Case Report

Olfactory Reference Syndrome: a case report

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ABSTRACT

Olfactory reference syndrome (ORS) is a psychiatric condition characterized by the false belief that an individual emits an offensive or foul odour from their body. It causes lot of embarrassment and social impairment to these patients. Treatment options include antidepressants and antipsychotics. Here we present a case of Olfactory Reference Syndrome who responded to combination of antipsychotics and antidepressant.

Keywords: olfactory reference syndrome, blonanserin, fluoxetine, depression.

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INTRODUCTION

Olfactory reference syndrome (ORS) is a psychiatric condition characterized by the false belief that an individual emits an offensive or foul odour from their body [1].] This odour is not perceived by others and usually causes significant distress to the patient. The patient often exhibits behaviours trying to mask this apparent odour in order to not inconvenience those around them [2]. The disorder substantially impairs functioning, and patients typically avoid social situations, sometimes even work, to avoid the embarrassment of smelling bad [3]. We report a case of ORS in a 42 year old male on medication currently following up with us.

CASE REPORT

A 42 years old male educated upto 8th standard, working as a painter visited our OPD with complaints for 7 years. He would get foul smell of decayed things which other people could not perceive. Over 2 years the severity of the smell increased and he started feeling that other people around getting the smell from him and were annoyed with him. He would enquire with his friends and relatives if they were perceiving the smell but none agreed to it. Gradually he started distancing himself from everyone. He became irregular at his workplace too. He consulted many Ear, Nose, Throat Specialist but all investigations were within normal limits.

Gradually his condition started worsening. He strongly believed that his nose was emitting foul odor despite being convinced by his relatives & multiple doctors he consulted. Thereby he was referred to a psychiatrist after 2 years of onset of symptoms. He was started on some tablets and felt better with medications. But he discontinued them after 6 months of treatment without following up with the doctor.

His symptoms reappeared after 3 months and again he started getting foul smell emitting from his nose. Also, he felt that people were talking about him and smell coming from his nose. He got very much distressed with his symptoms that he tried to kill himself by slashing his throat and wrist. He was admitted to our hospital, treated for the same and after becoming medically and surgically stable was referred to our OPD for psychiatry opinion. On enquiry he gave above history and informed us that he also started alcohol consumption about 90ml daily of country liquor due to uncontrollable foul smell he was perceiving. He tried various ways of getting rid of the smell like –

- Putting oil, cold or warm, in nose
- Putting drops of aritha powder & ginger boiled in water in nose
- Some ayurvedic drops in nose for around 1 month
- Salt & water for nearly 1 year whenever he had foul smell
- Salt & baking soda
- Warm oil or ghee
- Recently he had started putting honey & claims to feel better with it to some extent

He had no other delusions or hallucinations. He denied any other substance use or having any other medical or surgical illness. We diagnosed him as having Olfactory Reference Syndrome and started on tablets Clozapine 25 mg, Blonanserin 8mg and trihexyphenidyl 4mg in divided doses. Also tablet fluoxetine 20mg was added to control his depressive features. Gradually dose of clozapine was up titrated to 100mg and Blonanserin to 16mg, rest were kept same.

After 2 weeks of follow up on above doses he perceived 40 % improvement. Currently he is on above medications and is regularly following up with us.

DISCUSSION

The treatment of ORS remains limited, mainly confined to antipsychotics, antidepressants and psychotherapy [4]. This condition is recognized by DSM-5 under the chapter of Obsessive Compulsive and Related disorders (OCRD) and is being considered to be included in ICD-11 [5]. A differential diagnosis of delusional disorder was made but was ruled out, owing to the presence of repetitive behaviour carried out in an attempt to camouflage the odour [6].

As seen in this case, major depressive disorder is the most common comorbidity associated with ORS and may be accompanied by suicidal thoughts and actions. It usually follows a primary diagnosis of ORS [7]. If left untreated, the prognosis of ORS is generally poor, eventually culminating into a chronic condition, or getting converted into some other psychiatric modality in the patient. Males, especially single, unemployed and socially inactive tend to be affected more than females of the same age.

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