Author's response to reviews

Title: Atypical course in severe catatonic schizophrenia in a cannabis dependent male adolescent: a case report

Authors:

Anders Hakansson (anders_c.hakansson@med.lu.se)
Björn-Axel Johansson (bjorn_axel.johansson@med.lu.se)

Version: 3 Date: 24 June 2015

Author's response to reviews: see over
Dear Editor,

We hereby submit our updated version of our case report, along with our responses to each of the comments requiring a response, listed below.

Yours sincerely,
Anders Hakansson
Björn Axel Johansson

Reviewer’s report

Title: Atypical course in severe catatonic schizophrenia in a cannabis dependent male adolescent: a case report

Version: 2 Date: 21 May 2015

Reviewer: Huseyin Bayazit

1. Which of the following best describes what type of case report this is? None
2. Do you believe the case report is authentic? It’s a good sample of long term follow up psychotic patient.
3. Do you have any ethical concerns? No
4. Is the Abstract representative of the case presented? Yes but it should be more brief

The abstract is now 30 percent shorter.

5. Does the Introduction explain the relevance of the case to the medical literature? There are some points to be clearly explain

The relevance is now better explained. See the last paragraph in the introduction.

6. Does the article report relevant patient information? Yes
7. Does the article report relevant physical examination findings? No

Physical examination findings are reported in the case presentation, including urine toxicology, blood screen, a computer tomography (CT) of the brain, an electroencephalogram (EEG), a magnetic resonance imaging (MRI) of the brain, the evaluation of a pediatric neurologist, as well as blood pressure and heart rate.

8. Does the article report important dates and times in this case? Yes
We now describe the diagnostic criteria fulfilled by the patient, i.e. the rationale behind the diagnosis catatonic schizophrenia. Our patient fulfilled the ICD-10 criteria (A, B: 1, 3-5 and C) for catatonic schizophrenia. Diagnostic assessments according to ICD-10 can be found in the case report at page 6, paragraph 1. Also, we have attempted to add and to clarify the information about how other diagnoses were ruled out in different phases of the clinical course of the case.

In the case presentation we report different types of interventions. This includes medication prescribed already at the emergency room visit, the subsequent hospitalization and the referral to a residential addiction treatment center, the re-hospitalization, an intramuscular dose of olanzapine, a naso-gastric tube for nutrition, oral medication (diazepam, risperidone), 12 bilateral ECT treatments, and the referral to another residential addiction treatment center. For the second episode, we describe the re-hospitalization including compulsory psychiatric treatment, medication (zuklopentixole, risperidone), and subsequent outpatient follow-up.

The interpretation is improved, mainly in the third paragraph of the introduction.

1- The abstract is too long. It should be concise.
The abstract is now 30 percent shorter than in the previous version. We also believe it is markedly clearer than before.

2-In the introduction part it should be explained the hypothesis of the work more clearly. And you should state what it will contribute to our understanding.

We have revised and clarified the last paragraph in of the introduction, in order to express the aim of the case presentation.

3-How did you rule out Neuroleptic Malignant Syndrome and catatonia? It is not stated in the case presentation. After neuroleptic medicine it may develop as a side effect. In the case presentation you stated that after medication,
   - Convulsions in arms and
   - Urine incontinence occurred
Was there rigidity or any changes in vitals?

Neuroleptic Malignant Syndrome (NMS) was ruled out because changes in the level of consciousness, muscular rigidity - deviant muscular movements (bizarre postures) and autonomic instability (urine and faeces incontinence and salivation) began before therapeutic doses of antipsychotic medication was prescribed. A normal EEG, absence of leukocytosis, hyperthermia and tachycardia also support other diagnostic alternatives. This now has been included in the discussion.

4- In the discussion part; it’s not clear why it’s classified as cannabis induced psychosis. There are a lot of stress factors in the patient’s life such as parent’s separation, movement from his country, trying to adapt a new environment, multi drug abuse etc. These stress factors also may trigger psychosis.

This is now more extensively and clearly addressed in the third and fourth paragraphs of the discussion.

Reviewer’s report

Title: Atypical course in severe catatonic schizophrenia in a cannabis dependent male adolescent: a case report

Version: 2Date: 21 May 2015

Reviewer: Mehmet akif Camkurt

1. Which of the following best describes what type of case report this is? Unexpected or unusual presentations of a disease

2. Do you believe the case report is authentic? This case report is authentic in terms of disease symptoms
3. **Do you have any ethical concerns?** I didn’t read anything about written or verbal approval

*Written approval was provided by the patient, as stated at the end of the manuscript.*

4. **Is the Abstract representative of the case presented?** Yes

5. **Does the Introduction explain the relevance of the case to the medical literature?** Yes

6. **Does the article report relevant patient information?** Yes

7. **Does the article report relevant physical examination findings?** Yes

8. **Does the article report important dates and times in this case?** No

*We have gone through the manuscript again to make sure the temporality of relevant events is clearly stated.*

9. **Does the article report the diagnostic assessments?** Yes

10. **Does the article report the types of intervention?** Yes

11. **Does the article report a summary of the clinical course of all follow-up visits?** Yes

12. **Is the interpretation (discussion and conclusion) well balanced and supported by the case presented?** No

*The interpretation is improved, mainly in the third paragraph of the introduction.*

13. **Does the case represent a useful contribution to the medical literature?** A little

14. **Was written informed consent to publish this case obtained?** No

*Yes, the patient gave his written informed consent, and this is stated at the end of the manuscript.*

15. **Is the anonymity of the patient protected?** Yes

16. **Level of interest:** An article whose findings are important to those with closely related research interests

17. **Quality of written English:** Not suitable for publication unless extensively edited

*We have thoroughly gone through the text, trying to improve and clarify the language throughout the paper.*
18. Declaration of competing interests: I have no conflict of interest

19. Additional comments to authors?

1-“A link has been described between heavy cannabis smoking and chronic psychosis.”this sentence should be removed from abstract

The sentence has been removed from the abstract.

2- First paragraph of introduction is completely unnecessary. Should be removed. Because in this case neither genetic nor neurodevelopmental disturbances are important.

We thank you for this suggestion. This paragraph has been removed from the introduction.

3- Introduction section is too long for a case report, should be shortened according to the case. Introduction section should include a short explanation of regular presentation of adolescent psychosis, drug use-abuse in adolescents and presentation of affective psychosis in adolescents

The Introduction is now 34 percent shorter than in the first version, and includes explanations of the issues mentioned by the reviewer.

4- 2nd and 3rd Paragraphs in introduction section could be considered as first paragraphs of discussion.

The introduction has been shortened, and we do believe these two paragraph – although somewhat shorter now – contribute to the background knowledge related to the present case report.

5- During reading, it is hard to cooperate with case presentation. Chronological order of symptoms and interventions are vague. Case presentation is too long also.

Chronological order of symptoms and interventions are now more precisely described. The case presentation is 9 percent shorter than in the first version.

6-Describing “a potentially unique clinical course” is too speculative for this case report.

We have deleted this statement.

Instead, we try to clarify in the last paragraph of the introduction (explaining the rationale of the present case report) and in the last paragraph of the discussion, that the long asymptomatic interval between the first and the second episodes is unusual.

7- Patients’ history reveals several factors like immigration, multiple substance use and stressful life events which could be potential risk factors in this case report. It is too hard to explain this case report as a “first episode related with cannabis and following regular schizophrenia” because of these potential risk factors.
We discuss this in the second last paragraph of the discussion.

8- Authors mentioned “affective psychosis” too much in the manuscript, in regard of differential diagnosis introduction section should include a short description of presentation of affective psychosis in adolescents.

‘Affective psychosis' now plays a less significant role in the text, but it is briefly mentioned in order to clarify its role as one of the potential differential diagnoses.

9- Patients' history defines a clear paranoid schizophrenia according to DSM IV along with catatonia. I think it is hard to classify this patient as catatonic subtype. It should be better to refine case topic as “Atypical presentation of psychosis with catatonic and paranoid features in a male adolescent”

After consideration we have decided to keep the title: ‘Atypical course in severe catatonic schizophrenia in a cannabis dependent male adolescent: a case report’. Catatonic schizophrenia can begin with positive signs, although – according to the literature – this is not very common among adolescents. As a part of the diseases hallucinations and paranoid delusions sometimes can emerge during the course. Our patient fulfilled the ICD-10 criteria (A, B: 1, 3-5 and C) for catatonic schizophrenia.

10- Effects of drug use and abuse and other risk factors are confusing for this case report.

Given the temporal association between the patient’s first psychotic episode and heavy cannabis smoking, and given the literature describing the link between cannabis and psychosis, we believe it is reasonable to emphasize the potential role of substance use (cannabis) in the differential diagnostics related to the present case. However, this is also put into perspective along with other potential ethiologies, and highlighting the fact that the second episode was not substance-related.

11- An episode starting at age 17 is not so unusual I think. Defining onset of positive symptoms at age 17 as “atypical” should be refined. Because it is somehow expected age and presentation for schizophrenia. The interesting points about this case report are paranoid symptoms together with catatonia and severity of episodes. I recommend authors to focus these specifications and mention other factors as triggers.

The word ‘atypical’ refers mainly to the long asymptomatic interval. It is not stated in the manuscript that the age of onset is unusual. However, according to literature, schizophrenia in adolescents often begins with negative symptoms, further making the clinical course of the present patient somewhat atypical.

12- There are some grammatical and spelling errors in the text. I recommend text to be reviewed by a native speaker.

We have thoroughly gone through the text, trying to improve and clarify the language across the paper.