SERTRALINE AND BUSPIRONE IN ADOLESCENT DELUSIONAL BODY DYSMORPHIC DISORDER

Sir,

Delusional body dysmorphic disorder (BDD) is currently known to respond well to serotonin reuptake inhibitors (SRIs). However, patients with this disorder show a variable response to this class of drugs. We report a case of pimozide-resistant delusional BDD who failed a subsequent trial of clomipramine but ultimately responded to a combination of sertraline and buspirone.

U.K., a 14-year-old girl, had been suffering for about 6 months from the belief that her eyes were becoming smaller and that her lower lip was smaller than her upper lip. The patient was deeply convinced about this belief, would spend an hour each day examining her face in front of a mirror and would apply lipstick to conceal the imagined defect. However, this behavior was never ego dystonic and she had no insight in to the psychological nature of her illness. She avoided meeting people, stopped going to the school, remained sad and expressed loss of interest, hopelessness, worthless and demonstrated vegetative signs suggestive of a mild depressive episode. During the entire illness, she never had obsessive-compulsive symptoms qualifying for a disorder. Family history was positive for paranoid schizophrenia in father but there was no history of any obsessive-compulsive spectrum disorder.

The patient was diagnosed with delusional BDD and treated with pimozide up to 4 mg/day, which was discontinued after 5 months in view of severe extrapyramidal symptoms and no apparent improvement in her beliefs. Subsequently, she was treated with clomipramine up to 200 mg/day for 3 months. Her depressive symptoms improved but her beliefs on the imagined defect persisted with the same intensity. Therefore, buspirone was added for augmentation. At a dose of 200 mg/day of clomipramine and 15 mg/day of buspirone, the patient had two episodes of generalized seizures. An EEG and cranial CT scan did not reveal any abnormality to suggest focal brain pathology. Clomipramine, due to its seizurogenic potential, was replaced with sertraline, which was increased to 150 mg/day while buspirone was continued at 15 mg/day. Within two months of commencing this combination, the patient started showing improvement. Her frequency of mirror gazing decreased and she became more social. In another two months, she had rid herself of the delusional beliefs and was back to school. Currently, she is asymptomatic on this regimen for the past two years.

To our knowledge, this is the first adolescent case of BDD where a combination of clomipramine and buspirone and sertraline and buspirone were tried in the same patient. Similar reports in adults have been documented in literature (Guggenheim, 2000) while the safety and efficacy of sertraline alone in adolescent BDD has been shown only anecdotally (El-khatib & Dickey, 1995). In addition, this case offers other interesting

facets. BDD, whether delusional or non-delusional, responds to antidepressants, particularly SRIs. A recent double-blind trial comparing clomipramine with desipramine demonstrated the efficacy of the former irrespective of whether the patients had insight or held their dysmorphic perception with delusional intensity (Hollander et al., 1999). Moreover, there are reports of cases resistant to pimozide, the traditional choice for delusional BDD, subsequently responding to SRIs, which also happened in this patient (Wada et al., 1999). Thus the emerging consensus is that SRIs may be considered as first line agents in the treatment of BDD (Phillips et al., 1998; Hollander et al., 1999).

An intriguing observation in our case was the non-response to one SRI and a subsequent response to another. Such a preferential response to one SRI over another has been cited before (Dominguez & Puig, 1997). Hence, a failed trial of one SRI should not deter a clinician from trying a second SRI. Augmenting with buspirone represents another alternative. Finally, another finding of significant clinical importance is that the presence of obsessive-compulsive symptoms, syndromal or otherwise, in BDD are not a pre-requisite for response to SRIs considering that these agents have additional anti-obsessive properties and that BDD is an obsessive-compulsive spectrum disorder (Hollander et al., 1999). This too was adequately demonstrated by this report.

REFERENCES

Dominguez,R.A. & Puig,A. (1997) Olfactory reference syndrome responds to clomipramine and not fluoxetine: a case report. *Journal of Clinical Psychiatry*, 58, 497-498.

El-khatib,H.E. & Dickey,T.O. (1995) Sertraline for body dysmorphic disorder. *Journal of American Academy of Child and Adolescent Psychiatry*, 34, 1404-1405.

Guggenheim,F.G. (2000) Somatoform disorder. In : *Comprehensive Textbook of Psychiatry*, Vol, 1, Edn. 7, (Eds.) Sadock, B.J. & Sadock, V.A., pp 1529, Philadelphia : Lippincott, Williams & Wilkins.

Hollander,E., Allen,A., Kwon,J., Aronowitz,B., Schmeidler,J., Wong,C. & Simeon,D. (1999) Clomipramine vs desipramine crossover trial in body dysmorphic disorder. *Archives of General Psychiatry*, 56, 1033-1039.

Phillips,K.A., Dwight,M.M. & McElroy,S.L. (1998) Efficacy and safety of fluvoxamine in body dysmorphic disorder. *Journal of Clinical Psychiatry*, 59, 165-171.

Wada,T, Kawakatsu,S., Nadaoka,T., Okuyama,N. & Otani,K. (1999) Clomipramine treatment of delusional disorder, somatic type. *International Clinical Psychopharmacology*, 14, 181-183.

HARPREET S. DUGGAL, DPM, Resident, SOUMYA BASU, DPM, Resident, SIDDHARTHA DUTTA, MD, DPM, Senior Resident, VINOD K. SINHA, MD, DPM, Associate Professor of Psychiatry, C.I.P., Kanke, Ranchi - 834006. (e-mail: bobduggal@yahoo.com)*

***Correspondence**