Body Dysmorphic Disorder: A Decade of Mandatory Psychiatric Evaluation in Cosmetic Rhinoplasty Aspirants

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Facial Plast Surg 2024;40:551–559.

Abstract

The aim of rhinoplasty is to make the patient happier with their nose. The patient's perception plays a substantial role in their outcome satisfaction. Body dysmorphic disorder (BDD) is an obsessive-compulsive disorder concerning body image, which negatively distorts the patient's perception, rendering them dissatisfied with the outcome even if the results are close to the defined objectives. In this paper, we present a protocol with a two-specialist approach (rhinoplasty surgeon and a psychiatrist) to standardize BDD diagnosis using the DSM-5 criteria. The patients deemed suitable for cosmetic rhinoplasty by the rhinoplasty surgeon's first consultation were sent for Mandatory Psychiatric Evaluation (MPE) for further consultation and second opinion. MPE was employed with a semi-structured clinical interview by a psychiatrist incorporating the Cosmetic Procedure Screening Questionnaire and Appearance Anxiety Inventory. From 2010 to 2023, 1,602 patients attended our practice seeking cosmetic rhinoplasty, out of which, 892 were sent for MPE to the same psychiatrist. The MPE identified 2.5% (22/892) patients as having mild BDD; out of which, 15 were considered suitable for surgical intervention and underwent successful rhinoplasty (follow up: 1–10 years, $M = 4.33$ years). Although BDD is considered a contraindication in rhinoplasty, our experience shows that borderline and mild BDD can be offered surgery with good insight and support system. Moderate to severe BDD in our practice was filtered out at the first stage and was not offered surgical intervention. BDD among rhinoplasty aspirants is not as prevalent as previously reported. Standardized diagnostic protocols and studying the severity of BDD when present has clarified management of BDD in rhinoplasty aspirants in our practice. MPE is not easy to incorporate in every rhinoplasty practice, but we aim to present guidelines arising from our ongoing experience to help management of BDD in rhinoplasty.

Keywords
- body dysmorphic disorder
- rhinoplasty
- cosmetic surgery
- psychiatric disorders
- social anxiety
- depression
- preoperative assessment

How a rhinoplasty result is perceived by the patient is the cornerstone that determines the overall outcome of a rhinoplasty journey. In a rhinoplasty practice, the aim of the surgeon is to make their patient happier with their nose. From their perspective, the management of body dysmorphic disorder (BDD) in their patients includes identification and intervention in a way that is the safest for surgical outcomes. Rhinoplasty aspirants who have severe forms of

article published online February 8, 2024

Issue Theme Psychology in Facial Plastic Surgery; Guest Editor: Munish Shandilya, MS, FRCS (OTO), FRCS (ORL-HNS)

Thieme Medical Publishers, Inc., 333 Seventh Avenue, 18th Floor, New York, NY 10001, USA

DOI https://doi.org/10.1055/s-0044-1779045.
ISSN 0736-6825.

BDD may need professional psychiatric help. Those on the borderline with mild BDD may be carefully considered for surgical intervention if the "two specialists," the surgeon and the psychiatrist, think it is safe to do so. When a person aspires to have cosmetic rhinoplasty, it is important to understand what made them seek this change. Are the reasons as simple as improving symmetries of the face, or are there more complicated interplays with self-image, ranging toward more severe forms of body dissatisfaction, or even body shame? In the field of rhinoplasty, interest in outcome research has not only improved how to measure satisfaction but has also made us aware of the need to improve patient selection and to learn and anticipate the outcomes based on critical factors like general outlook, personality, and mental health.

BDD has perhaps attracted the most attention among those studying rhinoplasty outcomes because of its dramatic relevance when it is not recognized before surgery. BDD is an obsessive-compulsive disorder characterized by an excessive preoccupation over nonobservable or slight defects to one's appearance. According to the fifth edition of the Diagnostic and Statistical Manual of Mental disorders (DSM-5),[1] to meet diagnostic criteria for BDD, the individual must be excessively preoccupied with nonobservable or slight defects. In addition, at some point over the course of the disorder, the individual must engage in repetitive behaviors in response to their concern about their appearance, including mirror-checking, camouflaging behaviors (trying to hide perceived flaws using makeup, clothing, etc.), reassurance-seeking, excessive grooming, and comparing their appearance with others. The individual must experience marked distress and impairment in multiple areas of functioning as a result of this disorder. Finally, the symptoms must not involve a preoccupation over body fat or weight, which meet the diagnostic criteria for eating disorders.

Individuals with BDD, as described in psychiatric literature, tend to have a very poor quality of life. As mentioned in the diagnostic criteria, they engage in repetitive time-consuming rituals; in many instances, they would be unemployed or disadvantaged at work, they are socially isolated, and they have much higher rates of suicidal ideation.[2,3] Rhinoplasty surgeons are made aware of BDD as a condition that may threaten outcomes if not picked up in time, leading to disastrous results. Indeed, clinical reports and retrospective studies on BDD patients from psychiatric clinics show that operating on such patients is often associated with dissatisfaction, no change, or even increase in BDD symptoms, engaging in legal action against their surgeon and may harm themselves or the surgeon.[3–7] It has therefore been concluded based on these findings that cosmetic rhinoplasty surgery on BDD patients should be considered contraindicated.[5,8,9] Caution must be heeded in interpreting these results, however, as there is likely a selection bias in such retrospective studies given that the patients are chosen from psychiatric clinics. After all, their BDD symptoms are severe enough for them to be there in the first place.

While BDD has a prevalence of approximately 0.5 to 3.2% in the general population,[10–14] it has a much higher prevalence of approximately 20.7 to 52% in rhinoplasty practice,[15–19] which sounds alarming. Before looking deeper into the question of prevalence, we looked at this group of patients from a rhinoplasty surgeon's perspective focusing on their management. The importance of clarifying the diagnostic criteria (our two-specialist team protocol) and quantifying the severity of BDD appear to be the most relevant issues for managing BDD cases in a rhinoplasty setting. As noted by other authors including Dr Constantian and Dr de Brito, patients who are being treated by a psychiatrist are likely to be those with more severe forms of BDD and are not the same type of patients with BDD that rhinoplasty surgeons typically encounter in their practices.[20,21] There is an increasing realization among the surgeons offering rhinoplasty that their patients that are being evaluated for BDD are a different subset that typically do not demonstrate the severity of BDD encountered in the psychiatrist's clinics. Rhinoplasty patients with BDD as seen in rhinoplasty clinics typically present with nasal deformities, not necessarily subtle or barely perceptible as stressed in the diagnostic criteria. The characteristic preoccupation is albeit a common part of their clinical spectrum. They are generally functional patients with defects observable especially by specialist rhinoplasty surgeons. These aspirants of cosmetic rhinoplasty with observable nasal defects, however, may have unrealistic expectations, insisting on surgery with the risk of not being satisfied with their results, even if their specified goals are met.[19,20,22,23] BDD in rhinoplasty can be missed if not carefully investigated and eventually lead to disastrous results. Indeed, a survey of cosmetic surgeons found that 84% of them had operated unknowingly on a BDD patient, and 82% of these surgeons believed that these patients had poor postoperative outcomes.[24]

While surgical rhinoplasty in severe forms of BDD has been considered a contraindication, the practice of surgical rhinoplasty in milder forms of BDD remains a topic of debate and is controversial.[25] We believe that by having the right protocols in place, patients with milder forms of BDD can benefit from rhinoplasty. Therefore, from a rhinoplasty surgeon's point of view, it is important to establish the severity of BDD in rhinoplasty as mild, moderate, and severe, to isolate those with milder forms who may benefit from rhinoplasty. The severe form of BDD is not very difficult to recognize in the clinics if adequate time is spent and protocols are put in place. What is perhaps more difficult is making decisions about whether to operate on patients in the mild and moderate range. The milder forms must be carefully considered for surgical rhinoplasty when it is safe to do so. The aim of this present paper is to introduce our protocol for assessing patient suitability for cosmetic rhinoplasty using a two-specialist approach. In our experience, the practice of having an MPE, which is our protocol of a semi-structured clinical interview using the DSM criteria,[26] although difficult to incorporate in every rhinoplasty practice, was beneficial in the management of rhinoplasty in the presence of BDD and other comorbidities. Surgical intervention in a group of mild BDD patients was offered in patients who had good insight and strong family support when the psychiatrist colleague

Table 1 Assessment for body dysmorphic disorder in rhinoplasty aspirants

Three main options to deal with the question of BDD in rhinoplasty
1. Surgeon's gut feeling—4% success rate in correctly identifying BDD if based only on gut feeling[27]
2. Screening questionnaires for BDD picks aspirants with possibility of BDD with high sensitivity and specificity
3. Mandatory psychiatric evaluation in all patients that the surgeon feels are good candidates for cosmetic rhinoplasty, includes screening tools for diagnosis and severity of BDD

Abbreviation: BDD, body dysmorphic disorder.

agreed to the safety of such management. A successful safe intervention would improve the quality of life of these patients who suffer comparatively more than those without BDD. Our experience with rhinoplasty in those with mild BDD is in press.

Method

Patient Selection

The most suitable patients for cosmetic rhinoplasty in our experience are those that had a reasonable expectation, expected to have an average perception, good insight, a good support circle and capacity to cope with suboptimal outcomes. To identify such patients, we adopt a two-specialist approach for assessing the patients, which comprises of an initial consultation with the primary surgeon, followed by an MPE with a psychiatrist only on the patients approved by the surgeon in the initial meeting. ►**Table 1** outlines the three main options surgeons have for identifying BDD in rhinoplasty practices. ►**Fig. 1** gives an overview of our two-specialist approach for assessing patients for BDD.

A total of 1,602 patients from 2010 to 2023 were seen in four of our rhinoplasty clinics in Ireland. These are the UPMC Whitfield Clinic in Waterford and three clinics in Dublin, namely the Bon Secours, the Beacon, and the Blackrock hospitals. A total of 892 rhinoplasty aspirants (633 females, 259 males) were accepted as good candidates for offering surgery by the primary surgeon after the first consultation and were additionally sent for MPE. A total of 22 of these aspirants were identified as having mild BDD. None of this initial group had moderate or severe BDD. A total of 15 of the mild BDD patients were accepted for surgery and operated on, all of whom were happy with their results. Despite a satisfactory improvement, 8 of the 15 mild BDD patients requested revision surgery which was not offered (see ►**Fig. 2** for a schematic representation). Any person referred for MPE who did not comply was politely declined for surgery. The information about this nonuniversal request for psychiatric evaluation is typically shared with the new rhinoplasty aspirants at every stage allowing them a timely choice.

The Initial Consultation

All cosmetic rhinoplasty aspirants go through an initial consultation with the surgeon, where the aim is for the surgeon to answer the question: "Can I make this person happier with their nose?" Several red flags may convey to the surgeon that they won't be able to achieve this (►**Table 2**). It is important to note, however, that these red flags are not the be-all and end-all factors for determining patient suitability, but rather it is ultimately the surgeon's gut feeling after considering such factors that determines whether or not the patient is a patient whom the surgeon is happy to operate on.

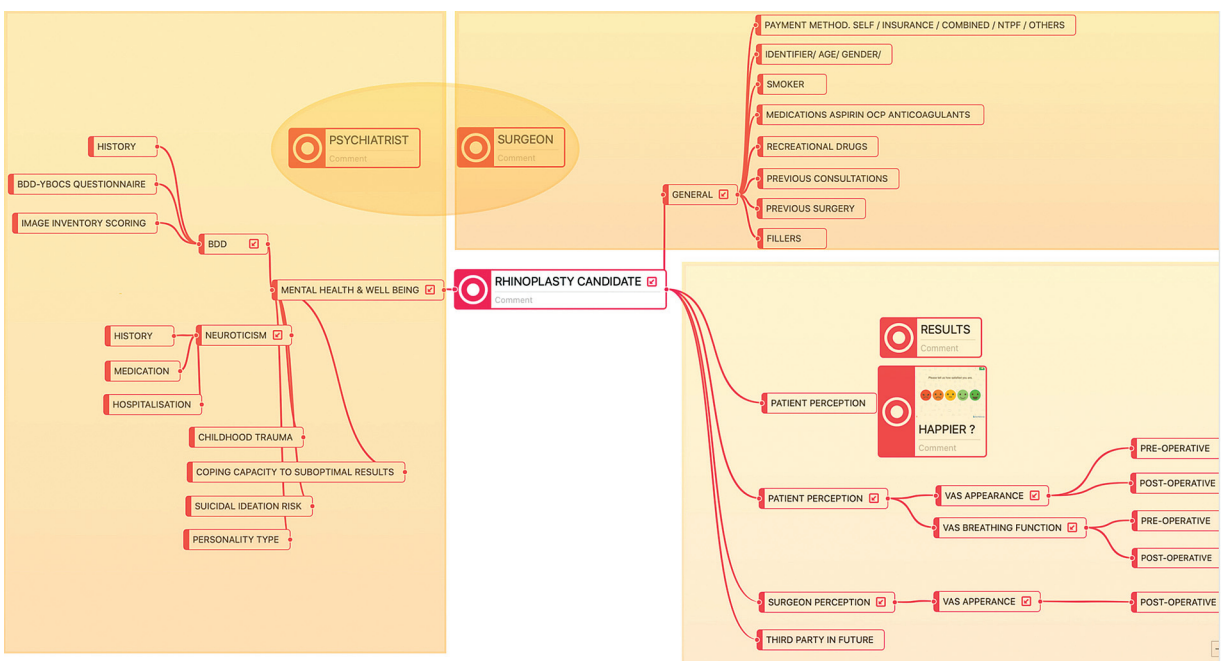

Fig. 1 Overview of our two-specialist preoperative and postoperative assessment protocol for rhinoplasty. BDD, body dysmorphic disorder VAS, visual analogue scale; BDD-YBOCS, Yale-Brown Obsessive Compulsive Scale modified for body dysmorphic disorder.

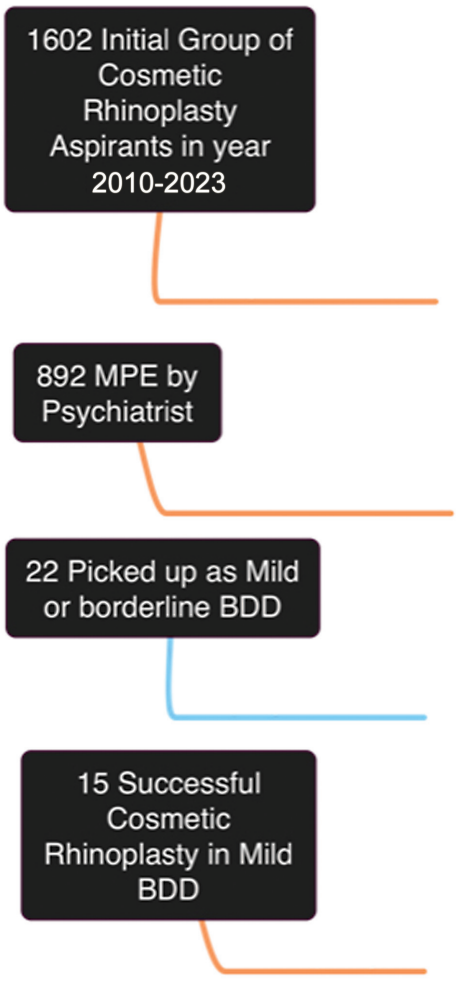

Fig. 2 Schematic representation of the flow of patients in our cosmetic rhinoplasty practice from 2010 to 2023. BDD, body dysmorphic disorder, MPE, Mandatory Psychiatric Evaluation.

Table 2 Red flags in cosmetic rhinoplasty consultations

• Delusional thoughts and descriptions about their nose
• Describing their nose as ugly (body shame)
• Not engaging/doesn't smile
• Poor family support
• Flattery
• Bad-mouthing previous surgeons
• Unrealistic expectations
• Not responding positively to digital morphing and being unclear as to what their desires are
• Having anxiety and/or depression
• Past trauma
• Aspiring for the nose of a celebrity
• Insisting on changes that are not suitable for the face

Only when the surgeon is happy to operate on the patient, is the patient sent for an MPE.

Digital Morphing of Clinical Pictures

During the first consultation, clinical pictures of rhinoplasty aspirants who are being considered as good candidates for surgery are digitally modified (morphed) and shared with the patient to see how they are perceived. This is a good stage to decide if the expectations and perception are matching and achievable.

The Mandatory Psychiatric Evaluation

All patients whom the surgeon is happy to operate on go through MPE with a psychiatrist. The practice of MPE started as a consultation in-person, which had to be modified as a zoom meeting during the corona virus 2019 pandemic and has remained an option. During the MPE, the psychiatrist asks the patients questions about themselves about the following topics (►**Fig. 3** and ►**Table 3**).

Childhood

What was their family structure growing up? Were they loved or cared for by their family? Did they make good friends? Did they do well in school? Were they bullied? Did they experience any traumatic events growing up? In general, did they have a happy childhood?

Surgery Motivation and Expectations

Why do they want the surgery? Why now? Why with this surgeon? Why rhinoplasty and not just injections? Why not in a different country? What do they expect from the surgery? Are they aware of suboptimal results? How often do they think these occurred? Are they concerned about these? Is there a need for further discussion about these? All these questions are to see why the patient has come to the decision they have come to.

Medical and Psychiatric History

Have they had any previous consultations with other surgeons? Have they undergone any previous surgeries? Have they been hospitalized before? Do they have any history of mental illness (depression, anxiety, BDD, obsessive-compulsive disorder, etc.), have they ever had any counselling, did they take any medication?

BDD

The psychiatrist asks the patient questions pertaining to the diagnostic criteria of the DSM-5. To assess the severity of BDD, the psychiatrist administers to the patient either the Appearance Anxiety Inventory or the Cosmetic Procedure Screening Questionnaire. Furthermore, the patient's level of insight and their support circle are also evaluated. Finally, have they ever had any suicidal ideation?

Surgery-Specific Questions

Does the patient have the capacity to cope with suboptimal results? Do they have any current psychiatric concerns or warnings? (BDD, depression, anxiety, etc.) Do they have any history of smoking, alcohol abuse, or drug abuse?

Managing Mild Body Dysmorphic Disorder Patients

Patients who were diagnosed as suffering from mild BDD were isolated. This separation of mild BDD from the more severe forms emerged as the central benefit of MPE. This allowed us to have clarity in determining the management protocols. The following factors dictated if surgical

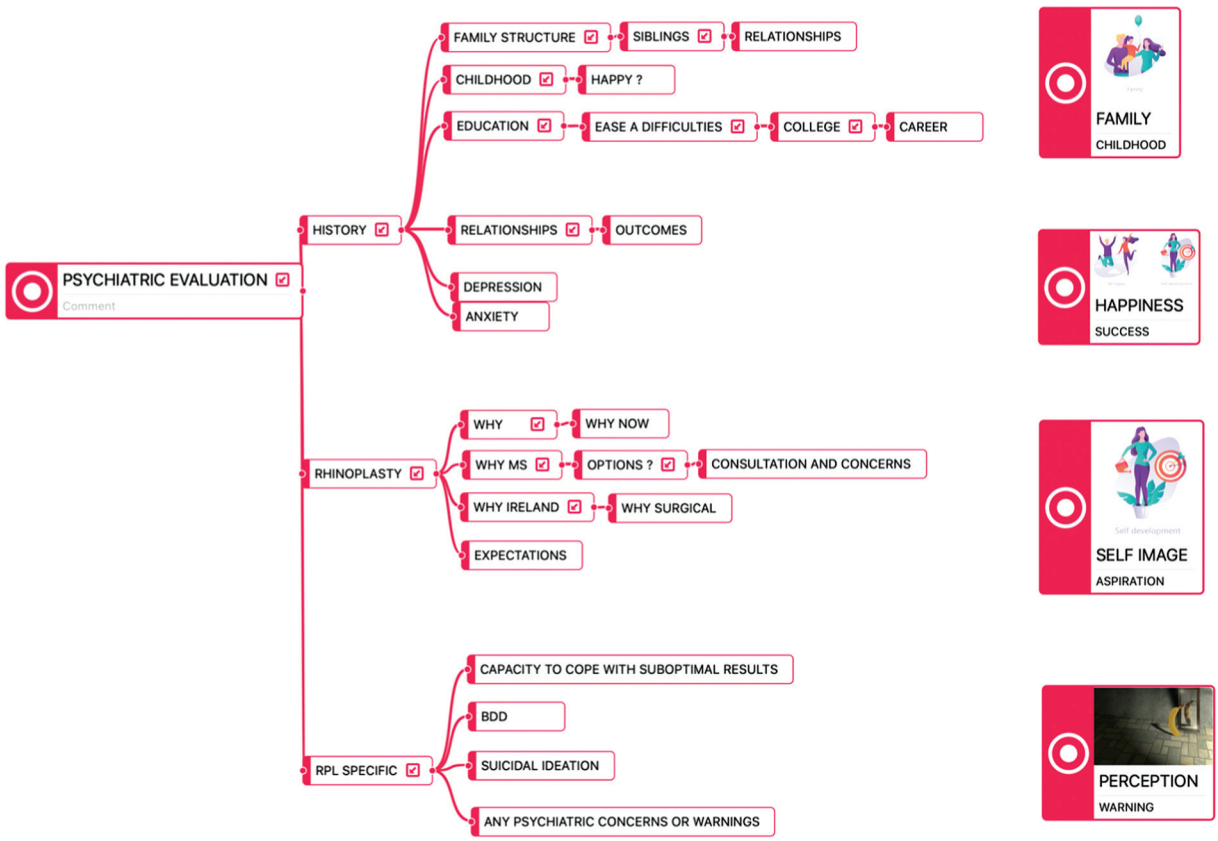

Fig. 3 The structured clinical interview by the psychiatrist. BDD, body dysmorphic disorder; MS, Munish Shandilya; RPL, rhinoplasty.

Table 3 Description of the Mandatory Psychiatric Assessment from the psychiatrist's point of view

Purpose of the interview
The purpose of the interview is explained to the patient. The patient is informed that this is an attempt to identify psychological risk factors for dissatisfaction; specifically an enquiry into motivations and expectations of the patient, as well as a mental health evaluation to look for evidence of Body Dysmorphic Disorder. The patient is given an opportunity to comment on this and express any concerns. The patient is asked if they have heard that patients can be dissatisfied with results
Developmental history
A standard developmental history is taken. This will include questions on where the patient is born, description of family structure and childhood. The patient is asked generally about any adverse events. A history is taken of the patients, education and training, as well as occupational activities. The patient is asked to describe relationships, social activities, hobbies and interests. Past medical history and mental health history is taken. During this section of the interview, the psychiatrist is observing openness, functioning, support networks
Motivation in seeking surgery
The patient is asked about previous cosmetic interventions; when, where and to rate satisfaction. The following questions are asked: Why this surgery? Why now? Why this surgeon? Why this country? Who have they seen so far? How did they come to see this surgeon? Why not abroad? Can they finance this procedure? What do their family and friends think? Who have they told? Has anyone important in their life expressed any concern about them going forward for surgery? What are their hopes and expectations? How have they found the consultation with the surgeon?
BDD
The patient is asked specific questions relating to the symptoms of BDD, preoccupation, anxiety, checking, avoidance behavior and comparison behavior. They are asked about consciousness of the nose in public, and their relationship with photographs. The patient is asked to describe and rate the nose, looking for exaggeration. In suspected BDD, the patient is asked to complete a COPS and/or an AAI. The patient is asked to predict how they may manage with dissatisfaction and is informed about rare but potential mental health complications related to rhinoplasty. If a risk factor of concern is identified, this is shared with the patient and discussed. The surgeon is advised of this concern and caution is recommended

Abbreviations: AAI, Appearance Anxiety Inventory; body dysmorphic disorder; COPS, Cosmetic Procedure Screening Questionnaire.

Table 4 Factors that influence whether cosmetic rhinoplasty can be offered among mild body dysmorphic disorder patients and the protocols we follow

1. Presence of good insight. Any degree of delusion in their thought process would be a red flag for the surgeon evaluating suitability for surgery (this of course gets picked up by the surgeon in any case)
2. Presence of good support circle
3. Surgical management when considered appropriate is deferred for at least 6 months to ascertain the capacity of the patient to understand vital information given
4. Even with good results, it is quite common among this group of patients to request further improvement. At present, we advise against multiple surgical interventions at the onset
5. The surgeon and the psychiatrist must believe that the patient can be made happier despite the presence of mild BDD

Abbreviation: BDD, body dysmorphic disorder.

management was to be offered to this group: (1) presence of good insight vs delusions. Any degree of delusion in their thought process would be of concern (this of course typically gets picked up by the surgeon in the early stages in any case); (2) presence of a good support circle with whom the management and its implications have been discussed; (3) surgical management, where it has been considered appropriate in a mild BDD case, is deferred for at least 6 months to ascertain the capacity of this patient to understand vital information given and allows patients time to respect the importance of this knowledge about how surgery may be perceived by such a patient; (4) even with good results, it is quite common among this group of patients to request further improvement; (5) finally, does the surgeon still think they can make the patient happier? At present, we recommend conservative surgical procedures for mild BDD cases and revision surgery is not advised. Before offering surgery, we request the consultant psychiatrist to review and give their opinion yet again on our decision to consider surgery. A second opinion at this stage is invaluable because surgery in mild BDD remains an area that is controversial and being studied. ►**Table 4** gives a summary of these factors.

Discussion

The ultimate goal in cosmetic rhinoplasty is to make the patient happier with their nose. A major determinant of their satisfaction with the outcome is the patient's perception of the results. BDD is an obsessive-compulsive disorder concerning body image, which negatively distorts the patient's perception, rendering them dissatisfied with the outcome even if the results are close to the defined objectives. Assessing the presence of BDD and its severity in rhinoplasty aspirants is paramount. Over the last decade, we have designed protocols in our rhinoplasty specialist clinic to identify and, if necessary, exclude patients where rhinoplasty outcomes could be negatively affected due to the presence of conditions like BDD and/or comorbidities. This present paper aimed to understand the magnitude of the problem of BDD in rhinoplasty practice, clarifying the prevalence, the diagnosis, and the management.

The Prevalence of Body Dysmorphic Disorder in Rhinoplasty Clinics

The prevalence of BDD in the general population is approximately 0.5 to 3.2%[10–14] and ranging from 20.7 to 52% in cosmetic rhinoplasty practices. Katherine Philips, a leading researcher in BDD research puts this figure at 20%.[23] The rhinoplasty surgeons are surprised at the higher figures quoted earlier in the literature, and with clarity of diagnostic criteria, this question will be answered better. In this present study, 2.5% (22/892) of the patients deemed suitable after the first consultation with the surgeon, turned out to have mild or borderline BDD. Of the 1,602 rhinoplasty aspirants that presented to our specialist clinic, 892 were considered as good candidates and sent for MPE. The 710 that were not selected for the next stage, failed due to inappropriate expectations, personality traits, poor insight–high delusionality, or failing the answer to "Can I make this patient happier with their nose." This large group, however, was not screened for BDD as surgery was not going to be offered. Moderate to severe BDD patients were excluded at this stage, as none of the 892 patients sent for MPE had a diagnosis of anything higher than mild or borderline BDD. Where appropriate, a second opinion from a psychiatrist was discussed to help such patients who were being denied surgery as the right option for them.

The Two-Specialist Concept for Diagnosis of Body Dysmorphic Disorder

For diagnosing BDD, the emphasis placed on the subtlety of the physical defect causing inordinate distress warrants careful address. A rhinoplasty aspirant looking for a very small change, which a specialist rhinoplasty surgeon can appreciate and offers to correct, in an otherwise good candidate for cosmetic rhinoplasty, must not be mistaken for a BDD diagnosis. It would be important to differentiate a subtle but correctable change and a perceived defect that isn't really there. The presence of good insight, as opposed to delusions, and the surgeon's ability to recognize these in their patients, is critical. On the other hand, surgeons on their own often fail to identify BDD in their patients when they actually have it. In a facial plastic clinical setting, one study found that surgeons were only able to correctly identify 4.7% of all their patients who screened positive for BDD.[27]

In our rhinoplasty practice, we have a two-specialist model with a surgeon teaming up with a professional psychiatrist to diagnose BDD and comorbidities. A team of two specialists with expertise in defining what is a correctable deformity and to what extent this is affecting the individual is helpful in standardizing the application of the diagnostic criteria (DSM-5). Indeed, It has been recommended in the

literature that cosmetic surgeons and mental health professionals should work closely together to ensure a more accurate assessment for surgery suitability.[8,25,28,29] The two specialist model for diagnosis improves the application of diagnostic criteria and brings a uniformity of the entity of BDD in rhinoplasty and enriches the scientific publications and their future use and inference. In the past, the varied use of diagnostic criteria and definition has been noted in the literature and the need for clarification was identified.[18,30] Our protocol of MPE involves a standardized clinical interview using DSM-5 criteria. Over the last decade, our protocols reflect the changes the previous authors have alluded to, including the psychiatrist and surgeon combination,[25,29,30] the need for clarity in BDD definition in a rhinoplasty context,[18,30] and the use of a semi-structured clinical interview to diagnose BDD.[31]

The stage at which this teamwork between the surgeon and mental health professional takes place depends on a team's preference. We have presented our protocol, where the patient first goes through an initial consultation with the surgeon, to be followed by an MPE with a psychiatrist only if the surgeon has accepted the rhinoplasty aspirant as someone they would offer surgery to.

Severity of Body Dysmorphic Disorder and its Management in Rhinoplasty

The Initial Consultation

There is no debate on the notion that surgery on a patient with severe BDD is contraindicated, as surgery on these patients can lead to dire consequences. Nevertheless, many patients with severe BDD seek rhinoplasty. The severe form of BDD, however, doesn't warrant as much cause for concern as it is easy to identify by an experienced rhinoplasty surgeon during the consultation, thus rendering surgery on such patients very unlikely. "Can I make this patient happier with their nose" being the guiding principle, an experienced surgeon will be able to exclude most patients that are unsuitable for surgery by answering this question. The red flag behaviors (►**Table 2**) will help in answering this question, but ultimately it is the surgeon's gut feeling developed through years of experience and validation from a robust protocol such as MPE that will be the best resource to rely on. In our rhinoplasty practice, no patient with moderate or severe BDD has been missed during the initial consultation and sent for MPE.

Mandatory Psychiatric Evaluation

The more important issue in patient selection is deciding where to draw the line in patients with milder forms of BDD between those who are likely to benefit from surgery and those who may not. One of the central benefits of MPE is isolating this group of mild BDD patients, and drawing this line based on the patient having good insight, a good family support circle, the capacity to understand and respect the importance of vital information given about how surgery may be perceived by these patients, and the surgeon's belief that they may still be able to make the patient happier. One may simply decide to take the more conservative approach by screening each patient and refusing surgery on anyone who exhibits any form of BDD, regardless of its severity. It has been shown, however, that patients with mild BDD can benefit from surgery,[32,33] and so refusing surgery on such patients would be a disservice to them. Indeed, operating on patients with milder forms of BDD necessitates having a dedicated diagnostic protocol to identify, isolate, and assess the patient's suitability for surgery. Offering surgery to mild BDD patients who have a good support system and availability of second opinion of a psychiatrist at every stage is critical, especially when offering an intervention that is not universally accepted and is being studied at present.[32,33]

By employing MPE in every seemingly good candidate for rhinoplasty, the advantages are: (1) we gather information in a wider group that helps us understand these patients better; (2) we get a better understanding of personality types and degree of neuroticism; (3) information about other mental health issues gets incorporated into the overall evaluation, and we have realized that BDD is only one of the concerns in achieving good outcomes in cosmetic rhinoplasty. There are several other factors that may be responsible for suboptimal results; (4) the protocol of a mandatory psychiatry evaluation allows a substantial benefit of the availability of professional psychiatric second opinion at every stage where required in a chosen patient. It must be said here that such professional help is difficult to source, and a long waiting period may become part of this journey. In our experience, discerning patients have respected this and accepted it as a necessary aspect given the benefit and assurance it brings to the process; (5) an experienced surgeon's gut feeling remains one of the most important tools in understanding and evaluating their patients of cosmetic rhinoplasty at every stage. It has been our experience that with MPE, and its contributions to our understanding, and validation of our opinions, the gut feeling has become increasingly robust and more reliable as the experience increases. The advantages MPE are summarized in ►**Table 5**. ►**Table 6** shows the lessons we have learnt after a decade of employing MPE.

An MPE type of protocol is difficult to incorporate in all rhinoplasty practices and validated questionnaires are adequate as screening tools to identify possible BDD cases and are practical in most rhinoplasty clinics. Where and how to incorporate professional psychiatrist help is best decided by individual rhinoplasty surgeons and teams depending on their personal ethos and practice structure. As our understanding, knowledge, and experience increases, the teams where MPE type protocols are practical can contribute toward guidelines that are applicable and beneficial to all rhinoplasty practices.

This is a description of an ongoing audit and tweaking of protocols based on our understanding of BDD and mental health concerns in a rhinoplasty practice of a single surgeon. Two psychiatrists participated in our work, one pediatric and one adult psychiatrist. The primary aim of our practice protocol is to optimize outcomes in the patients that we offer surgery.

Table 5 Advantages of Mandatory Psychiatric Evaluation

1. Information is gathered from a wider group that helps us understand these patients better
2. We get a better understanding of personality types and degree of neuroticism.
3. Information about other mental health issues besides BDD gets incorporated into the overall evaluation, which may contribute to sub-optimal results
4. Availability of professional psychiatric second opinion at every stage were required in a chosen patient. Such professional help is difficult to source and significant waiting periods may become part of this journey. In our experience, discerning patients have respected this and accepted it as a necessary aspect given the benefit and assurance it brings to the process
5. It has been our experience that with MPE, and its contributions to our understanding and validation of our opinions, the most important tool, the gut feeling, becomes more robust and reliable as we gain more experience

Abbreviations: BDD, body dysmorphic disorder; MPE, Mandatory Psychiatric Evaluation.

Table 6 Lessons learnt from a decade of Mandatory Psychiatric Evaluation

• BDD in Rhinoplasty practice is not as prevalent or as confusing as it was when we started
• Severe BDD is not difficult to diagnose and Mild BDD can both be safely avoided or carefully managed with a clearly defined safe approach
• Mild BDD if offered surgery, should be offered as one conservative procedure, carefully avoiding further requests for intervention

Abbreviation: BDD, body dysmorphic disorder.

Going forward, we will be looking for feedback and prepare guidelines to the role of mental health professionals that may be suitable for different types of practices. We are considering the choice of data collection and outcome measures for the next set of patients starting mid-2023.

Conclusion

(1) MPE proved to be the backbone of our rhinoplasty practice allowing us safe selection among rhinoplasty aspirants. (2) The two-specialist model helped universal application diagnostic criteria. (3) Mild or borderline BDD patients were evaluated and successful surgical intervention was possible in 68% of this group (15/22). BDD in rhinoplasty is less of a threat to a rhinoplasty practice when understood well and guidelines for best practice should be defined based on the outcomes one can expect in a given patient.

Conflict of Interest
None declared.

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