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REVIEW ARTICLE

Cotard Delusion

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Abstract

Cotard's syndrome is a rare syndrome, characterized by the presence of nihilistic delusions. The syndrome is typically related to depression and is mostly found in middle-aged or older people. A few cases have been reported in young people with 90% of these being females.

Keywords: Cotard Syndrome; Nihilistic Delusions; Existence Denial; Negation Delirium.

Introduction

Walking Corpse Syndrome or Cotard's Syndrome is an uncommon neuropsychiatric disorder in which patients experience delusions or false beliefs that they are dead, do not exist, are putrefying or have lost their vital organs. In some cases, they can even smell the rotting flesh. The condition can simply be described as "*existence denial*". It is sometimes accompanied by symptoms of guilt, anxiety and negativity. Paradoxically, some patients may have delusions of immortality.

Studies indicate that the disease is more prevalent in older patients with depression. It is also more likely to occur in patients with disorders like schizophrenia, bipolar disorders, brain injury, brain atrophy, seizure disorders, depression, brain tumors, stroke, migraine and in patients with delirious states. Women may be more commonly affected than men.

Though the exact cause is not known, lesions in frontal and temporal regions (front and sides) of the right hemisphere of the brain have been associated with the disease.

Some patients suffering from '*Walking Corpse Syndrome*' have died of starvation since they deprived themselves of food thinking that they are already dead. The patients also have a tendency to attempt suicide and harm themselves.

History

The syndrome is named after *Jules Cotard* (1840–1889), a French neurologist who first described the condition, which he called *le délire de négation* ("negation delirium"), in a lecture in Paris in 1880 [12,13]. He described the syndrome as having degrees of severity that range from mild to severe. Despair and self-loathing characterize a mild state. Severe state is characterized by intense delusions and chronic depression.

In one of his lectures, Cotard described a patient with the pseudonym of Mademoiselle X, who denied the existence of several parts of her body and her need to eat. Later she believed she waseternally damned and could no longer die a natural death. She eventually died of starvation.

Pathophysiology

The underlying psychopathology and neurophysiology of Cotard's Syndrome may be related to other problems involving delusional misidentification.

Causes and Risk Factors

Walking Corpse Syndrome occurs due to lesions in

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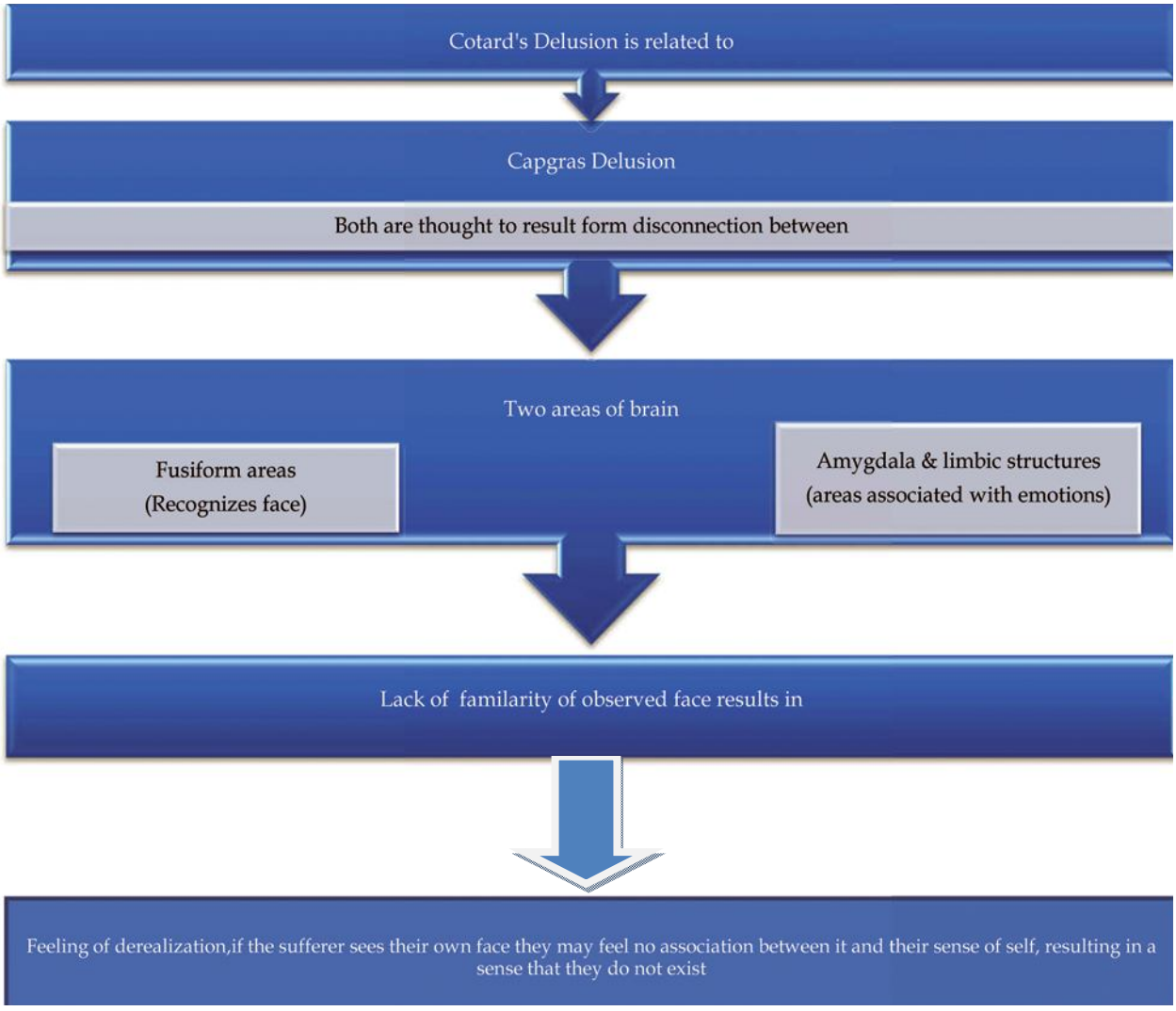

frontal and temporal regions of the right hemisphere of the brain.

- ☞ The exact cause for **'***Walking Corpse Syndrome***'** is not known.
- ☞ Studies suggest that the cause is localized in the frontal and temporal regions of the right hemisphere of the brain.
- ☞ *Risk Factors* that have been associated with Cotard's syndrome are-
  - √ The condition is more common in older individuals with depressive disorders
  - √ It is associated with other mental disorders like schizophrenia, bipolar disorders and dementia
  - √ It has been associated with other conditions affecting the brain like brain atrophy, brain tumors, seizure disorders, brain injury, migraine, Parkinson's disease and stroke
  - √ It could also be a consequence of an adverse drug reaction to acyclovir, an antiviral drug, in patients with kidney failure.

Sign and Symptom

- ☞ People with **'***Walking Corpse Syndrome***'** believe that they are dead.
- ☞ Patients with **'***Walking Corpse Syndrome***'** have a vague feeling of anxiety in the initial stages. This is followed by a belief that they are dead, do not exist, are putrefying (they can even smell rotting

flesh) or have lost their vital organs. Some patients actually feel that they are immortal.

- Clinical features include *depression, feeling of guilt*, *negativity* and *insensitivity to pain*. The patients may also believe that they are *paralyzed or have auditory or smell-based hallucinations*.
- People affected by this disorder *cannot recognize their own face* and *do not show any interest in social life or pleasure*. They are always *paranoid and neglect their own hygiene*. They have a *suicidal tendency or may harm themselves*. They lose sense of reality and have distorted view of the world.

Stages

Yamada suggested a classification of Cotard's syndrome; he divided it into three stages based on the symptoms:

Germination Stage

In this stage, the patient shows characteristic features of depressive mood, extreme worry of unwellness and excessive fear of one's illness, despite medical treatment.

Blooming Stage

In this stage, the patient experiences true features of the syndrome i.e. delusion of being dead or immortal; this stage is associated with anxiety and negativism.

Chronic Stage

In this stage, the individual shows severe depression due to emotional disturbances or paranoia.

Diagnosis

'*Walking Corpse Syndrome***'** is diagnosed based on the patient's and symptoms. Tests are used to exclude other conditions as well as to diagnose associated diseases. These tests include:

1) History
2) Symptom
3) Test includes

Blood Test

CT Scan (Computed tomography)

MRI (Magnetic Resonance Imaging)

SPECT (Single-photon emission computed tomography)

Electroencephalogram (EEG)

Treatment

Walking Corpse Syndrome / Cotard's syndrome is treated with medications in combination with electroconvulsive therapy.

Treatment of 'Walking Corpse Syndrome' includes the following:

Identification and Treatment of Risk Factors

Risk factors for **'***Walking Corpse Syndrome***'** should be identified and treated.

Antidepressants, Antipsychotics and Mood Stabilizer Medications

Antidepressants, antipsychotics and mood stabilizers are used in the treatment of Cotard's syndrome. Based on the underlying condition, the patient should be treated with a single drug or combination of medications. Mood stabilizers have beneficial effects in patients with bipolar disorder.

Electroconvulsive Therapy

Many cases have shown that a combination of electroconvulsive therapy (ECT) with medications was more effective to manage the condition as compared to medications alone. ECT involves placing electrodes on the patient's head and administering the small impulses.

Prognosis

The overall prognosis of disease is determined by severity of the disorder and the treatment strategies used to manage it. Some patients recover with proper treatment. Some die of starvation. The patients also

have suicidal tendencies and should be watched over.

Interesting Case of Cortard Delusion

Ms. L, a 53-year-old Filipino woman, was admitted to the psychiatric unit when her family called 911 because the patient was complaining that she was dead, smelled like rotting flesh, and wanted to be taken to a morgue so that she could be with dead people. Upon interview in the hospital, the patient expressed fear that "paramedics" were trying to burn down the house where she was living with her cousin and her brother. She also admitted to hopelessness, low energy, decreased appetite, and somnolence.

Ms. L reported that she had been on antidepressants while in the Philippines (where she had resided for the last 18 years, having moved to the US only a month ago), but could not recall the name or dosage of the medication.

After organic causes were ruled out, treatment with quetiapine and bupropione SR was started. The patient was initially reluctant to take medication or eat. She subsequently developed an electrolyte imbalance (hypokalemia and hyponatremia), which necessitated intravenous electrolyte repletion. The patient was also isolative, spending much of the day in bed and neglecting her personal hygiene and grooming.

With her family's support, the decision was made to take the patient to court for treatment over objection. Subsequently, the patient's medication regimen was bupropion SR and olanzapine (intramuscular if she refused the oral form). A few days later, the patient had a questionable syncopal versus seizure episode, necessitating transfer to a medical unit.

After three days, she returned to the psychiatry floor where her medication regimen included olanzapine, escitalopram (because of the questionable seizure on bupropion), and lorazepam (for agitation).

Ms. L showed improvement in symptoms over one month on olanzapine 25mg daily, escitalopram 20mg daily, and lorazepam 2mg daily. At discharge she denied nihilistic or paranoid delusions and hallucinations and expressed hopefulness about her future and a desire to participate in psychiatric follow-up care.

Discussion

Previous reports of patients with Cotard's syndrome have indicated that ECT has tremendous advantages in resolution of patient's symptoms when pharmacotherapy has failed [2,3]. In contrast, Ms. L responded well to pharmacological medications at lower doses than previously needed for this degree of illness.

The family was supportive of the medical team's decision to take the patient to court for treatment over objection. Additionally, the family made daily visits, during which they attempted to encourage her to eat food that they had prepared. Other case studies have shown selfstarvation to be associated with Cotard's syndrome [3]. This has legal implications since it fulfills the criteria for danger to self and sometimes necessitates involuntary commitment [4] and, in this case, treatment over objection.

We believe incorporating guidelines from a recent study on the mental health of Filipino Americans, which advocate utilizing family members in treatment of the patient and judicious use of medications due to the observed response of Asians at lower doses of medications [5], contributed to our success.

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