

# The surgeon who operated on himself

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After performing cosmetic surgery on himself, Dr. T passes out and is brought to the emergency department. He wants to leave once he is medically stable. What would you do?



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### CASE Self-surgery

Dr. T (a pseudonym), a middle-aged male surgeon, arrives in the emergency department (ED) by ambulance after vomiting and losing consciousness at his office. Paramedics place him on an involuntary psychiatric hold, which is permitted in California, after learning that he had been performing surgery on himself.

Dr. T has developed medical complications after attempting to repair his own umbilical hernia. He states that the hernia resulted from weakened periumbilical abdominal muscles after multiple abdominal liposuctions, during which he inserted a cannula through the umbilicus. Dr. T initially repaired the hernia 4 months ago, but the wound margins had dehisced. He had performed the procedure at his ambulatory care surgical suite with help from his surgical assistant. Dr. T says he has performed many procedures on himself, including abdominal and chest liposuction, dermal filler injections, and skin laser resurfacing to improve perceived blemishes and remove hair. These procedures often resulted in poor cosmetic outcomes.

Which disorder best accounts for Dr. T's presentation?

- delusional disorder, somatic type
- Munchausen syndrome
- body dysmorphic disorder (BDD)
- factitious disorder

### The authors' observations

Clinical interviews confirmed that Dr. T met DSM-IV-TR criteria for BDD (*Table 1, page 54*).<sup>1</sup> He is excessively preoccupied with perceived physical defects, which cause clinically significant distress, and this preoccupation is not better accounted for by another mental disorder.

Although Dr. T denied any psychotic symptoms during clinical interviews and Mini-Mental State Exam assessment, a reported 77% of BDD patients meet criteria for delusional disorder, somatic type (*Table 2, page 55*).<sup>1,2</sup> Both disorders can be diagnosed concurrently if a patient meets criteria for both disorders.<sup>1</sup> Phillips et al<sup>3</sup> have suggested that delusional and non-delusional BDD may constitute the same disorder, spanning a continuum of insight. This hypothesis is supported by reports that selective serotonin reuptake inhibitors (SSRIs) work equally well for both BDD variants.<sup>4</sup>

### HISTORY Accomplishment, anxiety

When we ask Dr. T why he operated on himself, he replies that he did not have time to go to an-

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## Clinical Point

Although many individuals with BDD struggle socially and financially, some patients are successful and quite accomplished

**Table 1**

### DSM-IV-TR criteria for body dysmorphic disorder

- |  |
|--|
| A. Preoccupation with an imagined defect in appearance. If a slight physical anomaly is present, the person's concern is markedly excessive    |
| B. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning     |
| C. The preoccupation is not better accounted for by another mental disorder (eg, dissatisfaction with body shape and size in anorexia nervosa) |

Source: Reference 1

other surgeon. He disagrees when we suggest that he feared that his privacy and professional reputation might be compromised. Dr. T states, "Doctors with walking pneumonia prescribe pills for themselves; this is the same in principle" and "There is no law against operating on oneself." When we ask if he regrets his actions, he says "I was just overconfident. I did them under local anesthesia and I have a high pain tolerance." He denies enjoying the pain. He reports that his friends and significant other consider him "courageous" for operating on himself. He denies further plans to perform surgery on himself.

Dr. T has no history of psychiatric hospitalizations or suicide attempts. He has a history of "situational anxiety" and over 3 years his general practitioner prescribed unknown dosages of sertraline, alprazolam, and propranolol, but he did not take these medications regularly and denies taking any other medications. Except for impaired judgment, his mental status exam is within normal limits. He has no other medical problems. He denies alcohol or illicit drug use or a desire to harm himself or others. Dr. T states that as a younger man he was an accomplished athlete and is now an avid body builder who exercises daily and is proud of the intensity and rigor of his workouts.

**Patients with BDD are most likely to have a comorbid disorder in which category?**

- a) mood

- b) psychotic (excluding delusional disorder)  
c) anxiety  
d) personality

### The authors' observations

Dr. T does not meet DSM-IV-TR criteria for a current mood or anxiety disorder; however, he has taken medications for what he described as "situational anxiety." This pattern is consistent with data suggesting that BDD patients feel an unusually high degree of stress in their lives.<sup>5</sup> Crerand et al<sup>6</sup> found that >60% of BDD patients had a lifetime history of an anxiety disorder.

Dr. T's history highlights traits often observed in patients with BDD. As is common in men with BDD, he follows a rigorous exercise regimen.<sup>7</sup> He also was a competitive athlete, and hypercompetitiveness has significant positive correlation with BDD symptoms.<sup>8</sup> He is preoccupied with excessive body hair, which is more prevalent in men than in women with BDD.<sup>9</sup> Dr. T's work required a keen sense of aesthetics, and it has been observed that individuals with BDD have increased aesthetic sensitivity.<sup>10,11</sup>

Although many individuals with BDD struggle socially and financially, some BDD patients are successful and quite accomplished. In a study of 156 Pakistani medical students, 5.8% met criteria for BDD.<sup>12</sup> In *The broken mirror*,<sup>13</sup> BDD expert Dr. Katharine Phillips describes caring for many high-functioning health care professionals who suffer from BDD, yet "they provide their patients with superb care ... many with this disorder are productive, some are very high achievers."

### EVALUATION Bad scars

Dr. T has multiple surgical scars on his chest and abdomen (*Photo, page 56*), ecchymoses, and tenderness on palpation. His vital signs are within normal limits and he is otherwise medically healthy. Notable laboratory findings include elevated white blood cell count and platelets, and decreased hemoglobin.

Table 2

## DSM-IV-TR criteria for delusional disorder

A. Nonbizarre delusions (ie, involving situations that occur in real life, such as being followed, poisoned, infected, loved at a distance, or deceived by spouse or lover, or having a disease) of at least 1 month's duration
B. Criterion A for schizophrenia has never been met
C. Apart from the impact of the delusion(s) or its ramifications, functioning is not markedly impaired and behavior is not obviously odd or bizarre
D. If mood episodes have occurred concurrently with delusions, their total duration has been brief relative to the duration of the delusional periods
E. The disturbance is not due to the direct physiological effects of a substance (eg, a drug of abuse, a medication) or a general medical condition
<b>Somatic Type:</b> This subtype applies when the central theme of the delusion involves bodily functions or sensations. Somatic delusions can occur in several forms. Most common are the person's conviction that he or she emits a foul odor from the skin, mouth, rectum, or vagina; that there is an infestation of insects on or in the skin; that there is an internal parasite; that certain parts of the body are definitely (contrary to all evidence) misshapen or ugly; or that parts of the body (eg, the large intestine) are not functioning
<b>Source:</b> Reference 1

A CT scan shows a large hematoma over the anterior abdominal wall extending toward the flanks with extensive subcutaneous emphysema. The peritoneum is intact. These findings raise the medical team's concern about possible infection and vascular instability. The involuntary psychiatric hold for observation is continued after evaluation in the ED.

### What percentage of cosmetic surgeons have refused to operate on a patient because of suspected BDD?

- a) 4%
- b) 18%
- c) 23%
- d) 84%

### The authors' observations

There is a disconnect between Dr. T's perception of his physical attributes and the treatment team's observations. He perceives himself as marred by physical defects, while the treatment team sees him as a handsome and attractive person—excluding his scars from self-surgery.

Patients with BDD frequently are concerned about perceived physical defects that objective observers would consider slight or not noticeable. Three-quarters of individu-

als with BDD seek surgery or other medical treatment for their perceived physical flaws.<sup>4</sup> Many patients minimize their BDD symptoms and their distress when talking with health care professionals.<sup>14</sup> Approximately 20% of cosmetic surgery patients report ongoing psychiatric treatment at the time of surgery.<sup>15</sup> Eighty-four percent of cosmetic surgeons state they have refused to operate on a patient because of BDD.<sup>16</sup> However, it may be difficult for surgeons to distinguish a "perfectionist" from a patient with BDD.<sup>17</sup> Even "positive" cosmetic surgery outcomes do not ameliorate BDD symptoms because most patients develop new areas of concern. In a small study of patients with minimal defects who requested cosmetic surgery, surgery did not reduce symptoms of BDD, disability, or psychiatric comorbidity in 6 out of 7 patients at 5-year follow up.<sup>18</sup>

Specialized medical equipment, such as surgical instruments and dermabrasion or laser hair removal devices, can be purchased on the Internet, which may increase the likelihood of individuals attempting procedures on themselves. Veale<sup>14</sup> published a retrospective case series of patients who were turned down or unable to afford cosmetic surgery who performed

### Clinical Point

Even 'positive' cosmetic surgery outcomes do not ameliorate BDD symptoms because most patients develop new areas of concern

### Clinical Point

Although self-surgery appears infrequently, it reflects the severe emotional pain and desperation felt by some patients with BDD

Photo

### Dr. T's chest and abdomen during presentation to the ED



Note the asymmetry of the nipples and scarring from prior self-surgeries

self-surgery. These efforts did not lead to the desired effect, and patients continued to be plagued by their original concerns as well as self-inflicted scarring and damage.

Dr. T had the training and resources to perform cosmetic procedures on himself. Unfortunately, these efforts led to disfigurement. Phillips<sup>13</sup> states that although self-surgery appears infrequently, it reflects the severe emotional pain and desperation felt by some patients with BDD. Self-surgery is associated with an increased rate of serious suicide attempts.<sup>14</sup> Carefully monitor any BDD patient for suicidal ideation, intent, or plans.

### TREATMENT Refuses follow-up

Dr. T is admitted to the medical service and stabilized with IV fluids and antibiotics. The consultation-liaison service followed him during hospitalization. Because repeated inter-

views do not uncover grave disability or an imminent danger to himself or others, the involuntary psychiatric hold is discontinued. Dr. T declines psychiatric follow-up care, but says he would consider seeing a mental health professional in the future.

### The authors' observations

This case involves challenging ethical, legal, and countertransference issues. One of the first dilemmas the treatment team encountered was the decision to continue the involuntary hold for observation and assessment. The ED physician and psychiatric resident were faced with telling a fellow physician that he had to remain in the hospital despite his adamant desire to leave. Dr. T's articulate arguments against staying in the hospital were addressed in order to deliver needed medical treatment. The psychiatric, surgical, and internal medicine teams discussed these

countertransference concerns extensively during Dr. T's hospitalization.

Clearly, Dr. T demonstrated poor judgment by operating on himself, and we aimed to ensure that he received appropriate psychiatric follow-up, but it could not be mandated. After intense and strongly debated ethical and legal discussions with the hospital's ethicists and risk management team, we determined that we could not file a report with the state medical board because there was no evidence of incompetence, malpractice, or imminent risk to patients. A detailed description of these discussions is omitted from this article to preserve Dr. T's confidentiality. However, Dr. T will have to disclose and explain the involuntary psychiatric hold on his next medical license renewal.

Our decision was influenced by Phillips,<sup>13</sup> who found that although patients with BDD may have minimal insight into their illness, "their judgment remains intact in areas unrelated to their body image problem. Attention span and memory are well preserved, and physical and neurologic examinations are normal." Although Dr. T meets criteria for BDD, mental illness in physicians is not synonymous with impairment.<sup>19</sup>

### BDD treatment options

With medications and psychotherapy, patients with BDD generally have a good prognosis. A recent meta-analysis found that SSRIs and cognitive-behavioral therapy are effective treatments for BDD.<sup>20</sup> In

general, higher doses of SSRIs are needed to treat BDD compared with depression. Other medications with evidence of efficacy for BDD include the serotonin norepinephrine reuptake inhibitor venlafaxine<sup>21</sup> and the anticonvulsant levetiracetam.<sup>22</sup> However, clinicians often don't have the opportunity to try these approaches because BDD patients are difficult to engage in treatment, as is evident in Dr. T's case. Innovative approaches that combine practical and evidence-based strategies have been manualized.<sup>23</sup> These approaches can help clinicians engage BDD patients in treatment and recognize underlying issues of distorted body image.

#### References

1. Diagnostic and statistical manual of mental disorders, 4th ed, text rev. Washington, DC: American Psychiatric Association; 2000.
2. Phillips KA, Menard W, Fay C, et al. Demographic characteristics, phenomenology, comorbidity, and family history in 200 individuals with body dysmorphic disorder. *Psychosomatics*. 2005;46:317-325.
3. Phillips KA, McElroy SL, Keck PE Jr, et al. A comparison of delusional and nondelusional body dysmorphic disorder in 100 cases. *Psychopharmacol Bull*. 1994;30:179-186.
4. Crerand CE, Franklin ME, Sarwer DB. Patient safety: body dysmorphic disorder and cosmetic surgery. *Plast Reconstr Surg*. 2008;122(4S):1-15.
5. DeMarco LM, Li LC, Phillips KA, et al. Perceived stress in body dysmorphic disorder. *J Nerv Ment Dis*. 1998;186(11):724-726.
6. Crerand CE, Franklin ME, Sarwer DB. Body dysmorphic disorder and cosmetic surgery. *Plast Reconstr Surg*. 2006;118(7):167-180.
7. Phillips KA, Diaz SF. Gender differences in body dysmorphic disorder. *J Nerv Ment Dis*. 1997;185(9):570-577.
8. Woodie DS, Fromuth ME. The relationship of hypercompetitiveness and gender roles with body dysmorphic disorder symptoms in a nonclinical sample. *Body Image*. 2009;6(4):318-321.
9. Perugi G, Akiskal HS, Giannotti D, et al. Gender-related differences in body dysmorphic disorder (dysmorphophobia). *J Nerv Ment Dis*. 1997;185(9):578-582.
10. Veale D, Ennis M, Lambrou C. Possible association of body dysmorphic disorder with an occupation or education in art and design. *Am J Psychiatry*. 2002; 159(10):1788-1790.

### Clinical Point

SSRIs and CBT are effective treatments for BDD; in general, higher doses of SSRIs are needed to treat BDD compared with depression

## Bottom Line

High-achieving individuals, such as physicians, may present with body dysmorphic disorder (BDD). Many persons with BDD seek cosmetic surgery to correct perceived flaws, and some resort to self-surgery. Symptoms of BDD often are kept secret, and patients frequently refuse treatment. Many continue to suffer privately despite a good prognosis with appropriate medications and therapy.

continued

## Related Resources

- BDD Central. [www.bddcentral.com](http://www.bddcentral.com).
- Phillips KA. The broken mirror: understanding and treating body dysmorphic disorder. New York, NY: Oxford University Press; 2005.

### Drug Brand Names

Alprazolam • Xanax                      Sertraline • Zoloft  
Levetiracetam • Keppra                Venlafaxine • Effexor  
Propranolol • Inderal

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11. Phillips KA, Menard W. Body dysmorphic disorder and art background. *Am J Psychiatry*. 2004;161:927-928.
12. Ather MT, Mehri S, Saqib GA, et al. Body dysmorphic

disorder: gender differences and prevalence in a Pakistani medical student population. *BMC Psychiatry*. 2008;8:20.

13. Phillips KA. The broken mirror: understanding and treating body dysmorphic disorder. New York, NY: Oxford University Press; 2005.
14. Veale D. Outcome of cosmetic surgery and 'DIY' surgery in patients with body dysmorphic disorder. *Psychiatric Bulletin*. 2000;24:218-220.
15. Sarwer DB, Zanville HA, LaRossa D, et al. Mental health histories and psychiatric medication usage among persons who sought cosmetic surgery. *Plast Reconstr Surg*. 2004;114:1927-1933.
16. Sarwer DB. Awareness and identification of body dysmorphic disorder by aesthetic surgeons: results of a survey of American Society for Aesthetic Plastic Surgery members. *Aesthet Surg J*. 2002;22:531-535.
17. Glaser DA, Kaminer MS. Body dysmorphic disorder and the liposuction patient. *Dermatol Surg*. 2005;31(5):559-560.
18. Tignol J, Biraben-Gotzamanis L, Martin-Guehl C, et al. Body dysmorphic disorder and cosmetic surgery: evolution of 24 subjects with a minimal defect in appearance 5 years after their request for cosmetic surgery. *Eur Psychiatry*. 2007;22(8):520-524.
19. Myers MF. The psychiatrist's role in the management of impaired colleagues. *Directions in Psychiatry*. 1995;15:1-8.
20. Ipser JC, Sander C, Stein DJ. Pharmacotherapy and psychotherapy for body dysmorphic disorder. *Cochrane Database Syst Rev*. 2009;(1):CD005332.
21. Allen A, Hadley SJ, Kaplan A, et al. An open-label trial of venlafaxine in body dysmorphic disorder. *CNS Spectr*. 2008;13(2):138-144.
22. Phillips KA, Menard W. A prospective pilot study of levetiracetam for body dysmorphic disorder. *CNS Spectr*. 2009;14(5):252-260.
23. Veale D, Neziroglu F. Body dysmorphic disorder: a treatment manual. West Sussex, United Kingdom: Wiley-Blackwell; 2010.

## Clinical Point

BDD patients often are difficult to engage in treatment; manualized strategies may help them recognize underlying issues of distorted body image

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