



## The ethics of the cosmetic consult: Performing procedures on the body dysmorphic patient<sup>☆</sup>

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### Case scenario

Rosie is a 26-year-old woman who comes to Dr. Dee's clinic for evaluation of numerous facial lesions. She appears distressed and anxious, stating that she wants her facial lesions treated and removed for an improved appearance. These lesions "annoy" her, and she feels as though they make her look "ugly." On physical examination, skin-colored papules are noted on her bilateral cheeks, chin, and forehead. In a similar distribution are multiple honey-colored, crusted papules. Dr. Dee explains to the patient that these lesions are consistent with dermal melanocytic nevi (nondangerous growths) and that their treatment entails elective surgical excision. Dr. Dee advises that surgical removal will result in multiple scars on her face. She further explains that the crusted papules are excoriated nevi with impetiginization and encourages Rosie to not manipulate these lesions.

Tearing up with disappointment, Rosie insists that she would like to pay for the surgeries, and she is not worried about the outcome as long as her "flaws" are removed. She further states that if Dr. Dee does not perform the excisions, then she will remove the lesions herself. On further questioning, Rosie admits that she has previously seen multiple other dermatologists and plastic surgeons for the same complaint. In addition, she reveals that these facial lesions impair her daily life. She admits to staring at the mirror for hours trying to remove the "deformities" herself and refuses to go to public places because of the "ugliness" of the facial lesions.

Dr. Dee should:

- Excise all the lesions because that is why the patient made the appointment. She has the means to pay and plans on removing them regardless.
- Send the patient home without excising, stating, "I understand that these lesions bother you but risking their excision with a scar may not look better".
- Treat the impetiginized lesions with antibacterial medication and arrange for follow-up in which she can discuss referral to psychiatry.
- Refer the patient to psychiatry.

### Discussion

The 2017 consumer survey on cosmetic dermatologic procedures by the American Society of Dermatologic Surgery (ASDS) shows that the percentage of consumers considering a cosmetic medical procedure has doubled since 2013 (ASDS, 2017). ASDS members performed over 7 million procedures in 2016. Among these were 1.7 million neuromodulators injections and 1.35 million soft tissue filler procedures (ASDS, 2017). Women make up the overwhelming majority of consumers of these cosmetic procedures. For example, in 2017, 88% of neuromodulators and 91% of consumers of soft-tissue fillers were women (ASDS, 2017).

In addition, millennials are now increasingly asking for cosmetic procedures. Since 2012, the number of patients under age 30 years who seek cosmetic procedures has increased by 50% (ASDS, 2017). The top 3 reasons for cosmetic procedures were to "feel more confident," "look as young as I feel or better for my age," and "feel more attractive." With the continued growth of patients seeking cosmetic procedures, an increasing number of dermatologists and plastic surgeons will encounter patients with body dysmorphic disorder (BDD).

According to the Diagnostic and Statistical Manual of Mental Disorders V classification, BDD is part of the obsessive compulsive and related disorders category (American Psychiatric Association, 2013). Patients with BDD present with an obsession or "preoccupation with one or more perceived defects or flaws in physical appearance that are not observable or appear slight to others" (American Psychiatric Association, 2013). Patients attempt to relieve these preoccupations through repetitive behaviors such as mirror checking, skin picking, and comparing one's appearance to others. The preoccupations can be extremely distressing and debilitating, causing social and occupational impairment (Castle et al., 2004).

The prevalence of BDD in the dermatologic or plastic surgery setting is higher than in the general population and reaches up to 15% (Ribeiro, 2017). Most studies report a higher prevalence of women with BDD, and their areas of concern are often the face, breasts, hips, legs, and body size/weight (Anderson, 2003; Higgins and Wysong, 2018). BDD can affect all age groups and has a mean age of onset of around 12 years with persistence into later years.

Patients with BDD often have other comorbid psychiatric disorders. In a lifetime, a patient with BDD may fulfill the criteria of two or more

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psychiatric disorders with the most common being a mood disorder, bipolar disorder, obsessive compulsive disorder, and/or eating disorder (Phillips et al., 2005). Of note, BDD has one of the highest suicide rates (attempted or completed) compared with other psychiatric illnesses, which makes screening and diagnosis imperative to guide patients to proper care (Vashi, 2015).

Unfortunately, diagnosis for those afflicted with BDD can be quite difficult, and for slight abnormalities, deciding whether the preoccupation is disproportionate or within a normal range of concerns may be difficult. Therefore, many tools and questionnaires have been developed to screen for BDD. The Body Dysmorphic Disorder Questionnaire–Dermatology Version is a validated questionnaire that is quick and easy to administer in-office to determine whether a patient meets the criteria for the disorder (Dufresne et al., 2001). Questions include the following with a yes/no response: “Are you very concerned about the appearance of some parts of your body which you consider especially unattractive? If yes, do these concerns preoccupy you? That is you think about them a lot and they’re hard to stop thinking about?”

This is followed by two questions that rate the severity of the distress and impairment in functioning due to the preoccupation on a scale of 1 to 5 (no distress, mild, moderate, severe, and extreme/disabling interference). The completion of the survey involves another set of yes/no questions: “Has your defect often significantly interfered with your social life?”; “Has your defect often significantly impaired your school work, your job, and your ability to function in your role?”; “Are there things you avoid because of your defect?” (Dufresne et al., 2001).

A positive screen for BDD consists of the presence of preoccupation as well as at least moderate (score of  $\geq 3$ ) distress or impairment in functioning. In addition to using questionnaires as described, clinicians can look for red flags that include doctor shopping and excessive time spent mirror checking or camouflaging. Psychiatric history including medication usage along with inquiry into suicidality is essential to allow for acute intervention if needed.

Insight determination (good/fair, poor, or absent) is part of the diagnostic criteria (Ribeiro, 2017). A poor, absent, or delusional insight poses difficulty for the physician to convince his or her patient that the flaws are minimal and do not necessitate intervention. Surgical or cosmetic intervention in BDD cases is almost never the right decision. The best way to proceed is to empathize with the patient and respond in a nonjudgmental manner. Referral to psychiatry is the best avenue of management, with cognitive behavioral therapy and antidepressants such as serotonin reuptake inhibitors as the mainstays of treatment.

### Analysis of case scenario

Numerous studies have shown that patients with BDD usually have poor psychological outcomes after cosmetic procedures (Option A; Phillips et al., 2001). In a study of 250 adults with BDD, 68.7% of treatments (dermatologic, surgical, dental, and other nonpsychiatric medical treatments) were found to lead to no improvement or worsening in overall BDD severity. Effectively, only 7.3% of all these treatments led to an overall improvement in BDD with less focus on the area of concern (Crerand et al., 2005). In a study of 50 patients with BDD, 81% were dissatisfied or very dissatisfied with their cosmetic intervention (Veale et al., 1996). Plastic surgeons who have operated on patients with BDD reported that patients’ preoccupation with the perceived defect appeared to be greater after the intervention, and only 1% were considered symptom-free after the procedural intervention (Sarwer, 2002).

In those suspected of having BDD, recommendations include avoiding all invasive procedures, especially elective ones. It is important to empathize with the patient and approach the patient in an

objective and nonjudgmental way. Laying out the pros and cons of a procedure for the patient may help with the clinic visit interaction (Option B). Any surgical procedure is accompanied by its risks, including scarring and infections. In a report of 33 cases with surgically excised nevi on the face, six cases had scar hypertrophy (Kumar et al., 2016). Cosmetic treatments should be done with caution in patients with BDD because cases of dissatisfied patients being aggressive toward their provider, whether in the form of assault, lawsuit, or even murder, have been reported (Anderson, 2003; Sweis et al., 2017). In one survey in the United States, 40% of plastic surgeons reported a threat (physical or legal) from dissatisfied patients with BDD (Sarwer, 2002).

Managing the patient as a whole and not just focusing on his or her BDD symptoms is essential. Treatment of secondary findings such as bacterial infections and impetiginization, such as in the case scenario, is important. This patient’s self-inflicted excoriations are not uncommon in BDD and manifest in approximately one-third of patients (Phillips and Taub, 1995). Patients may cause significant secondary lesions, including scarring, bleeding, and infections (O’Sullivan et al., 1999).

Treating the patient’s secondary impetiginization with follow-up is the proper solution (Option C). This approach develops trust with the patient and during a follow-up visit, the patient may be open to psychiatry intervention. The most important aspect of management is psychiatric treatment (Option D) alongside acute medical care if needed. Patients with BDD often present to the dermatologist or plastic surgeon to seek treatment for their defect. However, this type of intervention is seldom effective. In a study of 200 patients, treatment was sought by 71.0% and received by 64.0% of patients, but only 3.6% reported an improvement in their BDD symptoms (Crerand et al., 2005). Proper referral to a psychiatrist who is well-versed in the treatment of BDD with cognitive behavioral therapy and serotonin reuptake inhibitors is the treatment of choice.

### Bottom line

The illusion that perfection is attainable by simple noninvasive procedures gives patients false beliefs. In this modern era, social media and digitally enhanced pictures can alter an individual’s natural beauty. Patients with BDD are particularly fragile and susceptible to this cyber and social pressure. Recognizing BDD and familiarizing yourself with how to handle these cases are crucial steps to any practice, particularly in cosmetic and plastic surgery clinics. Managing the patient with an elective cosmetic surgery usually has poor outcomes in those with BDD. Do not argue with patients about how they look and do not defy their faulty beliefs, but rather empathize and acknowledge their distress. After establishing a good rapport and connection with your patient, patiently question about suicidal risk and suggest a referral to psychiatry.

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