Letter to the Editor

Capgras' Syndrome in an Elderly Patient With Dementia

To the Editor: Capgras' syndrome is an eponym named after the French psychiatrist Joseph Capgras, who first described the disorder in 1923 in a French woman complaining of seeing doubles or imposters of her husband.¹ It is a disorder in which a person holds a delusion that a close relative like a spouse or parent, a friend, or even an object has been replaced by an identical looking imposter or replica.² The disorder is classified as a delusional misidentification syndrome that involves persistent alterations in entities of personal significance.³ These alterations are classified in the DSM-IV and ICD-10 under unspecified persistent delusional disorders.⁴ There is a prevalence of 0.12% in the general population, and the disorder is seen more frequently in women, blacks, and schizophrenics.⁵ Capgras' syndrome has a high (15%) incidence in patients diagnosed with schizophrenia⁵ and has an incidence between 2% and 30% in those with Alzheimer's disease.^{6,7} It can present in acute, transient, or chronic form. Described here is a case report of Capgras' syndrome in an elderly patient with dementia.

Case report. Mr A, an 80-year-old white man, was brought to the hospital with the complaint of increasing confusion. His confusion had started 1 month ago when he woke up after a nap and walked up to his wife and asked, "Who are you?" He asked their children why this woman made him dinner. This delusion, consistent with Capgras' syndrome, fluctuated on and off for the next month. Mr A also had visual hallucinations of seeing his wife in the house when she was in fact in a different room or in the same room but at a different spot. This symptom was consistent with doppelganger hallucinations. While in the hospital, Mr A had visual hallucinations of helicopters and thought he had a conversation with a man who did not exist. At one point, he became aggressive and tried to strangle a nurse. Mr A had no previous psychiatric history. His past neurologic history was a traumatic brain injury at age 13 years when he was hit in the head with an ax. His score on the Montreal Cognitive Assessment was 19/30.

An electroencephalogram was nonsignificant. Urine analysis, chest x-ray, and vitamin B_{12} , folic acid, and thyroid-stimulating hormone levels were all within normal limits. *Treponema palladium* antibody, antiperoxidase antibody, and paraneoplastic antibodies were negative. A lumbar puncture was negative for fungal, viral, and bacterial infection but did show elevated protein levels. Computed tomography scan of the head showed chronic small vessel ischemic changes and moderate parenchymal loss but no acute changes. The neurology consultant diagnosed Mr A with unspecified dementia.

Mr A was started on quetiapine 12.5 mg twice a day in the hospital and showed improvement in his psychotic symptoms within the next few days. He was discharged home on quetiapine 12.5 mg twice per day and 25 mg at night.

Capgras' syndrome presents at younger ages in conditions other than neurodegenerative diseases (52 vs 72 years), which include schizophrenia, major depressive disorder with psychosis, paranoid schizophrenia, schizoaffective disorder, and cerebrovascular disease.⁸ Evidence shows that Capgras' syndrome is also associated with traumatic brain injuries, cerebrovascular accidents, multiple sclerosis, dementia including Alzheimer's disease, and Lewy body dementia.⁸ Diagnostic workup usually includes electroencephalogram findings, head computed tomography, magnetic resonance imaging, and neuropsychological testing.⁹

Treatment has ranged from typical antipsychotics and atypical antipsychotics to even antidepressants. In the past, pimozide was used successfully.^{10,11} But, more recently, atypical antipsychotics such as quetiapine have been prescribed to decrease Capgras' delusions.¹² Two case reports showed positive response to mirtazapine.^{13,14} Prognosis relates to the etiology of the cause. If the cause is treatable, such as an infection or a depressive episode, the prognosis is more favorable.¹⁵ Patients with schizophrenia have a poorer prognosis.¹⁵ In patients with dementia, such as Mr A, the prognosis is less understood. Medications can alleviate the symptoms, but relapses may occur with the progression of the neurodegeneration.

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