A case of Olfactory reference syndrome

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Case report

An army soldier in his early thirties was referred to the neurology ward with a history of urinary incontinence for the last 2 months. He complained of incontinence of urine and an unpleasant odour of urine which was noted by others as well. He complained that some of the gestures of his colleagues such as wiping their nose, or covering their faces as a response to his unpleasant body odour. He stated that these thoughts occupied most of his waking time although he acknowledged that his thoughts on the odour were excessive and unreasonable. Detailed questioning revealed he was repeatedly checking his underwear for urinary stains and was taking extra baths and wearing additional undergarments which he frequently changed in order to mask the odour. Clinical evaluation revealed that the preoccupation of the smell of urine was what led to him presenting as incontinence and there was no objective evidence of urinary incontinence. Detailed neurological evaluation excluded spinal cord pathology and a contrast enhanced CT of the brain and EEG was normal.

A detailed history from our patient revealed that what he experienced was not true incontinence but the smell of urine which he perceived and attributed to incontinence which could be a discrete entity (the olfactory reference syndrome) or could be a component of other disorders such as schizophrenia, depression or temporal lobe epilepsy. Clinical assessment comprising of neurological and psychiatric aspects as well as the investigation findings concluded that the patient had olfactory reference syndrome. He was commenced on cognitive behavioural therapy and he showed significant improvement.

Discussion

Olfactory reference syndrome (ORS) is defined as a psychiatric condition characterised by persistent preoccupation about body odour accompanied by shame, embarrassment, significant distress, avoidance behaviour and social isolation. Referential thinking is where patients have delusions of reference, falsely believing that other people perceive the odour. ORS symptoms most often begin when the patients are around their mid 20s but some reports suggest onset during puberty and adolescence, with a male preponderance of 2:1. The individuals are preoccupied with the belief they emit an unpleasant or offensive body odour. Flatulence, faecal or anal odours, general body odours, halitosis and genital odours are the most common but they also perceive other odours such as sweat, armpit odour, sperm, urine and malodorous hands and feet. There is referential thinking and they misinterpret the behaviour of others assuming it is a reaction to how the patient smells. The patient is ashamed, embarrassed and concerned about offending others that they engage in repetitive and safety behaviours intended to check, eliminate or camouflage the odour.

ORS leads to functional impairment where the individual often avoids other people or believe that others avoid them. They are worried and avoid activities, break off engagements, refuse travel and become housebound. The distress and impaired functioning leads to psychiatric hospitalisation, depression and suicidal ideations [1].

This is a chronic illness persisting for years and possibly worsening with time if the patient does not receive appropriate treatment. ORS may be associated with depression, personality disorders, schizophrenia, hypochondriasis, alcohol and drug abuse, obsessive compulsive disorder and body-dysmorphic disorder.

Worldwide there have been only 84 reported cases of ORS [2]. ORS has been described for more than a century but the pioneering report describing 36 patients was in 1971 [3,4].

ORS is not included in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV). For the DSM V it is being proposed to add ORS to an appendix of conditions that need further research in order to have an agreed definition that researchers can use [5].

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