

A Rare Case of Olfactory Reference Syndrome

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Abstract: Olfactory reference syndrome is a rare condition often missed as the patient presents to general physicians and get into a cycle of medical treatment and doctor shopping with unsatisfactory results. Often confused with hypochondriasis or delusional disorder, they invariably end with secondary depression with high suicide risk. The management is difficult with no proven single drug of choice and non cooperation from patients for a psychiatric assessment and management. This case report is interesting and unique with diagnostic dilemma and management difficulties.

Keywords: ORS, delusion, monosymptomatic hypochondriasis, depression.

INTRODUCTION

Olfactory reference syndrome is a condition in which the person believes that his or her body emits foul smell and feels that others have a negative opinion about him[1]. The patient feels embarrassed and may develop secondary depressive symptoms. The main difficulty in clinical evaluation of ORS is distinguishing it from delusional disorder, mono-symptomatic hypochondriasis and olfactory hallucination[2]. ORS often starts in early age, commonly in males[1]. ORS was first described by pryse-philips.

In literatures ORS has been discussed under various terminologies like- ORS bromhidrosisphobia, mono-symptomatic hypochondriasis, chronic olfactory paranoid syndrome[3] and mono symptomatic hypochondriac psychosis (MHP)[4]. In Japan the same condition is called Taijinkyofusho[5-6]

There is a lot of ambiguity between the diagnosis of ORS and MPH[7]. MPH being characterized by delusions of parasitic infestation or delusion of foul odor emanating from the body[8]. There was no absolute distinction between ORS and MPH[9]. Recently in some literature ORS has been said to be a variant of obsessive compulsive disorder[10]. Some literature say that ORS is a subtype under OCD spectrum[11,12], which includes Bodydysmorphophobia, and Hypochondriasis[13-15]. Due to sharing of common phenomenological and neurobiological properties and adequate response to the SSRI 'S, it has made researchers to club it together[16].

This report is a case of ORS in a middle aged male patient who presented with delusion of emitting

foul odour from his body and subsequently developed depressive symptoms.

CASE REPORT

A 35 year old male from rural area who works as a daily wage labor, presented with complaints of emitting foul smell from his body since 8 years. He described foul smell as that of sewage water and that it was extremely disgusting to him.

At first, he believed that this was perceived only by his family members at home, but he gradually observed that this odour was more intense. He reported that he has observed several people on street and at his work center have felt uncomfortable about the odor from his body. They demonstrated this by shifting their eyes away, touching their nose, clearing their throat or moving away from him. However interestingly no one has told him verbally about the odour directly.

He even believed other people including his family members started commenting about his body smell and they started avoiding him. Because of this he was feeling sad and started avoiding social gathering and later developed ideas of hopelessness and worthlessness and occasionally suicidal wishes.

He however denied hearing of voices and other first rank symptoms of schizophrenia. Mental state examination revealed dysphoric mood, feelings of worthlessness, referential ideas and olfactory hallucination. He has consulted many physicians, ENT specialist and dermatologist but no improvement with their medication and did not feel reassured with normal clinical findings and investigations. The patient always came alone for consultations. Our repeated request to

involve his family members was refused by the patient stating that they would not accompany him to psychiatrist due to his severe body odour. Hence we were unable to get collateral information regarding his illness, extent of his psychopathology and socio occupational personal dysfunction. We could not ensure compliance too.

All the routine investigations like blood, biochemical and thyroid function, VDRL and HIV were normal. No pathology was detected in CT and EEG.

We commenced him on oral T. Olanzapine 10 mg and Oral T. Sertraline 50 mg. At second follow up visit he showed minimal improvement in his depressive symptoms but no improvement in his referential symptoms. Unfortunately the patient did not come for follow up.

DISCUSSION

In our particular case, we felt there was a diagnostic dilemma. The initial differential diagnosis was psychotic depression with nihilistic delusions. However on detailed history he reported the onset of foul odour first with no remedy despite battery of investigation and medical treatment for a long duration. He believed that he had severe foul odor just like that from sewage despite confronting him that the doctors were not having similar perception of smell. He believed that certain behaviors of family and people on the streets made him believe for sure he was emitting foul odor. The patient also reported he could smell foul odour emanating from his body and he bathed couple of times daily and used excessive deodorant. This phenomenon was more suggestive of olfactory hallucination. Subsequently he developed delusions of reference about people avoiding him and commenting upon his foul body odour. He also developed depressive symptoms with death wishes but no active plans to hurt self.

Pryse Phillip accepts that odor symptom in ORS is hallucination but it can be considered as delusion too in certain cases. Delusion may become predominant[1,9]. Our patient believed that he was emitting foul odor and other people were giving a clue by their behavior. Our case too shows the same that his referential ideas were secondary. We also faced significant challenge in establishing rapport with the patient since he was not happy for being referred to a psychiatrist. He believed it was a medical condition.

The diagnostic check list prepared for ORS states that ORS is neither monosymptomatic nor monodelusional, maybe accompanied by hallucinations, delusions with paranoid content[9,17]. The literature shows that these symptoms are secondary rather than primary[18].

Here patients take bath and changes clothes and very often uses more body spray and they try to avoid social gathering or interactions[1]. This may be chronic and may worsen the patient quality of life some may go for suicide attempt[1,19]. Hence the need for emphasis on patients with co morbid depressive symptoms to be evaluated thoroughly for risk of suicide to provide an early and effective treatment. In the present case depression developed secondarily to the delusions.

The proposed treatment option for ORS is ambiguous. Delusional structure of this syndrome commonly accompanied by depression, responds well to pimozide and other antipsychotics[20,21]. While some patients respond only to antidepressants[18], others respond to combination of antidepressants and antipsychotics[8]. Unfortunately our particular patient was lost to follow-up and any kind of improvement or worsening of the patient's condition could not be observed.

CONCLUSION

ORS is under recognized and hence underreported and often confused with other conditions like delusional disorder or depression. Patients with ORS may also develop other psychiatric illness like depression and may need to be followed up for long time. Depression can develop reactively to the delusions. Identifying and treating the depression and suicide promptly are integral part of ORS.

These patients usually end up with dermatologist or physicians who may unintentionally further delay the patient's chances of getting timely psychiatric help by focusing on organic causes rather than psychiatric. This further makes it important to ensure the dermatologist and General physicians are well aware of this differential diagnosis to avoid any unnecessary delay in referring to psychiatrist for further management.

Early identification with Effective and timely intervention should be the main focus in the management of patients with ORS with a goal of improvement in the patient's quality of life.

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