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BODY DYSMORPHIC DISORDER - A CASE REPORT

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ABSTRACT

This article presents a case study of a patient with body dysmorphic disorder (BDD). BDD is an increasingly recognized somatoform disorder that is clinically distinct from obsessive-compulsive disorder, eating disorders, and depression. Patients with body dysmorphic disorder are preoccupied with imaginary defects in the appearance of one or more body parts, causing clinically significant stress, disability. These patients have a poor quality of life, are socially isolated, depressed, and at high risk of suicide. Here it is defined as preoccupation with imaginary or superficial minor imperfections. "pimples" on face or "big" nose. If there is a slight physical anomaly, the concern is clearly overdone. Primary occupation must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. Supportive care, mental education, role-plays, reminders, pre-discharge counseling, discharge counseling, and social group work were performed. At the end of treatment, the patient knowledge of and coping with the disease has improved.

KEYWORDS: Body dysmorphic disorder, Mental illness, FAMILY.

INTRODUCTION

Body dysmorphic disorder is defined as being obsessed with "imaginary" defects in one's appearance. Alternatively, if there is a slight physical abnormality, the person's concerns are way too far. This occupation is associated with many time-consuming rituals, such as looking in the mirror and constant comparisons. These patients have a poor quality of life, are socially

isolated, depressed, and at high risk of suicide.[1] Here it is defined as preoccupation with imaginary or superficial minor imperfections. "pimples" on face or "big" nose. If there is a slight physical anomaly, the concern is clearly overdone. Primary occupation must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. Furthermore, symptoms may not be well explained by another psychiatric disorder (e.g. dissatisfaction with body shape and size in anorexia nervosa.[2] Patients with BDD are preoccupied with perceptions of their physical imperfections, causing significant social distress and occupational impairment, and disrupting their lives.[3]

CASE REPORT

A 50-year-old male patient presented with complaints of Excessive thoughts regarding his nose(worries that it is geffing bigger in size), not linking his face and nose, repeatedly looking his face in mirror, suicidal ideations, sadness of mood, crying spells and reduced intreast in talking to people since 20 year.

PAST HISTORY

Patient was admitted in the hospital 4 times for similar complains.

History of RTA in the last 2 year in toxicated state.

MEDICATION HISTORY

In 2018 patient was advised with

- Cap. Fluoxetine 20 mg BD,
- Tab. Risperidone 2mg BD,
- Tab Clonazepam 0.5mg TDS,
- Tab. Quetiapine 100 mg HS

In 2020 patient was advised with

- Cap. Fluoxetine 20 mg BD,
- Tab. Risperidone 2mg BD,
- Tab. Imipramine 20mg TDS,
- Tab. Benzhexol 2mg BD,
- Tab. Clonazepam 0.5mg BD,
- Tab. Trifluoperazine 5mg BD,
- Tab. Quetiapine 100 mg HS

In 2021 patient was advised with

- Cap. Fluoxetine 20 mg BD,
- Tab. Risperidone 2mg BD,
- Tab. Benzhexol 2mg BD,
- Tab. Clonazepam 0.5mg BD,
- Tab. Trifluoperazine 5mg BD
- Tab. Quetiapine 200 mg HS

In 2022 patient was advised with

- Cap. Fluoxetine 20 mg BD,
- Tab. Clonazepam 0.5mg BD,
- Tab. Trifluoperazine 5mg TDS,
- Tab. Quetiapine 200 mg HS

Patient advised with following Medications

- Cap. Fluoxetine 20 mg BD,
- Tab. Clomipramine 50mg HS,
- Tab. Benzhexol 2mg BD,
- Tab. Clonazepam 0.5mg BD,
- Tab. Trifluoperazine 5mg BD,
- TAB. Sildenafil 50 mg SOS 1 tab,
- Tab. Quetiapine 200 mg HS,

1.1 PHYSICAL EXAMINATION

General examination the patient was fair, cooperative and coherent, Head, Eyes, Ears, Nose, Throat, Mouth, Neck (HEENTMN) were found Normal, CNS: Conscious and oriented, no neurological deficits, CVS: S1, S2 (positive), EF 60%, no murmurs noted, RS: BLAE (+). No signs of wheezing or crackles, GIT: soft, non-distended.

1.2 MENTAL STATE EXAMINATION

Patient is conscious, oriented to time place and person. Patient is sitting on lot, wearing gray tshirt and black pant. Patient is fairly built and nourished properly groomed, maintains hygine by himself. Eye to Eye contact- Initaited and Mainained. SPEECH- Low tone low volume increased reaction time. Patient report his mood as sad. Perception- Denies disturbance. Attentation and Concentraion- On asking these word to repeat immediately ‘SIKKO, TOPI DARIYO’ patient repeated same words. On asking to repeat after 3 minutes not able to do Recall.

1.3 HAMILTON DEPRESSION RATING SCALE (HAM-D)

1. DEPRESSED MOOD: (sadness, hopeless, helpless, worthless)- Frequent weeping.
2. FEELINGS OF GUILT- Self-reproach, feels he/she has let people down.
3. SUICIDE- Ideas or gestures of suicide.
4. INSOMIA :INITIAL (Diffculty in falling asleep)- Absent.
5. INSOMIA: MIDDLE- Absent.
6. INSOMNIA: (EARLY HOURS OF THE MORNING)-Absent
7. WORK AND INTEREAST:- Unable to work stop working because of present illnesss only.
8. RETARDATION: (slowness of thought and speech, impaired ability to concentrate, decreased motor activity)- Slight retardation during the interview.
9. AGITATION- Occasional.
10. ANXIETY PSYCHIC- Worrying about minor matters.
11. ANXIETY SOMATIC- Moderate.
12. SOMATIC SYMPTOMS GASTRO-INTESTINAL- Mild.
13. GENERAL SOMATIC SYMPTOMS- Mild.
14. GENITAL SYMPTOM- Absent.
15. HYPOCHONDRIASIS- Absent.
16. DIURNAL VARIATION- Absent.
17. Observational Symptoms- Severe.

PATIENT DEMOGRAPHICS

Allergies: No allergies were noted. Medical history: Diagnosed with Body Dysmorphic Disorder 10 year ago. Patient was admitted in SSG Hospital 4 times for similar c omplains Patient was on Rx. And Ptient has History of RTA in 2018 in toxicated state. 3 times ECTs given on 24/11/2020,2711/2020 and 01/12/2020. Medication history: Cap.Fluoxetine 20mg TDS, Tab.Risaperiodone 2mg BD, Tab. Quetiapine 100mg OD, Tab. Clonazepam 0.5mg TDS Patient was not taking any medications.

FAMILY HISTORY

Father: Patient father is 60 years old, illiterate, he is doing auto driver. He is Supportive in nature.

Mother: Patient Mother is 55 years old, illiterate, she is a house wife. She also loving and supportive in nature, caring children.

Patient Sister: Patient's Sister is 12th pass, house wife. K/C/O Psychiatric illness on Rx. 6 years.

Patient wife: Patient wife is 46 years old, illiterate, she is a house wife. She is emotionally attached with patient.

1st Sibling: is a patient elder daughter, 16 years old and now studying in 12th standard. She is take care of the patient.

2nd Sibling: is a middle younger son ,15 years old and now studying in 9th standard. No interpersonal conflict.

3rd Sibling: is a younger son, 12 years old and now studying in 6th standard. No interpersonal conflict.

SOCIAL HISTORY

Patient was chronic Alcoholic consumption since 17 years IIML 1-2 glass 2 times.

OPERATING DEPARTMENT PRATITIONERS

On origin duration and progress patient was relatively asymptomatic before 20 years. Patient report that 20 years back he used to have a very handsome face beautiful nose, and since then his nose has become ugly. Patient started developing thoughts that his nose is not straight, tilted to one side and because of his nose patient face look ugly. Thought were insidious is onset, gradually progressive patient report that initially he used to think about his nose during some part of the day 4-5 times a day. But since past few days he is having thoughts throughout the day patient reports that he sees in mirror 15-20 times a day, when he sees he face in mirror he becomes sad he starts getting worried about his nose he does not like his face. Some times after looking his face into the mirror he develops palpitations, tremor in whole body. Patient reports that such an episode to avoid thoughts, he lies down on bed it's give him some relief but does not stop the thoughts, completely patient is also reports that he might rather die than living often such an ugly face. Patient report that he has low mood all thought the day he continues touches his nose 40-50 times per day. On the asking the reason he reports that he tries to make his nose straight and also constantly pinch it so that is does not get any bigger in size. Patient reports complaint of reduced interest in talking to people. Patient reports that earlier he used to attend all the social functions he used to attend all the social functions and he was singer and dancer but since past few years he avoiding social functions and meeting people and also stopped working. On the asking reason for the same patient said am afraid that if he goes out people will make fun of his nose and would laugh of

him. He feels very ashamed due to his face. On the asking the reason why he not working patient reports that 2 months back he tried to sell fruits, but he was having excessive thoughts regarding his nose, his illness so he could not continue it. Patient reports multiples times that he wants to do surgery of his nose to make it straight even if there is risk in surgery patient said am ready to take all the responsibilities. He also asks for medications that can straight his nose during the interview. Patient also has ideas of suicidal patient thinks that there is no point in living now and it would be better if he dies, patient reports that he has thoughts like this since past 15-20 days he thinks that he would die by having or drowning in water tank. On the asking the reason he reports that he cannot do anything in life with such face and nose so it's better for him to die. Patient report that he also attempted to shoot himself with the gun due to these thoughts about 18 years back.

FINAL DIAGNOSIS: Body dysmorphic disorder.

DISCUSSION

Body dysmorphic disorder (BDD) is characterized by an obsession with imaginary or insignificant physical abnormalities. This is perceived as a serious blemish that requires extreme measures to cover up or fix. Thoughts are pervasive and intrusive and can lead to stress, shame and social isolation.[4] This condition was first described by Enrico Morselli in 1886. We use the term "dysmorphia" to refer to normal-looking individuals who believe they have an ugly physical defect that is noticed by others. The disorder was renamed Body Dysmorphic Disorder in 1987. and was not officially classified as a psychiatric disorder until reclassified as a somatoform disorder in the 3rd revision of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM-III-R).[5]

CONCLUSION

Patients gained insight into their illness. Families have a better understanding of the patient's illness. Thus, psychosocial interventions play an important role in determining treatment outcomes. It has been shown to improve patient compliance and patient retention on treatment. Psychosocial interventions can improve efficacy of pharmacological treatments by enhancing medication compliance, treatment maintenance, and skill acquisition. And it can be considered as a viable alternative to other techniques in management of uncomplicated crown fractures.

CONFLICT OF INTEREST STATEMENT

The author declares no conflict of interest.

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