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COTARD SYNDROME IN A MIDDLE AGED MAN WITHOUT ORGANICITY

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ABSTRACT

Cotard's syndrome is a rare neuropsychiatric condition characterized by delusions of nihilism / non-existence concerning one's own body first described in 1880. Most commonly seen in severe depression, psychoses mostly associated with organic lesions of the nondominant temporoparietal regions of brain. Till now E.C.T remains the treatment of choice. Presented case report is of middle aged man with cotard syndrome with duration of untreated illness of few months and without any organic cause.

INTRODUCTION

Cotard's syndrome is a rare neuropsychiatric condition characterized by anxious melancholia, delusions of non-existence concerning one's own body. Delusion of nihilism remains the centre of the syndrome given by Jules Cotard who first formulated this condition in 1880.[1] Encountered primarily in psychoses such as schizophrenia and in bipolar disorder, Cotard's syndrome has also been described in organic lesions of the nondominant temporoparietal cortex as well as in migraine. Cotard's delusion is the only self-certifiable syndrome of delusional psychoses.[2] Cotard's syndrome presents in three stages: (i) Germination stage—the symptoms of psychotic depression and of hypochondria appear; (ii) Blooming stage—the full development of the syndrome and the delusions of negation; and (iii) Chronic stage—continued, severe delusions along with chronic psychiatric depression.[3]

CONSENT

Informed, written consent was obtained from patient and a reliable attendant including the permission regarding publication of this case report.

CASE REPORT

Mr. A 38 year old male educated up to 8th class, married, resident of urban, nuclear ,middle socio- economic status family was forcefully brought by his wife to the outpatient department as patient had decreased interaction, irrelevant talk since 7 months, refused to eat from 10-15 days and also attempted suicide by trying to hang himself. Patient was admitted in inpatient unit as for potential risk to self and was not manageable at home. On evaluation, which included extensive and detailed interview of attendant and patient. Patient had pervasive low mood, loss of interest and enjoyment, increased fatigability with decreased appetite and sleep, pessimistic view of future, suicidal ideation, decreased self-care all in background of a stressful life event from last seven months. Onset was insidious and progressive in nature. Patient over the time developed delusion of nihilism and reference. Patient would close the windows of his house saying he does not need air to breath as his body does not exist. Patient for the same reason stopped going out and also stopped eating due to which he had marked weight loss. Patient in two weeks prior of getting admitted in hospital attempted suicide three times by hanging to ceiling fan with rope but was saved by family members on asking about this to the patient he reported his life is not going to change, even if he is dead, so he wishes to end it. He would also keep lying on bed as he reports his hands and legs does not exist so he is unable to get up, without them, and walk. Patient was pre-morbidly well-adjusted with no family history of mental illness, with personal history of smoking cigarettes in dependent pattern for last 10 years. Past history unremarkable of any psychiatric or mental illness. Mental state examination revealed sad affect, marked agitation, ideas of hopelessness, suicidal ideation, delusion of reference and nihilism (of being dead). He lacked insight into his illness. On the basis of the history and mental status examination a diagnosis of severe depression with psychotic symptoms was made with comorbidity of nicotine dependence syndrome currently using substance. His Hamilton Depression Rating Scale score at time of admission was 36 and PANSS scores were 16 on positive symptoms and for negative symptoms it was 39 with general symptoms on 50. General and systemic examination showed no abnormality. His investigations including CBC, RBS, LFT, KFT, thyroid function test and MRI brain did not reveal any abnormality. Patient was started with desvenlafaxine 50mg/day and olanzapine 10mg/day later which were increased to 100mg/day and 20 mg/day respectively. Patient was also subjected to modified E.C.T every alternate day and received total 5 Modified E.C.T were given. With the associated Supportive psychotherapy and repetitive reassurances patient showed improvement during the 17 day course of hospital stay and upon discharge the HAM-D scores were reduced to 6 and PANSS scores to 9 on positive symptoms and to 11 on negative symptoms with the general symptoms on 19. Patient was on regular follow up since discharge in the Outpatient department and the improvement is maintained after discharge.

DISCUSSION

Few differentials diagnosis should be considered like delusional disorder as delusion of nihilism constitute the most conspicuous characteristic and present for at least 3 months and is clearly personal. But the point against it is full blown depressive episode prior to the delusion. Also schizoaffective disorders can be considered as both psychotic and affective symptoms are prominent within the same episode of illness but criteria of depressive episode is met.Berrios and Luque presented an analysis of 100 cases from united kingdom reported that in terms of clinical profile, no difference was found between men and women or between underlying diagnostic categories; depression to be most common diagnosis seen in patients presenting with Cotard's syndrome. In terms of phenomenology, nihilistic delusions concerning body and existence to be most frequent followed by Anxiety, guilt and hypochondriacal delusions.[3] According to the study conducted by Sahoo and josephs more than 40%

of patients of cortard were associated with neurological diagnoses which included seizures, cluster headaches, encephalopathy and seizures, supranuclear palsy, sagittal sinus thrombosis and frontal lobe dysfunction.[5] Also patients with Cotard's syndrome had more brain atrophy in general and more median frontal lobe atrophy in particular.[6] Age seemed to increase the likelihood of developing cotard .Most of the case studies show patients more than 55years.[3]The presented case is unique in terms of onset of the syndrome at an early age and duration of illness of 7 months and with no evidence of organicity. M.E.C.T was proven effective and is maintaining well on combination of oral antipsychotics and antidepressant.

CONCLUSION

Cotard syndrome is a rare disorder and mostly associated with organicity. It is important to recognize the syndrome because specific underlying mechanisms are present, and prognostic and therapeutic consequences have to be taken into account.[7] As most case reports are of patients with underlying organicity or presents at later age. Presented case shows an early onset of the syndrome without any medical comorbidity except for nicotine dependence.

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CONFLICT OF INTERESTS

There are no conflicts of interests.

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