the disorder. They also have an increased risk of secondary complications such as pneumonia, malnutrition and dehydration. The mainstay of treatment has been drug therapies and electroconvulsive therapy.

Objectives

To compare the effects of benzodiazepines with other drugs, placebo or electroconvulsive therapy for catatonia in people with schizophrenia or other similar serious mental illnesses (SMIs).

Search methods

We updated our previous search (28 February 2007) by searching the Cochrane Schizophrenia Group's Study-Based Register of Trials (9 November 2016; 6 February 2019). This register is compiled by systematic searches of major resources (including CENTRAL, MEDLINE, Embase, AMED, BIOSIS, CINAHL, PsycINFO, PubMed, and registries of clinical trials) and their monthly updates, handsearches, grey literature, and conference proceedings, with no language, date, document type, or publication status limitations for inclusion of records into the register. We also manually searched reference lists from studies selected by the search.

Selection criteria

All controlled clinical trials that randomised people who have schizophrenia or other similar SMI and experiencing catatonia to receive benzodiazepines or another relevant treatment. We included studies that met our inclusion criteria and reported usable data. We excluded those not meeting our inclusion criteria or those not reporting usable data. We contacted authors when we required further information; and if we received no response, we put those studies aside as 'awaiting assessment'.

Data collection and analysis

Review authors extracted data independently. For dichotomous data we calculated relative risks (RR) and their 95% confidence intervals (CI) on an intention-to-treat basis using a fixed-effect model. We completed a 'Risk of bias' assessment for the included study and generated a 'Summary of findings' table using GRADE.

Main results

The searches found 130 citations, from which we could identify 22 possibly relevant studies. From these, we could only include one study. This study had a relatively small sample size of 17 participants who received lorazepam or oxazepam and were drug free for one week before the trial started. The only usable data reported by this study were clinically important change in symptoms of catatonia measured as 50% improvement on the Visual Analogue Scale (VAS). There was no difference in the numbers of participants showing a clinically important change in their catatonic symptoms (RR 0.95, 95% CI 0.42–2.16; participants = 17; studies = 1; very low quality evidence).

No data were reported for other important outcomes of hospital stay, clinically important change in satisfaction with care, global state, adverse effects or general functioning.

We did find a few studies meeting our inclusion criteria but they reported no usable data. We had to exclude these. Although poorly reported, these studies do illustrate that relevant studies have been undertaken – they are not impossible to design and conduct.

Authors' conclusions

Analysis of the results from this review, which was a head-to-head comparison of two benzodiazepine monotherapies, does not show a clear difference in effect. No data were available for benzodiazepines compared to placebo or standard care. The lack of usable data and very low quality of data available makes it impossible to draw firm conclusions and further studies with a high-quality methodology and reporting are required in order to determine more definitively the outcomes associated with benzodiazepine use in the clinical management of catatonia in persons with schizophrenia and other SMI.

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