Bipolar Disorder and Cotard’s Syndrome-A Case Report and Review

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I. Introduction

Cotard’s syndrome was first described by Dr. Jules Cotard, a French psychiatrist in 1880. This condition is generally thought to be characterized by various degrees of delusional beliefs in which nihilistic delusion that one is dead or the world no longer exist, is the core feature. This is a rare syndrome and till today prevalence and incidence is not known. This syndrome is usually encountered in middle aged or older people with more commonly affecting females.

Cotard’s syndrome is seen most commonly with severe major depressive patients but also occur with various psycho-organic conditions like Schizophrenia, Bipolar disorders, depersonalisation disorder, dementia, temporal lobe epilepsy, parkinson’s disease, brain injury. We report a case of cotard’s delusion in bipolar disorder type-II who presented with self destructive behaviour in the form of self starvation leading to sudden collapse.

II. Case Report

A 58 years married muslim male from a middle class family of an urban area who was undergoing treatment for Bipolar disorder type –II for the last two and half years. He was presented with sad feeling, lack of energy and lack of initiation, confining to self, sleep disturbance for about 3 weeks. His sad feelings was without obvious reason. He began to have feelings of guilt about himself and felt that he had done something wrong in his life. His sleep and appetite were reduced during this period. Gradually he started showing no interest to his daily chores and even failed to interact with his family members.

He started self talking mentioning “I had committed some sin, my life is over”. He started believing that he didn’t have his both hands and legs and also stomach and intestine were putrefying. Gradually he claimed that he was a death person. Subsequently he refused for food thereby leading to sudden collapse following which he was admitted in RIMS Psychiatry ward.

During first few days of admission, he refused to have food or any medications. He repeatedly said that his life was over and express regret for his past activities like a sinner. His nihilistic thought were severe enough to involve lives of his two sons and one granddaughter. He repeatedly called out their names to verify their existence.

On examination, he was not appropriately dressed, average local built and good attire. His speech was coherent and irrelevant most of the time. His mood was depressed with restricted affect. Nihilistic delusion of his body parts were absent and he was a death man, was present. His judgement and insight were absent. Systemic examination revealed no abnormality and also neurological examination were of normal range.

All routine investigations were normal range except for hypoglycaemia and electrolyte disturbance for first 3-4 days of admission. Special tests like thyroid function test, CT scan-brain didn’t reveal any abnormality.

Patient was managed with injection Olanzapine 10 mg, injection lorazepam 4 mg for first 2-3 days. As soon as he started accepting orally, we gave Olanzapine 10 mg, Lamotrigine 200 mg, quetiapine 2 mg per day and responded well after 3 weeks. Mirtazapine 30 mg was also added as his depressed feeling was not improved well. He was discharged on 28th day with following medications Mirtazapine 30 mg, quetiapine 200 mg, lamotrigine 200 mg.

In subsequent follow up for about one year, he was in full remission with lamotrigine 200 mg and quetiapine 200 mg while mirtazapine was gradually removed at the end of six months.

III. Diagnosis

Bipolar Disorder Type-II Currently in Depression with Psychotic features with Cotard’s delusion

IV. Discussion

Cotard syndrome is typically related to depression occurring in middle-aged or older people and more common among females. As reported earlier, the patient’s rejection of food was life threatening and could have led to psychiatric–legal issues associated with self-starvation. Our case highlights the timely intervention
of such patients helping in prevention of further unwanted issues. Self mutilating behaviour and suicidal attempt among these patients also reported.  

Response to treatment is variable. The most commonly recommended treatment strategy is electroconvulsive therapy (ECT)\(^1\),\(^3\),\(^4\),\(^5\),\(^6\),\(^7\),\(^8\),\(^9\),\(^10\),\(^11\),\(^12\),\(^13\),\(^14\),\(^15\),\(^16\),\(^17\),\(^18\),\(^19\),\(^20\) But there are several reports of successful treatment with single or combined pharmacotherapy methods.

<table>
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<tr>
<th>Monotherapy</th>
<th>Combined therapy</th>
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<tr>
<td>Olanzapine(^2), aripiprazole(^3), fluoxetine(^5), duloxetine(^7)</td>
<td>elomipramine/amiltriptyline(^11), risperidone/fluoxetine(^2), risperidone/sertraline(^7), haloperidol/mirtazapine(^24), risperidone/citalopram(^2), amisulpride/clonazapine(^2), quetiapine/venlafaxine(^27), paroxetine/promipexole(^25), clozapine/fluoxamine/imipramine(^21), venlafaxine/clonazepam/risperidone/mirtazapin(^8), olanzapine/escitalopram/lorazepam(^10), haloperidol/olanzapine/escitalopram/lorazepam(^11)</td>
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But our case responded with mirtazapine/olanzapine/lamotrigine/quetipine combination which is different available reports. So, bipolar disorder with Cotard’s syndrome, antidepressant mirtazapine seems to have a role in addition to lamotrigine which has been widely used to treat simple bipolar depression.

The importance of this case is that inspite of regular medication for bipolar disorder, patient developed severe depression with nihilistic delusion with self starvation. This leads to sudden collapse creating a panic to his family members. But urgent intervention with medications as mention earlier, could return the patient’s optimum functioning within one month. Even though this syndrome is rare with newer antipsychotic treatment but such case do exist which may endanger the life, like in our case. So earlier the diagnosis and treatment, better the outcome.

References


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