LETTER TO EDITOR

A case report of Cotard's syndrome with catatoniform symptoms

Um relato de caso de síndrome de Cotard com sintomas catatoniformes

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Dear Editor

Cotard's syndrome (*délire des negations*), first described by Jules Cotard[1-4], is defined as a nihilistic delusion in which patient typically believes that he or she is dead, has lost his or her soul, has no functional body systems, or is rotting internally, or that the world no longer exists[1-4]. The syndrome is usually related to depression and is encountered in middle age or older people[1]. However, it can be seen in several other conditions and in younger patients[1-4].

Mrs. A, a 55 year-old woman, was brought to our psychiatric emergency service because she hadn't eaten or drank for the last two days. Her depressive symptoms had began 18 months before: she presented sadness, anhedonia and easy crying, which got progressively worse, with apathy, restlessness, prejudice in her daily activities, insomnia, weight loss (went from 105 kg to 54 kg in one year) and delusional nihilistic thoughts. Outpatient care was initiated, but without result.

During evaluation, the patient had no eye contact with the attending resident and remained stand, with slow pendulum movements, until finally felt down on the floor. She denied having any psychiatric disorder and repeated numerous times phrases like: "my throat is locked and nothing can be done about it", "I have no blood in my veins or pulse in my arteries" and "the sun won't rise up and the night won't end".

After a complete clinical evaluation, in which any organic cause for the psychiatric symptoms was discarded, patient was admitted on the psychiatric inpatient floor, under the diagnosis of severe depression with psychotic symptoms, according to the world health organization's tenth edition of the international classification of diseases (ICD-10)[5]. Because of her psychotic features and motor inhibition, a diagnosis of Cotard's syndrome and catatonia was considered.

Initial pharmacological prescription – once patient was admitted on the psychiatric unity – included olanzapine 10 mg/day, velafaxine 75 mg/day and lorazepan 2 mg 8/8h (which was maintained for about 2 weeks, but without response of the catatonic signs). Venlafaxine's doses were increased up to 450 mg/day and mirtazapine was added to the final dose of 45 mg. Association with aripiprazole was tried, still with no response of the catatonic, depressive or psychotic phenomena. Electroconvulsive therapy (ECT) was then initiated, and previous antidepressants and antipsychotics substituted by tranylcypromine (60 mg) and quetiapine (600 mg) respectively.

ECT was performed two times a week, initially with bi-frontal stimuli, on the dosage of 134.4 mC, without response after several sessions. Procedure was then changed to bi-temporal stimuli until the dosage of 864 mC. Patient began to show improvements after the 14th ses-

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sion of ECT and presented clinical remission of the psychotic and depressive symptoms, as well as weight gain, at the end of the 21th session, but presenting significantly secondary memory sequels. She received hospital discharge after five months of hospitalization and maintains outpatient care at a mood disorders specialized ambulatory from the same service.

Cotard's syndrome is known as a rare and severe presentation of major depression and can be associated with catatonic symptoms[2,3,4,6]. Lorazepam is recognized for the treatment of catatonia[5], as well as arypiprazole, but in this case, patient did not respond to these measures. Resistance of catatonic symptoms to BZD's treatment and absent response of the depressive and psychotic phenomena to proper medications were indications of ECT treatment[3,4,6,7].

Association of ECT and MAOI was considered due to the severity of the case[4]. Proper monitoring of patient vital signs and diet were established in order to secure introduction of MAOI[7,8]. Long inpatient care was needed because of case's severity and its subsequent clinical complications (mainly sacral eschar, dehydration and hypokalemia, due to immobility and food and water deprivation, respectively). It included medical care, nursery, psychological and occupational therapy, as well as familiar support.

We believe this case report is important due to its relevant, yet not frequent appearance in medical literature. Cotard's syndrome is a potentially fatal condition and can implicate in a heavy burden to patient's family and community. The use of ECT, although frequently seen as a taboo by general public and even by colleagues of other medical specialties, has potential to change the course of this severe pathology. Also, its characteristics can precipitate several other medical conditions as described in this case, and a multi-professional healthcare team is necessary to proper recognition and management.

CONFLICTS OF INTEREST

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