

Review Article

Dermatological non disease

Smitha Prabhu, C. Balachandran, Sunaina Hameed, Raghavendra Rao, H. Sripathi

Department of Skin & STD, Kasturba Medical College, Manipal, Karnataka India.

Abstract Dermatological non disease, popularly known as body dysmorphic disorder is encountered among 9-15% of patients visiting a dermatology clinic. It results in significant emotional distress and can be associated with other psychiatric disorders. Unfortunately the diagnosis is often missed. Patients insist on undergoing cosmetological procedures but are invariably dissatisfied with the results. This leads to litigations and even physical assaults, hence it is worthwhile for all dermatologists to be well aware of this entity.

Key words

Dermatological nondisease.

Introduction

Body dysmorphic disorder (BDD) was originally described by Morscelli in 1886 as a “preoccupation with an imagined or slight defect in appearance”.¹ It is classified as a somatoform disorder in the Diagnostic and Statistical Manual of Mental Disorders, fourth Edition (2000), which has defined three diagnostic criteria for BDD.²

1. A preoccupation with an imagined defect in appearance. If a slight physical anomaly is present, the person’s concern is markedly excessive.
2. The preoccupation causes clinically significant distress or impairment in social, occupational and other important areas of functioning.
3. The preoccupation is not better accounted for by another mental

disorder (i.e. dissatisfaction with overall body shape and size, as in anorexia nervosa)

Dermatologists have often described these patients as being “rich in symptoms but poor in signs”, hence the term dermatological non-disease. Various synonyms exist for this intriguing disorder, the notable ones being: body dysmorphic disorder, dysmorphophobia (older terminology), dermatological hypochondriasis, delusion of dysmorphosis, beauty hypochondriasis and Hasslichkeitskummerer (‘one who is worried about being ugly’).^{1,2,3,4} The symptoms begin in adolescence or early adulthood and average duration of illness was 16years in a series.⁵

Those parts of the body that are important in body image are often the focus of preoccupation, especially nose and face (46%), the skin (36%), scalp and hair (35%), eyes (14%), teeth (12%), genitalia (8%) i.e. scrotodynia or vulvodynia, and the mouth (orodynia or glossodynia).⁶ Preoccupation regarding genitals, height, excessive body hair and muscles are seen primarily in man,

Address for correspondence

Dr. Smitha Prabhu,
Dept. of Skin & STD,
Kasturba Medical College, Manipal, Karnataka
India
Email: drsmithaprabhu@yahoo.com

whereas those regarding breasts and legs are more seen in women.⁷ The patient adopts obsessive ritualistic behavior and may spend at least 1 hour or up to 8 hours repeatedly checking their imperfections on reflective surfaces. They tend to avoid directly looking into a mirror as it compounds their distress. This 'ritualistic' behaviour includes repeated combing, picking or applying make-up.

The preoccupations are obsessive and difficult to control and are described as 'tormenting' or 'devastating'. Patients tend to cover their 'flaws' either with their hair or a hat or excessive use of make-up.³ This tendency can even induce self-mutilating behaviour. The facial complaints may include excessive redness, flushing, dilated veins, facial hair, greasiness, large pores, acne, scarring and concerns about the shape of nose and teeth. Scalp complaints include burning scalp and hair loss. These patients suffer from low self-esteem and may not reveal their concerns unless asked about it. There are dominant feelings of shame, guilt and hopelessness; hence they even conceal their concerns from their physicians, though they have obsessive thoughts about undergoing dermatological or surgical procedures that will hopefully alter their appearance to their requirements. Eventually their worries become a handicap and they become isolated and home-bound as they refuse to face the world. BDD patients are solitary individuals and many are either unmarried or divorced.

Prevalence [3,5,7,8]

It is assumed to be present in up to 1-2% of

the general population, though the term 'slight defect in' is very subjective and often confusing. It is distributed equally in both gender, usual age of onset is adolescence and has a chronic course, with a mean duration of 16 years. It is thought to be more among successful second generation Asian/African American females.

The incidence has been estimated at around 8 to 16% in people visiting dermatology clinics and in 7 to 15% of those undergoing plastic surgery procedures, especially in 'poly surgery addicts'.⁶ However patients in this setting have more severe features of BDD.

Etiology and pathophysiology

Based upon their insight, these patients have been arbitrarily divided into 2 subsets: delusional and non-delusional types, i.e., a form of monosymptomatic hypochondriacal psychosis with loss of insight and those who have overvalued ideas about their appearance, but insight is maintained.³ It is being tentatively suggested that the delusional component of BDD may be mediated by an endogenous dysfunction in the limbic area due to overactivity and also due to neurochemical imbalance involving serotonin.⁷ Deckersbach *et al.* in a 2000 study have found that patients with BDD have impaired verbal and non verbal memory encoding strategies; implying lesions of the frontostriatal connections. This abnormality is also seen in patients with obsessive compulsive disorder, and both conditions respond best to selective serotonin reuptake inhibitors (SSRIs) in high dose.

Relationship of BDD to other psychiatric disorders [1,3,5,6, 9-12]

The most common psychiatric association described is depression, others less commonly described being obsessive compulsive disorder, social phobias, borderline personality disorders, schizophrenia and dementia. Phillips et al are of the opinion that body dysmorphic disorders may be included in the spectrum of obsessive compulsive disorders. Bipolar disorder is more frequent in men, whereas bulimia, generalized anxiety and panic disorder is more seen with women.

While BDD is classified as a somatoform disorder, its delusional variant is considered a type of delusional disorder of somatic type and is classified as a psychotic disorder. Many authors are of the opinion that BDD is an obsessive-compulsive spectrum disorder as there are apparent similarities in symptoms, comorbidity, family history and treatment.

Other manifestations of dermatological non-diseases¹⁰:

I. Bigorexia (Muscle dysmorphia)

It is seen almost exclusively in men and patients are obsessed about being small or inadequately muscular. In reality, many of these men are unusually muscular and large. Common features include obsessive weight-training, painstaking attention to diet and dietary supplements and potentially dangerous and illegal abuse of anabolic steroids.¹³

II. Vulvodynia

It is defined as 'chronic genital pain, burning sensation and irritation in the absence of obvious physical signs. It is seen only in the adult female and there may be history of depression and sexual dysfunction. Sub-types of vulvodynia include cyclical vulvovaginitis with symptom free intervals, which may vary with menstrual cycles and may be related with coitus; and vulvar vestibulitis syndrome with introital dyspareunia and tenderness with characteristic ever-present focal erythema. Pudental neuralgia is manifested as unprovoked burning pain radiation from vulva to perineum, groin and thighs, which is associated with a deep aching component or a deep itching sensation. There is characteristic 'burning sensation on movement of pubic hair' and post coital dyspareunia. Dys-aesthetic or essential vulvodynia is a non specific burning which has a neurological basis and is usually seen in older females.¹⁴

III. Scrotodynia and penilodynia

These are manifestations of psychosexual dysfunction where there is burning pain with minimal inflammation over glans and scrotum; may be associated with sweating or may be precipitated by a full rectum in a stressed out person.

IV. Proctalgia fugax

It is a chronic perianal pain occurring in young adult males. It is similar to the pain of chronic prostatitis. Similar pain in women is referred to as coccygodynia. Treatment is disappointing.

V. Familial BDD

Occasionally delusional type of BDD gives rise to familial BDD where the parent imposes a delusional idea upon the child, who develops BDD.¹⁵ BDD is said to be four

times higher among first degree relatives of patients with BDD.

VI. BDD by proxy

Here a patient believes that their child has a body defect.

VII. Folie a deux

Both partners suffer from feelings of bodily imperfections.

VIII. Koro

A unique disorder seen in a Chinese community, characterized by a delusional belief that the genitals are shrinking and will eventually disappear into the abdominal cavity, which will result in death. It can occur as an endemic.

Complications

Major depressive disorder is seen among 59% of patients with BDD and other complications include social phobias, anxiety, obsessive compulsive disorder (12%) and suicidal tendencies (24%).¹⁶ Repeated damaging surgical procedures, if undertaken, may lead to financial drain, loss of occupation and family problems including marital conflict.

Diagnosis

This is essentially clinical, and easy to make once suspicion arises. There are various questionnaires which help in clinical diagnosis of BDD.^{4,17}

Differential diagnoses

The differential includes other psychiatric conditions which manifest as low self-

esteem and depression, i.e. obsessive compulsive disorders, delusional disorders, schizophrenia, conversion disorder, social phobia and avoidant personality and narcissistic personality disorders. Sometimes BDD coexists with other psychiatric disorders.

Treatment [1,2,3,8,16,17,18]

Management is difficult and challenging as these patients are often very angry and dissatisfied and are not willing to accept the diagnosis. Suicide attempts and even violence and murder attempts against the attending physician have been documented.

Pharmacotherapy is the mainstay of treatment, in delusional as well as non-delusional subtypes. High dose SSRIs like fluoxetine 50 mg/day or fluoxetine 50 mg tid or qid are the preferred drugs. Pimozide may improve insight in the delusional group. Patients with somatic pain may benefit from tricyclic antidepressants like clomipramine 25mg at night, amitriptyline 50-150 mg /day or gabapentin 900-1500 mg/day. Discontinuation usually precipitates relapse in 80%.

Cognitive behavioral therapy is an adjuvant which includes encouraging patients to avoid ritualistic behaviour, gradually exposing them to feared social situations, self esteem building, modification of distorted thinking and teaching coping strategies; these include exposure therapy, audio visual self-confrontation and systematic desensitization. Group therapy and supportive and psychoanalytic therapy are helpful in mild non-delusional cases. The main drawback of treatment is that dysmorphic patients

are poor attenders at clinics, be it dermatological or psychiatric.

Medicolegal concerns

These patients often approach dermatosurgeons and plastic surgeons for cosmetological procedures, especially rhinoplasty. A majority of these patients (up to 80%) are dissatisfied with their consultations and results of surgery. These are the ones who go for litigation easily. Ideally a dermatosurgeon should take up these patients for procedures only after a detailed psychiatric evaluation. Occasionally, surgery may help in carefully selected cases, but then chances of litigation and the preoccupation to move to any other body part, are high.¹

References

1. Veale D, Boocock A, Gournay K *et al.* Body dysmorphic disorder. A survey of fifty cases. *J Psychiatr* 1996; **169**: 196-201.
2. APA. Diagnostic and Statistical Manual of Mental Disorders, 4th ed., text revision. Washington (DC): APA Press, 2000.
3. Cotterill JA. Body dysmorphic disorder. *Dermatol Clin* 1996; **14**: 457-63.
4. Phillips KA, Dufresne Jr RG, Wilkel CS, Vittorio CC. Rate of body dysmorphic disorder in dermatology patients. *J Am Acad Dermatol* 2000; **42**: 436-41.
5. Phillips KA, McElroy SL, Hudson JI Pope Jr HG. Body Dysmorphic disorder: an obsessive-compulsive spectrum disorder, a form of affective spectrum disorder, or both? *J Clin Psychiatry* 1995; **56** (Suppl 4): 41-51.
6. Perugi G, Akiskal HS, Giannotti D *et al.* Gender-related differences in body dysmorphic disorder. *J Nerv Ment Dis* 1997; **185**: 578-82.
7. Glaser DA, Kaminer MS. Body dysmorphic disorder and the liposuction patient. *Dermatol Surg* 2005; **31**: 559-61.
8. Wilson JB, Arpey CJ. Body dysmorphic disorder: suggestion for detection and treatment in a surgical dermatology practice. *Dermatol Surg* 2004; **30**: 1391-9.
9. Hardy GG, Cotterill JA. A study of depression and obsessiveness in dysmorphic and psoriatic patients. *Br J Psychiatry* 1982; **140**: 19-20.
10. Cotterill JA. Dermatological non-disease: a common and potentially fatal disturbance of cutaneous body image. *Br J Dermatol* 1981; **104**: 611-9.
11. Phillips KA, McElroy SL, Hudson JI *et al.* Body dysmorphic disorder: An obsessive-compulsive spectrum disorder, a form of affective spectrum disorder, or both? *J Clin Psychiatry* 1995; **56**(Suppl 4): 41-51.
12. Brawman-Mintzer O, Lydiard RB, Phillips KA *et al.* Body dysmorphic disorder in patients with anxiety disorders and major depression: a comorbidity study. *Am J Psychiatry* 1995; **152**: 1665-7.
13. Castle DJ. Body dysmorphic disorder in men. *Br Med J* 2001; **323**: 1015-16.
14. Siddappa K. Cutaneous and mucosal pain syndromes. *Ind J Dermatol Venereol Leprol* 2002; **68**: 123-30.
15. Seaton ED, Baxter KF, Cunliffe WJ. Familial dysmorphicphobia. *Br J Dermatol* 2001; **144**: 439-40.
16. Cotterill JA, Cunliffe WJ. Suicide in dermatological patients. *Br J Dermatol* 1997; **137**: 246-50.
17. Christine LM. Body dysmorphic disorder. *Dermatol Surg* 2005; **31**: 553-8.
18. Hollander E, Liebowitz MR, Winchel R *et al.* Treatment of

body-dysmorphic disorder with
serotonin reuptake blockers. *Am*
J Psychiatry 1989; **146**: 768-70.