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Is Olfactory Reference Syndrome a Diagnostic Entity Under Obsessive-Compulsive and Related Disorders?: A Case Report

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SUMMARY

Olfactory reference syndrome (ORS) is a rare psychiatric condition involving embarrassment and distress due to persistent mental preoccupation with the idea of emitting body odours foul and offensive enough to disturb others. This disorder is often accompanied by shame, embarrassment, significant distress, avoidance behavior, social phobia and social isolation. The patients may worry that they spread odours originating from their mouth, sweat, genital areas or the gut. This belief may lead the patients to misinterpret the behaviours of others, they may frequently smell themselves, shower and change clothing during the day. There are differences of opinion whether ORS should be considered as a delusional disorder or appear in under the rubric of obsessive-compulsive related disorders. One of the reasons that create this uncertainty is the variation in the response to different treatments. The treatment strategies generally include the use of antipsychotics, the antidepressants, they are preferentially used in combination. In this report we aimed to discuss the case of a 33-year old male patient whose first complaints had been diagnosed 14 years prior, with a diagnosis of OCD with low insight. Shortly after improvement of the OCD symptoms he developed ORS symptoms. We aimed here to discuss the place of ORS in the diagnostic systems with reference to this case.

Keywords: Delusional disorder, obsessive-compulsive disorder, psychotic disorder

INTRODUCTION

Olfactory reference syndrome (ORS) is a rare psychiatric condition involving persistent mental preoccupation with the idea of emitting body odours foul and offensive enough to disturb others that leads to avoidance of social environments and self isolation. Perceived odors expressed in the literature include those originating from the mouth, genitals, anus, underarms, feet, urine, sweat (Pryse-Phillips 1971). The patients may misinterpret the behaviours of others such that they may frequently attempt to smell themselves, shower and change clothing during the day.

In order to differentiate this condition from olfactory symptoms observed in schizophrenia, depression and temporal lobe epilepsy, the term olfactory reference syndrome was recommended by Pryse-Phillips in 1971. ORS was mentioned with different names such as parosmia (Tilley 1895), autodysosmophobia (Bourgeois and Paty 1972), delusions of bromosis, olfactory hallucination (Pryse-Phillips 1971), chronic olfactory paranoid syndrome (Videbech 1966), monosymptomatic hypochondriasis (Bishop 1980), monosymptomatic hypochondriac psychosis (MHP) (Munro 1988), jiko-shu-kyofu (Suzuki et al. 2004).

There is an ongoing debate in the literature as to whether ORS is a separate disorder or the part of another disorder. Whereas ORS was described as "the somatic subtype of delusional disorder" in the DSM-IV (American Psychiatric Association 1994), in the DSM-5 (American Psychiatric Association 2013), it is classified under "other specified obsessive compulsive and related disorders" as "Jikoshu-kyofu" subtype of the "Taijin Kyusho" syndrome. ORS is treated with antipsychotics, antidepressants or combinations of both. The difference in classification and treatment creates a diagnostic dilemma in clinical practice. In this article, we present a case with ORS and discuss the place of ORS in diagnostic systems in reference to the case presented.

CASE

The 33 year old single, unemployed male patient man was admitted to the Outpatient Clinic of the Psychiatry

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Department of Istanbul Faculty of Medicine with complaints of anxiety believing that foul body odour emanated from his mouth, armpits and the anal region preventing him from mixing with people and causing self isolation. He described checking his trousers for remnants of excrement and abstained from using public transport lest he released bad odour. In winter he wore T-shirts avoiding thick clothes for fear of smelling of sweat; and abstained from verbal contact with people in case he had halitosis. His problems had started 7 years previously when bathing and cleaning took much time which recently became overwhelming such that he needed his mother to assist him. Consequently he experienced loss of morale, anhedonia, avolition and spent much of his time alone at home. His thought contents were pervaded with the problem of releasing bad odours which caused loss of concentration. The patient did not perceive the body odour but he was convinced of releasing it.

It was learned that his psychiatric complaints dated back to 2004 when he continually controlled his face in the mirror and picked his eyelashes to prevent being blinded by them. At the time he could not dismiss these intrusive thoughts which continued most of the day accompanied with severe anxiety. These symptoms receded by the start of 2011 when his ORS symptoms presented. The patient expressed that he did not benefit from the different medications he had been put on.

On admission, his physical and neurological examinations did not indicate any pathology. In his psychiatric examination he appeared his age, his self care was good, his speech was intelligible with normal tone and pace. His mood was depressive, affect was restricted. He described anhedonia. His associations were normal and relevant. His thought contents had referential and somatic delusions, depressive themes of hopelessness and worthlessness. Perceptional disorder was not detected; he lacked insight. His scores on the Yale Brown Obsessive-Compulsive Rating Scale (YBOCS) and the Hamilton Depression Rating Scale (HDRS) were 33 and 24, respectively. The doses of the agents included in his treatment at the time of consultation were rearranged as clomipramine (150 mg/day), clonazepam (4 mg/day), escitalopram (20 mg/day), quetiapine (200 mg/day). Pimozide (2 mg/day) was added to treatment. At follow up 5 months later, his score on the YBOCS fell to 22; his avoidance behaviours started to disappear; he could shower alone and use public transport without distress.

DISCUSSION

There are differences of opinion about whether ORS should be investigated as a delusional disorder or within the context of obsessive-compulsive related disorder. In DSM-5, ORS is classified under “other specified obsessive compulsive and related disorders” as the “Jikoshu-kyofu” subtype of the “Taijin Kyusho” syndrome. In the ICD-11 (World Health Organization 2018) it appears as the “olfactory reference syndrome” in the category of obsessive compulsive and related disorders. Hence, it is recognized as a diagnosis by itself in the diagnostic systems. We believe there to be various reasons for its inclusion under the heading of obsessive compulsive and related disorders in the ICD 11.

Characteristics of the case reported here supports this classification and can be used as a basis for the screening of the relationship between this entity and OCRD. The repetitive intrusion of the thoughts about releasing body odours with induction of anxiety resembles the thought contents in OCD. He had also repetitive behaviors. He checked his clothing and he smelled frequently himself. Our patient’s belief about emitting body odor were delusional. Although most ORS patients had delusional thoughts, not all lacked insight In one study (Philips and Menard 2011) it is reported 85% of ORS patients to have delusional thoughts with 15% having weak insight. Furthermore the degree of insight varies in OCD and related disorders. The patients with body dysmorphic disorder have also poor insight.

The first psychiatric complaints of the patient on fearing that his eyelashes could pierce the cornea of his eyes can be evaluated as an obsession; and the continual controls in front of the mirror as compulsive behaviour which the patient explained was done to ensure whether or not this had occurred. The repetitive intrusiveness of the thoughts and the complete belief in the them resulting distress meeet the diagnostic criteria of OCD with lack of insight. OCD symptoms can alter with time (Swedo S et al.1989). Thus after the disappearance of the obsession with his eye lashes, the symptoms of ORS had started. Evaluating the case with this history support the points of view on ORS being related to OCRD. Future research on this subject should help clarify ORS’s place in classification.

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