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The Challenging Management of a Cotard´S Syndrome: A Case Report

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Abstract

Psychiatric disorders exhibit diverse presentations, giving rise to a plethora of therapeutic approaches, wherein the trajectory and treatment response can serve as predictive indicators of recuperation. Catatonia, an autonomous syndrome, can manifest across various mental and organic contexts, boasting a worldwide prevalence impact of 9.2%. Even rarer is the convergence of catatonia with nihilistic delusions – a fusion exemplified by Cotard's Syndrome – a rarity observed among patients. Thus, drawing from the portrayal of a unique case involving an inaugural psychotic episode characterized by treatment resistance, the author emphasizes the importance of successive adjustments in antipsychotic therapy, fostering a more efficient approach to treating patients grappling with refractory psychotic conditions.

Keywords: psychiatric disorders; recuperation; catatonia; cotard's syndrome

Introduction and objectives

Psychiatric disorders can have different presentations and, therefore, several therapeutic proposals, with their course and response to treatment predictive of recovery. Catatonia is an independent syndrome that can occur in various mental and organic conditions, with a global prevalence of 9.2%, being this prevalence higher (23.9%) in patients undergoing Electroconvulsive therapy (ECT) with elevated creatine phosphokinase (CK) levels. A catatonic presentation associated with nihilistic delusions – Cotard's Syndrome – is an even rarer combination observed in patients, with few cases reported. Nonetheless, in each of these psychopathological conditions, the effectiveness of ECT is well established. Thus, from the description of a rare case of a first psychotic episode with therapeutic resistance, the authors emphasize the importance of successive adjustments in antipsychotic therapy for a more effective approach in the treatment of patients with resistant psychotic conditions.

Clinical Case Description

A 20-year-old woman of Caucasian ethnicity is brought to the psychiatric emergency service by family members due to anorexia and behavioural changes described as *'she stays quiet in the same corner, doesn't speak or eat'*. These changes have developed over the course of a month and worsened in the last week. The patient lives with her mother and sister in their own apartment, is single, has no children, and has no relevant medical history. According to her accompanying mother and sister, the symptoms reportedly began after she failed an exam at college. *'She became apathetic, had little interaction with the family; she sits on the couch staring into space, repeats things often, takes many showers, and has stopped eating'*; they also add, *'she hasn't been writing in her diary for a while, and she used to write daily, spending a lot of time staring at the same page in books'*.

In the emergency service, the patient remains in a catatonic and bewildered posture, only mentioning, *'I can't, I can't do it; my hair and skin are falling off'*. Given the described clinical picture, she is voluntarily admitted to the Psychiatry Service for a first psychotic episode with a predominance of negative symptoms and Cotard's syndrome. Laboratory tests, including thyroid function and serology, as well as imaging (brain CT scan), did not reveal any abnormalities and the psychiatric history without prior hospitalizations or follow-ups. History of psychomotor development in childhood within the normal range and good academic performance, without any failures. Currently in the second year of university education, having received her first negative grade in a course

subject. Reports of a pre-morbid personality as *'sociable, while valuing her solitude'*, with an ease in forming interpersonal connections and active engagement in academic life. No history of psychoactive substance or tobacco use, and alcohol consumption only in social contexts. Given the initial psychopathological presentation and the patient's catatonic clinical state with oral medication refusal, a treatment regimen was initiated consisting in haloperidol drops (5mg) once a day, intramuscular diazepam (5mg) three times a day and intravenous clomipramine (50mg) once a day.

On the second day of hospitalization, due to tremors, the antipsychotic got to be discontinued, keeping the medication instituted. On the fifth day, due to continued catatonic posture, thought blocking, delusions of ruin and guilt such as *"i'm harming my family, they'll be left without money"*, and repetitive speech "i'm losing my hair, it's falling out, and my head feels empty, there's nothing there" indicative of nihilistic delusions, the treatment regimen was maintained with clomipramine (50mg), and a paliperidone regimen was initiated, eventually reaching nine milligrams daily. However, after two weeks, the patient developed new symptoms of drooling, rigidity, and swallowing difficulty, leading to the gradual discontinuation of paliperidone. During this period, clomipramine had to be stopped due to sinus tachycardia.

Due to a modest improvement in the psychopathological picture, maintaining a state of perplexity, improvement in the catatonic condition, but still marked psychomotor slowing, lack of expressiveness and persistence of delusional ideas, as well as a lack of insight into the morbid condition, faced with the impossibility of reaching therapeutic dosages of the antipsychotics previously prescribed due to side effects, the treatment was readjusted.

Therefore, on the thirty-fifth day of hospitalization, the patient initiated ECT, having undergone progressive tapering of antipsychotic therapy up to that point. Eleven sessions were conducted, proceeding without complications. Clozapine was introduced at 12.5mg after the second ECT session and increased to 25mg after a week. During the ECT cycle, the patient exhibited a noticeable improvement in interpersonal connection and emotional expression shortly after the initial sessions. Further progression revealed increased spontaneity in speech and enhanced motivation, along with the ability to perform cognitive exercises that were previously challenging, as well as a resurgence of sensory-perceptual alterations and delusional ideas of ruin. By the antepenultimate ECT session, the patient was able to mention a symptomatic improvement more focused on motivation and an increased awareness of her morbid condition.

The patient was discharged on the eightieth day for outpatient psychiatric follow-up and was recommended maintenance ECT. At the time of discharge, she displayed an affable demeanour, with prosodic and spontaneous speech. No alterations in thought or perception were noted. Her mood was stable with resonant emotions, and she was smiling.

One year after hospitalization, the patient continues to receive specialized care, maintaining treatment with clozapine (25mg), and without a resurgence of psychopathological symptoms, achieving full recovery up to that point.

Discussion

Several studies demonstrate effectiveness in the treatment of Cotard's syndrome, whether through electroconvulsive therapy, antidepressants, or antipsychotics, in monotherapy or combination. However, in this clinical case, no improvement was observed with the instituted psychopharmacology due to the inability to reach therapeutic doses due to their side effects. The proposal for ECT proved to be crucial in the prognosis, with the patient showing improvements shortly after the second session, without any side effects. Another important aspect is the occurrence of this syndrome in female patients, but in older age groups. *Basu et al.* report two clinical cases of Cotard's syndrome, one of which involved catatonia, with both patients being over 60 years old.

Conclusion

Despite its rarity, Cotard's syndrome with catatonic symptoms is a condition encountered in psychiatric services and possesses clinical features that lend it a certain uniqueness in diagnosis and treatment. Therefore, the authors believe it is important to report this challenging clinical case, not only due to its relevance as a set of infrequent symptoms but also its association with iatrogenic refractoriness, highlighting the effectiveness of ECT in symptom management.

Declarations

Conflict of Interest Statement

The authors reject any conflict of interests, without any funder involved.

Data Availability Statement

The datasets presented in this article are not readily available because the data were extracted from a patient medical process and is thus personally confidential within the framework of the medical professionals involved in her treatment.

Ethics Statement

The Cova da Beira Hospital and University Center research ethical committee has confirmed that no ethical approval is required on them seem 31/2023. The patient provided her written informed consent to participate in this study. Written informed consent was obtained from the individual for the publication of any potentially identifiable data included in this article.

References

1. Basu, A., Singh, P., Gupta, R., & Soni, S. (2013). Cotard syndrome with catatonia: Unique combination. Indian Journal of Psychology and Medicine, 35(3):314-316.
2. Dugas, M., Halfon, O., Badoual, A., Nedey, M., & Contamin, E. (1985). Le syndrome de Cotard chez l'adolescent. *Neuropsychiatrie de l'Enfance et de l'Adolescence*, 33(6): 493-498.
3. Ghaffari, A., Mehdizadeh, A., & Pouya, F. (2013). Effect of cultural themes on forming Cotard's syndrome: Reporting a case of Cotard's syndrome with depersonalization and out of body experience symptoms. *Iranian Journal of Psychiatry*, 7(2):91-93.
4. Rogers, P., et al. (2019). Epidemiology of catatonia in a large dataset. *British Medical Journal*, 90(2).
5. Solmi, M., et al. (2018). Prevalence of catatonia and its moderators in clinical samples: Results from a meta-analysis and meta-regression analysis. *Schizophrenia Bulletin*, 44(5):1133-1150.
6. Weiss, C., Santander, J., & Torres, R. (2013). Catatonia, neuroleptic malignant syndrome, and Cotard syndrome in a 22-year-old woman: A case report. *Case Reports in Psychiatry*, 452646.

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