The surgeon who operated on himself
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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?
   a) delusional disorder, somatic type
   b) Munchausen syndrome
   c) body dysmorphic disorder (BDD)
   d) factitious disorder

The authors’ observations
Clinical interviews confirmed that Dr. T met DSM-IV-TR criteria for BDD (Table 1, page 54). 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). Both disorders can be diagnosed concurrently if a patient meets criteria for both disorders. Phillips et al 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.

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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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

**Clinical Point**

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

**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.
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.

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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 individuals with BDD seek surgery or other medical treatment for their perceived physical flaws. Many patients minimize their BDD symptoms and their distress when talking with health care professionals. Approximately 20% of cosmetic surgery patients report ongoing psychiatric treatment at the time of surgery. Eighty-four percent of cosmetic surgeons state they have refused to operate on a patient because of BDD. However, it may be difficult for surgeons to distinguish a “perfectionist” from a patient with BDD. 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. 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 published a retrospective case series of patients who were turned down or unable to afford cosmetic surgery who performed
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\(^{13}\) 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.\(^{14}\)

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 interviews 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, 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.

**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. 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 and the anticonvulsant levetiracetam. 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. These approaches can help clinicians engage BDD patients in treatment and recognize underlying issues of distorted body image.

**References**


**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.

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**Clinical Point**

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


Drug Brand Names

- Alprazolam - Xanax
- Levitracetam - Keppra
- Propranolol - Inderal
- Sertraline - Zoloft
- Venlafaxine - Effexor

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Clinical Point

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