Cotard Syndrome — A Case Report

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Abstract

Cotard’s Syndrome, is a very rare neuropsychiatric condition in which the sufferer holds a delusional belief that he or she is dead, does not exist, is putrefying or has lost his/her blood or internal organs. The syndrome is described to have various degrees of severity, ranging from mild to severe. It is seen in subjects with depression, schizophrenia and psychoorganic syndromes. The present case vignette is of a lady, who manifested the phenomenon of Cotard Syndrome in the background of depression.

Keywords

Cotard Syndrome, Depression, Nihilistic delusion

Introduction

Cotard’s Syndrome was first described by Jules Cotard, a French neurologist who called it as “le délire de negation” (“negation delirium”), in a lecture in Paris in 1880. He reported the case of a 43 year old lady who believed that she had “no brain, nerves, chest or entrails and was just skin and bone”, that “neither God nor the devil existed” and that “she was eternal and would live forever”. The syndrome is described to have various degrees of severity, ranging from mild to severe. In a mild state, feelings of despair and self-loathing occur, whereas in the severe state the person with Cotard’s syndrome actually starts to deny the very existence of self. The present case is of a lady with recurrent depressive disorder, in which the sufferer had nihilistic delusions typical of Cotard syndrome.

Case Report

A 55-year old married Bengali female school teacher had been brought by her family after being saved on having committed suicide within a week of her father’s death due to lung carcinoma. She had been treated by psychiatrists since 3 years for depression and had 2 such episodes in the past, triggered by stressors. In both the cases, she was treated by a psychiatrist with anti-depressants like Escitalopram, Sertaline, Mirtazapine along with benzodiazepines like Clonazepam, Alprazolam and Lorazepam and had recovered within 2 – 3 months of start of treatment. Her present episode started when her father’s palliative care started and was declared by the oncologists to be “beyond help”. The patient was again taken to the previous psychiatrist and was started on Mirtazapine 15mg/d and Lorazepam 2mg/d without improvement and her father died 15 days after start of her treatment. This catapulted her to feel much more depressed and within 2 – 3 days of her father’s demise she began to “talk irrelevantly” according to the family. According to them, she began to complain that her body was finished, her gut has become rotten and her brain had rotten due to which her mind had stopped working. She also began to say that like her father, her lungs had cancer and was rotting and the rotten bits were coming out when she coughed thus pointing to black specs in her sputum. She despite being explained to the contrary by her family would adhere firmly to her beliefs and accept no reason. She would spend sleepless nights, had decreased appetite, libido, self-care, socialization, had aches and pains in her body, felt lethargic, had frequent crying spells and sometimes gave a vacant stare towards...
the walls of her room. After 4 days of her father’s death, the patient was found in her locked room by her family in a drug overdosed and unconscious state in the afternoon. She was taken to a local hospital, the details of treatment are not forthcoming and she gained consciousness after a day. On being asked as to why she had done this, the patient said that she was as if already dead from inside and hence had chosen to die than to bear the suffering by living her wretched life. She was hence brought to the present therapists to get her treated by family members.

**Diagnosis**

Recurrent depressive disorder current episode severe depression with psychotic symptoms (nihilistic delusions amounting to Cotard syndrome) was considered.

**Management**

On investigation no abnormality was detected in routine tests and thyroid function test. She was augmented with Cap Venlafaxine, dose of which was increased to 225 mg/day along with Mirtazapine which was hiked to 30mg/d. She was also prescribed T. Clonazepam 4 mg/day and T. Risperidone 2 mg/day and kept on high suicidal risk management. The patient’s family members refused to admit the patient or to start her on ECT. She started appreciating that she has body parts and her brain had started functioning, although not to the extent which patient expected. Over the next 4 weeks patient achieved full remission, her delusions gone, and psychoeducation of patient and family was done. On subsequent follow-up, the patient had gained weight and was compliant with the medication when Clonazepam was tapered off and stopped.

**Discussion**

Cotard’s Syndrome currently is regarded more as a symptom complex than a syndrome, though the basic tenets of the century old description by Cotard still holds true. It is considered to be a very rare syndrome and the data with regards to its incidence and prevalence are not available. Although there are about 200 published articles on Cotard Syndrome, an operational definition is still lacking. In published literature the syndrome has been most commonly reported to occur in late middle life, although the age range in these reports is between 16 – 81 years. It is also more frequently reported in females. Clinical features of Cotard Syndrome vary in terms of the extent and number of nihilistic delusions and range from losing powers of intellect and feeling to leading the patient to deny both her/his own existence and that of the cosmos. Cotard syndrome has been seen in subjects with depression, schizophrenia and psychoorganic syndromes. In mild cases, the patient complains of becoming depressed and of beginning to believe that powers of reasoning and feelings were lost and the patient is more anxious which leads to nihilistic delusions. Ideas of subjective negation lead the patient to deny the existence of parts of body and then the whole self. The paradox of nihilism becomes even more pronounced when these patients at one time protesting that they did not exist start claiming to be all pervading over the earth and this has been termed as “The manic Cotard syndrome”. Other symptoms may include analgesia, mutism, self mutilating urges, suicidal ideas, illusions and hallucinations. Negativistic attitudes and behaviour are common like not eating etc. The neurobiology of Cotard syndrome has been studied with no definite breakthrough. Management of this syndrome essentially lies in treating the underlying condition. Electroconvulsive therapy remains the treatment of choice. If associated with organic state, underlying condition needs to be treated. Suicide risk needs to be addressed as these patients are often suicidal. Complete recovery may occur as spontaneously and as suddenly as its onset. Recovery may be rapid or gradual in mild cases. Association with organic causes resolve quickly. But, it may persist after depression has cleared in some cases. Chronic cases, the delusional state of negation usually waxes and wanes. It improves with other phenomenon in case of schizophrenia.

**Conclusion**

As in our case, this syndrome though a very rare neuropsychiatric syndrome is seen mostly in female and elderly population and can be cured by electro-convulsive therapy and/or medications. It can also be sometimes missed due to lack of a good clinical history and lack of awareness about the syndrome.
References


