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Cotard's Delusion-DEAD MAN'S SKETCH

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Abstract

Cotard'sdelusion (CD) is anerratic psychiatric disorder in which the patient believes to be dead, *i.e.*, the patient holds nihilistic delusions concerning his/her own existence. Taking into justification its rarity, and possible subdiagnosis due to inexperience, most of the literature consists of case studies, confounding a more systematic approach and leading to hitches in deciding the best clinical direction to offer the patient misery from CD. The patient eventuallygrieves from nihilistic delusions that they no lengthier exist. Though the delusional disorder was first recognized in the 17th century by Dr. Jules. It is neither classified under DSM-IV-TR nor ICD-10. There is main **three main stages** of this disease condition: **Germination stage**, **Blooming stage and Chronic stage.** Detecting Cotard delusion is habitually difficult because most organizations don't distinguish it as a disease. Patients habitually receive medication and therapy. Medications used to treat this delusional disorder include: Anti-anxiety, Antidepressants, Antipsychotics, Mood stabilizers medications, Psychotherapy, Play therapy etc. treatment modalitiesNevertheless,Cotard syndrome have been described in connotation with many other affective disorders, it is less often found in patients with catatonia.

KEYWORDS: Capgras delusion, Melancholia, Migraine, Dissociative disorder, Catatonia, Dementia,Multiple sclerosis

Introduction

Cotard's syndrome is a comparatively rare illness that was first described by Dr. Jules Cotard in the year of 1882.This rare case of Delusional disorder hasbeen reported in patients with psychotic disorders, mood disorders and medical conditions. Most cases of Cotard'sdelusion are more approachable to ECT than to pharmacological treatment. We present the case of a recent immigrant with Cotard's syndrome, in the framework of depression, to illustrate both how weakening the condition can be and how a course of effective, personalized therapy can improve outcome.[1]

Cotard's syndrome is anerratic neuropsychiatric condition categorized by anxious melancholia, delusions of non-existence concerning one's own body to the level of delusions of immortality. It has been most usually seen in patients with spartan depression. However, now it is thought to be less common possibly due to early institution of treatment in patients with severe depression with psychotic symptoms.[2,3]

Cotard delusion is a rare condition marked by the false belief that makes the patient realizes that his or her body parts are dead, dying, or don't exist. It usually occurs with severe depression and some

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other psychotic disorders. It can go together with other mental illnesses and neurological conditions. The patient might also hear it referred to as walking corpse syndrome, Cotard's syndrome, or nihilistic delusion.[4]

Methodology

We have performed a PubMed and Google Scholar quest in March,2022 by using the phrases "Cotard's Delusion","Cotard's delusional pathophysiology", "Delusional treatment", "Walking Corpse Syndrome" and "Delusions of negation".The search borne almost 130 papers, including reviews, case reports, case series, and small clinical studies. After excluding the 40 non-English reports without an English intangible content, we involved the remaining 90, regardless of publication date.

History

Cotard's syndrome was originally labelled in **1880** by the **French psychiatrist Jules Cotard**, who entitled it the délire des négations.The distinctive symptom of the syndrome is nihilistic delusion. Stereotypically, in this delusional disorder the patients believe they have lost organs, blood or body parts, or even that they are dead.This relatively occasionalsyndrome exists in patients with depression, schizophrenia and psychotic disorder triggered by a general medical condition, and it is often allied with dementia.

Delusions are the principal manifestation of a psychosis in neurologic disorders. Cotard's syndrome and other content-specific delusions may be observed in neurologic illnesses, organic lesions of the brain and distressing brain injury. In patients suffering fromCotard's syndrome, brain atrophy has been reported to occur more recurrently when equated with controls.[4]

Background

People with Cotard's syndrome believe that parts of their body are missing, or that they are dying, dead, or don't exist. They may think nothing exists.Cotard's syndrome is rare, with about **200 known cases worldwide**. People with this syndrome often become much less social. Sometimes, they may stop speaking at all. Some hear voices that tell them they're dead or dying.The CD is one of a variety of narrowly defined monothematic delusions characterized by nihilistic beliefs about the body's existence or life itself. The presence of CD within the context of schizophrenia is rare (<1%), and remains understudied.[5]

Anothewr Name - Cotard delusion, Walking Corpse Syndrome,Delusions of negation

Risk Factors

Researchers aren't definite what causes Cotard delusion, but there are a few conceivable risk factors. Quite a lot of studies indicate that the middling age of people with Cotard delusion is approximately 50. It can also transpire in children and teenagers. People under the age of 25 with Cotard's delusion incline to also have bipolar depression. Women are more probable to this special type of delusional disorderas well as Capgras syndrome can also be presenttogether. Other mental health conditions that might upsurge someone's risk of evolvingCotard delusion include:

- postpartum depression
- depersonalization disorder
- dissociative disorder
- catatonia
- bipolar disorder
- psychotic depression
- schizophrenia

This special type of delusion can also look to be associated with certain neurological conditionstogether with:

- stroke
- brain tumours
- brain infections
- multiple sclerosis
- Parkinson's disease
- dementia
- epilepsy
- migraines
- traumatic brain injuries[6]

Common Causes

The precise cause of Cotard'sdelusion is idiopathic. There are certain conditions that more probably cause this syndrome:

- MS (serious incapacitating disease of the brain and spinal cord)
- Parkinson's disease (nerve cell impairment in the brain leading to shaking, stiffness and pace difficulty)
- Dementia (forfeiture of memory power and judgment)
- Encephalopathy (a condition, where a virus or toxin disturbs the brain)
- Stroke
- Subdural bleeding (bleeding external area of the brain)
- Epilepsy
- Migraine[7]

Pathophysiology

The fundamental neurophysiology and psychopathology of Cotard'sdelusion might be associated to the problems of delusional misidentification. Neurologically, Cotard's delusion (negation of the self or personality) is thought to be related to Capgras delusion (people exchanged by impostors); each category of delusion is thought to result from neural miscarrying in the fusiform face area of the brain, which recognizes faces, and in the amygdalae, which subordinate emotions to a recognized face.

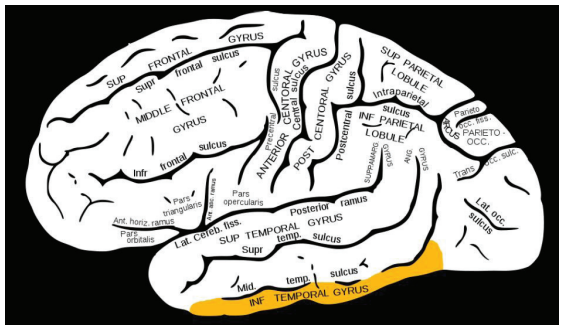
The neural discontinuation creates in the patient a sense that the face they are perceiving is not the face of the person to whom it belongs; therefore, that face absences the familiarity (recognition) normally allied with it. This results in derealization or a disconnection from the environment. If the pragmatic face is that of a person known to the patient, they experience that face as the face of an impostor (Capgras delusion). If the patient sees their particular face, they might perceive no connotation between the face and their own sense of self—which results in the patient believing that they do not exist (Cotard's syndrome). Cotard's syndrome is usually come across in people with psychosis, as in schizophrenia. Haemodialysisfixed the patient's delusions (of negating the self) within hours of treatment, which suggests that the occurrence of Cotard's delusion symptoms might not always be source for psychiatric hospitalization of the patient.[8,9]

Stages

Cotard's syndrome occurs in **three main stages**:

1. **Germination stage**: indications of psychotic depression and of hypochondria appear;
2. **Blooming stage:** full progress of the syndrome and delusions of negation;
3. **Chronic stage**: sustained severe delusions along with lingering psychiatric depression.[10]

Cotard's syndrome removes the person with the state from other people due to neglect of their personal hygiene as well as physical health. Delusions of negation of self-prevent the patient



from making sense of external certainty, which then produces aninaccurate view of the external world. Such delusions of repudiation are usually found in schizophrenia. Even though a verdict of Cotard's syndrome does not necessitate the patient to have had hallucinations, the strong delusions of negation are analogous to those found in schizophrenic patients.[11,12]

Symptoms

Clinical featuresof Cotard's delusion) include:

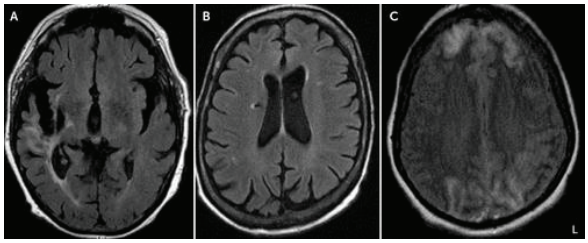
- Delusions one is dying, dead, or no extensive exists
- Spartan depression or sadness (melancholia)
- Attempts to self-harm
- Taking away from social activities
- Patients stop speaking
- Insensitivity to pain
- Refusal to eat leads to nutritional deficiencies
- Delusional voices say the patient is dead or dying

- Ideas of damnation or refusal
- Delusions of immortality[13]

Diagnostic Evaluation

DetectingCotard delusion is habitually difficult because most organizations don't distinguish it as a disease. This indicates there is no uniform list of criteria used to make a diagnosis. In most cases, it's only detected after other possible conditions have been ruled out.'Walking Corpse Syndrome' is spotted based on the patient's clinical history as well as symptoms. Tests are used to eliminate other conditions as well as to diagnose associated diseases. These tests include:

- Blood test
- EEG
- CT Scan
- MRI
- SPECT 14



Scanning reports shows the activeness of brain

Treatment

The principal way to treat walking corpse syndrome is to treat the fundamental medical condition that causes it. Patients habitually receive medication and therapy.Medications used to treat this delusional disorder include:

- Anti-anxiety medications
- Antidepressants medications
- Antipsychotics medications
- Mood stabilizers medications
- Psychotherapy
- Behavioural therapy
- CBT

ECT may be used as a last resort when medications and talk therapy do not work

Complications

Feeling like the patient already died can lead to several complications. For example, some people **stop bathing or taking care of themselves**, which can reason those around them to start estrangement themselves. This can then lead to further feelings of depression and isolation. In some cases, it can also lead to skin as well as teeth problems to the patient. In case of some patients, they stop eating and drinking as they have faith in their body doesn't need it. In unembellished cases, this can lead to **malnutrition and starvation**. **Suicide attempts** are also common in people with Cotardsyndrome. Some see it as a way to prove they're even now dead by showing they can't die again. Others feel like stuck in a body and life that doesn't look real. They hope that their life will get improved or stop if they **die again**.

Existing With Cotard Delusion

- Cotard delusion is anerratic but somber mental illness. While it can be hard to get the right diagnosis and treatment, it generally responds well to a mix of therapy and medication. Many people prerequisite to try several medications, or a combination of them, before they find something that works. If nonentity seems to work, ECT is often an active treatment. If one think that they have Cotard delusion, should try to find a doctor who seems open to listening to the symptoms and working with the patient to detect or address any other conditions you might have.

Reported Cases

Report No. 1 - Ms. L, a 53-year-old Filipino woman, was admitted to the psychiatric unit when her family called 911 because the patient was peevish that she was dead, smelled like decomposing flesh, and wanted to be taken to a mortuary so that she could be with dead people. Upon discussion in the hospital, the patient voiced fear that "paramedics" were annoying to burn down the house where she was staying with her cousin and her brother. She also admitted to hopelessness, low energy, decreased appetite, and drowsiness.Ms. L reported that she had been under treatment of antidepressants while in the Philippines but could not recall the name or dosage of the medication.After organic reasons were ruled

out, treatment with quetiapine and bupropione SR was started. At the time of discharge, she deprived of nihilistic or paranoid delusions and hallucinations and articulated hopefulness about her future and a craving to participate in psychiatric follow-up care.[15]

Report No. 2-'Mr. C' is a 58-year-old Navy veteran with a history of substance use disorder in sustained diminution, TBI, mild neurocognitive impairment, and a 15-year diagnosis of schizophrenia. Prominently, his sister designated that Mr. C agonized his first psychiatric break during adolescence. He was prescribed medication, but his parents, who directed their preference for treating his condition with prayer, declined these. He has been living with his sister for the past 20 years and partakes in all activities of daily living. He is a widower and is currently out of a job. His TBI history includes a single episode nearly 25 years ago when he fell off a moving train, necessitating extended hospitalization. Mr. C was carried in to our Veterans Affairs (VA) hospital by his sister after vocationof the Veterans' Crisis Line with SI. One week past there was an exchange with his brother-in-law resulting in Mr. C assaultive him with a crowbar and the sister superseding. On admission, the family reported that Mr. C was taking venlafaxine and quetiapine.[16]

Report No. 3- A 50-year-old male patient, native of Cajamarca, who had finished high school and lived with his son and daughter-in-law for three months. His family psychiatric background included a mother with BPAD, a father who was a heavy drinker, and two sisters with depression diagnoses. None of them had obtainableCotard's features in the course of their syndromes.Since the age of 13 the patient has presented behavioral changes, with marked isolation due to fearing other people and poor school performance so he recurrent third year of high school. The patient completed his studies with problems and had no interest in continuing, so he decided to work on his parent's farm. His relatives labelled him as "strange," "weird," of "repressed character," quiet, very dependent on his parents and as someone who took no initiative, ran no projects, did not bathe, and had no interest in personal hygiene. This behaviorkeeps on and for periods got shoddier.He was treated with olanzapine 10 mg/day and clonazepam 2 mg/day; with this therapy, he showed some development, was no longer anxious, and could go off home alone.During physical examination flaking lesions on the scalp were found, comprehensive rigidity, and short step gait. The rest of the bodily examination did not reveal any pathological findings. During mental inspection, the patient was found in a pharaonic position, with narrow consciousness, confusion, paralysis of self, derealization, and depersonalization. There were also symptoms like flat affection, paranoid mood, ambivalence, and feelings of guilt. Lastly, the patient exhibited decreased vital energy, insomnia, hypokinesia, and waxy flexibility, sustaining persistent positions as well as lack of spontaneity. On CT scan no alterations were found.It was decided to start dealing with aripiprazole 30 mg/day and clonazepam 2 mg/day. The patient was meaningfullyamended after two weeks of treatment. Delusions were lessened and emotional resonance upgraded.[17]

Report No. 4-A 45-year-old male patient was self-confessed to SVRR Government General Hospital, Tirupati by his family when he happeningdemanding that he had died and his gut was rotting. He seemed withdrawn and anxious. He spoke irrelevantly and proceeded to self-starvation. He protested about his organs and brain dysfunction and had faecal and urinary incontinency. He had been treated by psychiatrists 3 years back for severe depression and was on antidepressants. There was nothing significant family history of mental illness. Physical examination displayed mild pallor and dehydration with bilateral pitted edemashadowed by the mental examination, where the patient obtainable with sad effect, mutism and negativism, he also displayed rigidity in all 4 limbs. Blood analysis exposed that he was anemic (hb-10mg/dl) and had hypoproteinemia and hypoalbuminemia from malnourishment due to starvation. On monotonous lab investigations, no further anomalies were seen. The patient was given a test dose of IV Lorazepam (2mg/dl), there was no enhancement. Physicians, then continued to start the patient on ECT. The patient's care takers were uncertain towards the treatment at first, but upon further counselling and advocation by the health care officials, they agreed to go with the treatment and ECT was begun. He was ongoing on bilateral ECTexploitingThiopentane for induction and Succinylcholine as muscle relaxant. Abetment of delusional indicators were seen only after 8 ECT cycle.[18]

Report No. 5 - Mr. A.S, 43 years old, with a long-termhistory of psychiatric hospitalizations in his home country has presented himself at animmigrant

camp in Greece and sought psychological and psychiatric assistance for his condition. The patient described nihilistic delusions such as believing he did not have blood running through his veins and that he was immortal or that it was unbearable for him to die. Most tenacious symptoms included severe anxiety and continuing depression while he also stated various auditory hallucinations. The patient's history recommended that he was hospitalized 3 times in his home country in various psychiatric clinics and for substantial amounts of time. The first psychiatric hospitalization befell when the patient was 37 years old for about six months, mostly due to severe depression.Upon preliminary psychological assessment at the refugee camp the patient was denoted for psychiatric assessment and was subsequently detected with psychosis (ICD-10, F29), while the appearing psychiatrist testified suspecting Cotard's syndrome. During the first month of CBT sessions, self-help techniques such as deep breathing exercises and relaxations methods were introduced. Primarily, only minor enhancement of anxiety and depressive symptoms was reported by the patient and by week 6 further enhancement of depressive symptoms was testified.While nihilistic delusions somewhat improved with psychiatric medication, these persisted active until the end of the psychological intrusions and the subsequent transfer of the patient to a specialized mental health facility in Greece.[19]

Conclusion

Cotard's delusion is a very occasional as well as exceptional category of mental disorder but can be detected and scared by watching numerous social media videotapes in various multimedia platforms like Facebook and other sites. So, we, authors have taxed our best to cover the allied information regarding this seldom known disorder. We expect that the readers will get enough evidence about Walking Corpse Syndrome or Delusions of negation.

List Of Abbreviations

- CD-Cotard delusion
- ECT- Electroconvulsive Therapy
- MS-Multiple sclerosis
- CT-Computed tomography
- MRI-Magnetic Resonance Imaging
- SPECT -Single-photon emission computed tomography
- EEG- Electroencephalogram
- CBT-Cognitive BehavioralTherapy
- TBI-Traumatic brain injury
- Bipolar affective disorder

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