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Author's Response to: Deepening the understanding of the psychomotor response to critical illness

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Dear Editor

The Authors of the Delirium and Catatonia (DeCat) Prospective Cohort Investigation would like to thank Drs Kleinman, Ravindranath and Rodriguez for their excellent comments (1) regarding our recent publication (2). Kleinman et. al., raise the question of whether exposure to antipsychotics and / or benzodiazepines might have played a role in the development of catatonia and / or delirium in our cohort. This is certainly a possibility, and is a limitation we acknowledge. In regards to whether catatonic symptoms in delirious patients are induced by medications, we agree that we are not able to fully address this important question until the parent trials, within which DeCat is nested, have been completed and treatment assignments are unmasked. Only then, will we be able to appreciate the longitudinal development of psychomotor phenomena in critical illness. In many ICUs around the world, antipsychotics (typical and atypical) are commonly used in the treatment or management of patients with delirium (particularly in those with co-occurring agitation). To what extent the agitation frequently observed in the context of a delirium might represent a co-morbid (or even drug induced) catatonia remains unknown. To our knowledge, no definitive study has been published to adequately address Kleinman et. al.'s questions.

There are no clear guidelines regarding how delirious patients with comorbid catatonia should be treated with respect to antipsychotics or benzodiazepines. To appropriately

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address this question, a large-scale multi-site randomized clinical trial will be required. Until then, clinicians should remain vigilant to potential modifiable exposures (medications, metabolic, intoxication / withdrawal states, underlying psychiatric illness, etc.) that might contribute to the critical illness catatonia phenotype. We agree with the authors that we must first understand the phenomenology of acute brain dysfunction (delirium and catatonia) in the critically ill patient before we can explore risk factors or outcomes.

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