Delusional Denial of Heart and Lungs Despite Physical Symptoms of these Organs Resulting from a Severe Physical Disease in a Patient with Cotard’s Syndrome

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Abstract

Cotard’s syndrome, first described by Jules Cotard in 1880, is characterized by severe depressive symptoms and various delusions of negation, such as denial of internal organs and denial of existence. Here we report a case of Cotard’s syndrome observed in a schizophrenic patient with chronic thromboembolic pulmonary hypertension (CTEPH). Most notably, he showed delusional denial of heart and lungs despite physical signs and symptoms of these organs resulting from CTEPH.

Key words: Cotard’s syndrome, CTEPH, delusion of negation, heart, lung

Introduction

Cotard’s syndrome, first described by Jules Cotard in 1880, is characterized by severe depressive symptoms and various delusions of negation, such as denial of internal organs and denial of existence (1). Here we report a case of Cotard’s syndrome observed in a schizophrenic patient with chronic thromboembolic pulmonary hypertension (CTEPH). Most notably, he showed delusional denial of heart and lungs despite physical signs and symptoms of these organs resulting from CTEPH. Informed consent to report his clinical course was obtained from the patient and his wife.

Case Report

The patient was a 62-year-old married man suffering from schizophrenia. According to his wife, his premorbid personality was nervous, serious, and meticulous. At the age of 43, he developed auditory hallucinations and persecutory delusions, and was diagnosed with schizophrenia. Since then, he received psychiatric treatment at a mental hospital including six admissions. At the age of 60, he developed chronic thromboembolic pulmonary hypertension (CTEPH), and started to receive medical treatment. His physical condition deteriorated, and he was admitted to the internal medicine ward of our hospital. He showed symptoms of heart and lung problems, such as palpitations, respiratory distress, atrial flutter on electrocardiogram, and cardiomegaly on chest X-ray (cardiothoracic ratio: 59%). Five days later, he showed marked deterioration in psychiatric symptoms as described below and was transferred to our ward after another five days.

On admission to our ward, he had depressive symptoms such as depressed mood, diminished pleasure, decrease in appetite, insomnia, loss of energy, feelings of worthlessness and guilt, suicidal ideation, and depersonalization. He insisted “Write my death certificate, since I am already dead”, “I have no soul or body”, “I feel palpitations, but my heart is gone”, and “I have difficulty in breathing, but I have no lungs”. He also denied the existence of brain, stomach, intestines and bladder. But, he had no other delusions or hallucinations. We decide to increase the dose of quetiapine, which had been started the previous January, from 300 mg/day to 450 mg/day, in light of its effectiveness for depressive symptoms in
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Discussion

It is notable that the present case on one hand complained of palpitations and respiratory distress, and on the other hand denied the existence of heart and lungs, from which these symptoms originate. To our knowledge, there has been no previous report on the concurrence of physical symptom(s) of organ(s) and denial of that organ(s). As quoted by Debruyne et al.\(^\text{1}\), in the late 19th century Seglas cited the depersonalization phenomenon as an essential step in the development of Cotard’s syndrome. More recently, Wright et al.\(^\text{3}\) suggested that an important factor in the evolution of Cotard’s delusion is the delusional interpretation of feelings of depersonalization and derealization. In a previous report, we also stressed the importance of depersonalization and its interpretation in a depressive state in the development of delusion of negation\(^\text{4}\). Furthermore, McKay and Cipolotti\(^\text{5}\) suggested an association of Cotard’s delusion with an internalizing attributional style. The present case had both depersonalization and severe depressive symptoms, and his premorbid personality did not contradict the internalizing attributional style. The combination of these predisposing factors might lead to delusional denial of heart and lungs despite physical symptoms arising from these organs. Also, dysfunction of the temporal-parietal-occipital junction may be involved, since the association between depersonalization and this brain region has been reported\(^\text{6}\).

Disclosure of interests

All authors declare that they have no conflicts of interest.

References