DYSMORPHOPHOBIA WITH BIPOLAR AFFECTIVE DISORDER: A CASE REPORT

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This case report describes the progression of dysmorphophobic symptoms in the dimension of intensity from a normal age related concern, to primary dysmorphophobia, to a somatic delusion during depressive and manic phases of a bipolar affective disorder. The depressive episodes were resistant to drug treatment but responded to ECTs.

Dysmorphophobia was originally defined as "a subjective feeling of ugliness or physical defect which the patient feels noticeable to others although his appearance is within normal limits" (Morselli, 1986). As a symptom the feeling may be expressed as a preoccupation with appearance, an obsession, an overvalued idea or frank delusion (Birtchnell, 1988). Thus with the same content the symptom may appear in different forms. DSM-III-R recognised 'body dysmorphic disorder' as a new diagnosis under the category of somatoform disorder and defined it as preoccupation with some imagined defect in appearance in normal appearing person or an excessive concern about slight physical anomaly (APA, 1987). However, when the belief reaches delusional certainty with loss of insight, the diagnosis is delusional disorder, somatic subtype (APA, 1987). Phenomenologically, there may be a spectrum along the continuum of certainty of the belief and the presence of insight. Difficulty may arise in judging the intensity of the belief in clinical setting (Braddock, 1982) and hence, in assigning the diagnosis.

The following report shows progression of dysmorphophobic preoccupation into a delusion during the depressive and manic episodes of a bipolar disorder. Comments are also made on the treatment of such a case.

CASE

Ms. N, a single professional woman of average build and body weight felt since adolescence that her breasts were larger than average. She thought that this prevented her from being confident and smart. At the age of 23 years she was prescribed medroxyprogesterone for three months for menstrual disturbance. She developed facial hair growth and breast enlargement which were mild and not readily discernible to others. She began to have preoccupation with her appearance and thought that she looked ugly because of facial hair and enlarged breasts. Her concern about these slight physical changes was clearly excessive and caused personal distress but it had no significant effect on her functioning at work or at home.

After about four months she began feeling unhappy and hopeless. She developed lack of confidence, apprehension in meeting people and generalised disinterest in all activities. She had crying spells, frequent suicidal idea and once made an abortive attempt by trying to ingest mercury. Her sleep was disturbed throughout the night and appetite was poor. The patient attributed the symptoms to the changes in her appearance and requested for surgery to reduce breast size. Her belief in these physical defects and the effect of these on her appearance had now become delusional in intensity. She was treated with imipramine 75-200 mg/day for three months without significant improvement. At that time, she switched into a phase of euphoria, authoritativeness and spontaneous excessive speech lasting for two weeks. However, her belief about the physical defects remained unaltered. On haloperidol 15 mg/day she went back to the previous phase of depression. After further unsuccessful treatment with amitryptiline 175 mg/day and amitryptiline with lithium augmentation (lithium 900 mg/day), she was given nine modified electroconvulsive therapies, to which she responded, albeit slowly. The entire episode lasted eight months. While being euthymic she continued to have the preoccupation with enlarged breasts although it was no longer delusional and did not affect her functioning any more. She remained in this state for three years and was not on any drugs.

Following her engagement the concern about her breast size again become more intense. She started going to the bathroom repeatedly to check herself in the mirror, trying out brassieres and complaining that none actually fitted her well. Her interaction with people diminished. She stopped going to work within two weeks. She felt sad, often broke into tears and lost interest in most routine activities. Her sleep and appetite were also poor. She desired surgery to alter the breast size and said that it was not worth living otherwise. She was initially put on prothiaden 150 mg/day without any improvement. It was then changed to fluoxetine 20 mg/day, increased to 40 mg after three days and to 60 mg after seven days. After 12 days of fluoxetine therapy she rapidly worsened in her depressive state. She became extremely agitated pacing up...
and down the corridors of the ward and crying incessantly for help. She said there was hardly any remedy for her bodily defect. She repeatedly asked for poison expressing intense suicidal ideas. ECT was started at that time, fluoxetine was however, continued. She showed significant improvement after four ECTs and the depression disappeared completely after six ECTs. Within a week of the last ECT she could join her work.

Being maintained on fluoxetine 40 mg/day she has remained euthymic during a follow up of two months and has been functioning normally. However, the dysmorphophobic preoccupation with the breast size is continuing and causes some distress but no significant disability to her.

DISCUSSION

This patient illustrates the dysmorphophobic symptom in the dimension of varying intensity at different periods. She developed concern with her breast size during mid adolescence, which was perhaps a normal, age appropriate phenomenon. After having taken medroxyprogesterone which can induce breast enlargement (Jeffcoate, 1975) she developed dysmorphophobia as a syndrome characterized by excessive concern towards her breast size, causing significant distress. The same symptom further developed into a clear delusion during episodes of depression and mania. This observation is compatible with earlier reports by Bradock (1982), Birtchnell (1988) and Hollander et al. (1989). Dysmorphophobia as a symptom in other psychiatric syndromes including depression is well known (Barsky, 1989), although earlier it was thought to be uncommon (Hay, 1970). If present, it is usually delusional (Mckenna, 1984) as this case also shows.

Treatment of dysmorphophobia remains difficult (Birtchnell, 1988) and a good response to drugs is rare (Kellner, 1989). There is hardly any literature on the treatment of depression, when associated with dysmorphophobia. A recent report (Hollander et al., 1989) has suggested that these patients respond well to specific serotonin reuptake blockers like fluoxetine. However, this case was resistant to numerous antidepressant drugs including fluoxetine. Her depressive symptoms actually worsened and suicidal ideation increased on fluoxetine. Such paradoxical effect of fluoxetine has been reported recently by Teicher et al. (1990). This case showed satisfactory response to ECTs in both the depressive episodes, the recovery being particularly dramatic in the later episode. Along with depression, the delusion also disappeared, leaving a dysmorphophobic preoccupation of the same character and intensity as had existed earlier. This has not responded to continued treatment with fluoxetine.

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