Case Report

Cotard's Syndrome : a case report

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ABSTRACT

Cotard's syndrome, also known as the 'Walking Corpse' syndrome is characterized by denial of self existence in 69% cases and yet paradoxically 55% patients have delusions of immortality. Moreover, this syndrome occurs in middle aged and older people more commonly. In this case report, we present a case of a 29 year old female patient from a remote town who had depressive features with somatic complaints and somatic delusions that her blood had thickened and her joints have loosened and inability to walk. Unlike most of the cases of Cotard's syndrome she did not respond well to both pharmacotherapy as well as electroconvulsive therapy. We could give only 4 ECTs to the patient as relatives insisted for discharge on request. Few case reports have mentioned response to Cotard's after 11 ECTs. With this case report, we wish to highlight the need for training more mental health professionals in the periphery so that help becomes easily accessible.

Key words: *Cotard's syndrome, ECT, delusions.*

INTRODUCTION

Cotard's syndrome , also known as the 'Walking Corpse' syndrome was first described by Jules Cotard in 1880 as *Le délire des négations* ("The Delirium of Negation"),a psychiatric syndrome of varied severity; a mild case is characterized by despair and self-loathing, and a severe case is characterized by intense delusions of negation and chronic psychiatric depression [1].The person afflicted holds the delusion that he or she is dead; either literally or figuratively, yet the mentioned delusion of negation is

not essential for syndrome proper [2]. Statistical analysis of a hundred-patient cohort indicates that the denial of self-existence is a symptom present in 69 percent of the cases of Cotard's syndrome; yet, paradoxically, 55 percent of the patients might present delusions of immortality [3].The syndrome is typically found more commonly in middle aged and older people. Nevertheless, there have been case reports published of young people with over 90% of the patients being females [4-8]. In this case report, we have presented a case of a young female patient with Cotard's syndrome.

CASE REPORT

A 29 year old female patient Mrs X, recently married resident of Ratnagiri was brought to our Outpatient Department by her relatives. She was very restless, crying continuously and was unable to walk. She was brought on a wheelchair. She also was abusive and irritable towards her family members. On enquiring about details of her illness, it was found that her complaints started after she fell from a tree from a height of three feet and sustained minor injury on her left leg. Orthopaedic opinion was sought and MRI revealed a minor injury for which painkillers were advised. But Mrs X was continuously complaining of weakness in limbs, unable to walk, refusing to go out. She felt that the blood in her limbs had decreased, her muscles had got weakened, thinned out, joints had loosened, tingling and numbness in limbs . She felt that her limbs could not bear her weight anymore, she could fall anytime, so she started walking with support. This gradually spread to back, where she complained of back pain, abnormal protrusions at back and tingling sensations at back.

She felt that her jaw had loosened, made noise while she ate and spoke. She started having feeling on abdominal fullness, constipation and abdominal pain which was not explained by investigations and claimed all her body organs had vanished, she felt empty from inside .She developed sadness of mood , hopelessness about the future , claiming none of family members and doctors were able to understand her condition. She had disturbed sleep for 2 months and refused to eat anything since 3 days. She conveyed her desire to die to her parents and left home once without notice of her family and tried to kill herself by jumping out of the vehicle. On next day she was brought to us, when we saw her, she seems to in great pain and crying. Mental status examination showed preoccupation with somatic complaints, depressive features, suicidal ideations, nihilistic delusions and delusion of somatic type. She also had past history of depressive episode with somatic complaints, ideas of persecution and reference 10 years back for which she was treated by a psychiatrist with Risperidone 4mg and Trihexyphenidyl 4mg and improved completely within 6 months. She had second depressive episode with psychotic features one and half year back for which she took treatment for 2 months and stopped treatment due to weight gain. Provisional diagnosis of Major Depressive Disorder with psychotic features and Cotard's syndrome was made and patient was admitted to the psychiatry ward. She was in strict supervision by the staff and relatives to prevent any further attempt to harm herself. Her routine blood investigations, thyroid function test, serum B12 level ,electrocardiogram and chest Xray came normal.

She was started on antipsychotics Aripriprazole 10mg at night and Blonanserin 4mg twice a day and antidepressant Escitalopram 5mg twice a day and Mirtazapine 15mg at night. On serial MSE patient was not showing improvement, her active suicidal ideations had lead us to start her on electroconvulsive therapy. Currently, patient has been given 4 ECTs, her depressive symptoms have got better but patient shows non improvement in delusions. After 4 sessions of ECTs relatives started insisting on discharge

stating that they did not have enough man power and financial resources further. So, we had to discharge the patient on request. We advised regular follow ups and ECTs. Unfortunately, coming from a remote place patient did not follow up regularly further.

DISCUSSION

Our patient was a young female as against most of the reports on Cotard's syndrome except a few. It is further mentioned that 90% pts in the young age group affected with this syndrome are females[4-8].Patient was given typical as well as atypical antipsychotic but she did not respond to either of them. All the case reports till date have highlighted the importance of electroconvulsive therapy in these patients [9-10]. But we found no significant improvement even with electroconvulsive therapy. Unfortunately we could not with further sessions of electroconvulsive therapy due to premature discharge on request. There is one case report of a patient having catatonia with neuroleptic malignant syndrome with Cotard's syndrome in which patient responded after 11 ECTs [11]. Continuing with ECT could have helped the patient but as there was no one in the family who could stay for a few more days, we had to discharge her. This further highlights the lack of adequately skilled psychiatrists and staff in hospitals in periphery. Patients along with relatives have to travel long distances to seek help and hence are wary of longer duration of hospitalization leading to incomplete treatment. Patients become further non compliant if they have to travel long distances to take medications. Thus, we wish to highlight the importance of having skilled mental health professionals in the periphery where mental health services can be made easily accessible by providing adequate training in undergraduate training programmes to doctors as well as nursing staff.

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