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When Surgery Cannot Correct the Perceived Defect: Screening, Decision-Making, and Outcomes of Body Dysmorphic Disorder in Aesthetic Plastic Surgery

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Abstract

Body dysmorphic disorder (BDD) can bring a patient to an aesthetic surgeon seeking anatomical correction of a problem whose principal treatment requires mental health care. This critical narrative review examines prevalence, screening, surgical outcomes, consent, and referral in aesthetic plastic surgery. A documented PubMed update was undertaken on 30 October 2026, supplemented by reference tracing, full-text retrieval, and professional guidance. Primary studies were interpreted only when their methods and results could be examined in full text; secondary syntheses were identified separately.

The evidence requires three distinctions: appearance dissatisfaction versus BDD, screening positivity versus a confirmed diagnosis, and satisfaction with an operated feature versus improvement in the disorder. Prevalence estimates vary substantially with recruitment and assessment method. Screening instruments differ in content, reference standards, and validation populations; none independently determines surgical suitability. Psychiatric BDD cohorts report little sustained global improvement after cosmetic procedures. Selected rhinoplasty cohorts describe postoperative symptom or functional improvement, but some exclude previously diagnosed BDD, use screening thresholds rather than diagnostic interviews, and have substantial attrition. These findings do not establish aesthetic surgery as treatment for BDD or validate a subgroup of patients with active BDD for surgery.

Clinical assessment should integrate the anatomical indication with preoccupation, repetitive behaviors, impairment, insight, comorbidity, expectations, and safety. Suspected or diagnosed BDD warrants assessment by a mental health professional with relevant expertise before elective aesthetic intervention. Deferral should include an explained referral pathway and access to evidence-based treatment. The proposed clinical framework is a reasoning aid, not a validated prediction rule.

Categories: Plastic Surgery, Psychiatry, Psychology
Keywords: aesthetic surgery, bddq-as, body dysmorphic disorder, cosmetic surgery, patient satisfaction, patient selection, plastic surgery, screening

Introduction And Background

Aesthetic plastic surgery comprises elective operations undertaken primarily to change physical appearance rather than to restore function or repair disease, injury, or congenital abnormality. Functional and aesthetic objectives can coexist. Rhinoplasty is surgery that changes nasal shape or structure; septorhinoplasty also addresses the nasal septum and may aim to improve breathing. These distinctions matter because an improvement in nasal obstruction after a combined procedure is not evidence that an operation treats psychiatric illness. Professional guidance requires assessment of motivation, expectations, and psychological suitability alongside the proposed physical change [1].

Body dysmorphic disorder (BDD) is an obsessive-compulsive and related disorder involving preoccupation with perceived appearance defects that are unobservable or slight to others, associated repetitive behaviors or mental acts, and clinically significant distress or functional impairment. Concerns better explained by body fat or weight in an eating disorder require a different diagnostic formulation. Insight ranges from good or fair recognition of possible exaggeration to absent insight or delusional conviction. Ordinary dissatisfaction, subthreshold dysmorphic symptoms, and a diagnosis of BDD should therefore remain distinct [2].

In this review, screen-positive means that an individual meets a named questionnaire's prespecified screening rule; screen-negative means that the rule is not met. Neither term establishes whether diagnostic criteria are fulfilled. Unless a diagnostic assessment is reported, postoperative conversion from screen-positive to screen-negative is described as a change in screening status, not psychiatric remission [3].

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The surgeon must determine whether a requested anatomical change can reasonably address the patient's stated problem and whether the expected benefit justifies an irreversible intervention. This review examines how the evidence should inform that decision, with particular attention to diagnostic uncertainty, selection bias, and differences between local surgical satisfaction and overall psychological health.

Review

Literature retrieval and critical appraisal

The manuscript was revised in October 2026, with a documented evidence update on 30 October 2026. PubMed/MEDLINE was the bibliographic database searched. Searches were supplemented by reference tracing and targeted retrieval from journal websites, PubMed Central, Europe PMC, institutional or author repositories, and official guidance websites. These routes supplied full texts and bibliographic checks; Embase, Scopus, Web of Science, and PsycINFO were not searched independently. The exact PubMed queries are reproduced in the supplementary search details (Appendices).

Searches addressed surgery and outcomes, screening instruments, and psychiatric morbidity or treatment. Instrument abbreviations were searched alongside their full names: Body Dysmorphic Disorder Questionnaire (BDDQ), its Dermatology Version (BDDQ-DV) and Aesthetic Surgery version (BDDQ-AS), Cosmetic Procedure Screening Questionnaire (COPS), Body Dysmorphic Symptoms Scale (BDSS), and Body Dysmorphic Disorder Screening Test (BDD-ST). These are instrument names, not interchangeable diagnostic terms.

Eligible material comprised English-language full-text human studies and evidence syntheses relevant to BDD prevalence, assessment, elective aesthetic treatment, outcomes, ethics, or psychiatric care. Cross-sectional prevalence studies, instrument development and validation studies, prospective and retrospective cohorts, randomized psychiatric treatment trials, critical or systematic reviews, meta-analyses, and professional guidance were eligible. Adult aesthetic practice was the principal setting; mixed-age, reconstructive, functional nasal surgery, dermatological, or psychiatric samples were retained when they clarified a relevant question, with their applicability stated. Directly cited journal reports span 2010-2026; the professional guidance includes the 2005 National Institute for Health and Care Excellence (NICE) guideline, consulted in its current online form.

Non-English reports without an English full text, conference abstracts, isolated case reports, purely promotional material, duplicate reports without additional relevant information, and reports whose substantive methods and results could not be examined in full text were excluded from direct study-level synthesis. Full text meant a complete publisher report or complete repository or author manuscript, irrespective of whether the journal itself was open access. Abstracts were used for identification and bibliographic checks, not to infer selection criteria, methodological quality, or treatment efficacy. Where a full-text review supplied secondary evidence, its findings were attributed to that review rather than represented as independent appraisal of every underlying study.

The synthesis was purposive rather than exhaustive. Appraisal considered recruitment, diagnostic or screening definitions, instrument versions and reference standards, reasons for offering surgery, comparators, follow-up, attrition, concurrent treatment, outcome domains, and the distinction between patients and procedures as denominators. No independent duplicate selection, formal risk-of-bias scoring, or new meta-analysis was performed. Published pooled estimates are reported with their original setting and assessment approach and are not combined into a new estimate.

Prevalence by population and assessment method

Kaleeny and Janis reported a pooled estimate of 18.6% (95% confidence interval (CI), 15.1%-22.4%) across 65 studies and 17,107 participants in aesthetic, reconstructive, and related clinical settings. Between-study heterogeneity was substantial (I^2 = 97.27%). Differences in recruitment and assessment limit interpretation of this pooled proportion as the probability that an unselected aesthetic patient has clinician-confirmed BDD [4].

McGrath et al. required a structured diagnostic interview and reported a pooled estimate of 20.0% (95% CI, 10.0%-36.0%) in the cosmetic/dermatology subgroup, comprising nine studies. Their total sample of 7,159 participants covered 22 studies across all settings and is not the cosmetic subgroup denominator. Heterogeneity persisted within that subgroup (I^2 = 94.70%), and convenience sampling limited generalizability. Interview-based ascertainment therefore improves diagnostic specificity without removing recruitment bias [5].

Table *1* separates selected estimates by assessment approach. The differences cannot be attributed to the questionnaire alone because the populations, procedures, languages, and inclusion criteria also differ. No estimate in the table independently establishes severity, insight, suicidality, or surgical suitability.

Evidence and population	Assessment	Estimate	Interpretive limit
McGrath et al. 2023 [5]; nine cosmetic or dermatology studies	Structured diagnostic interviews	20.0% 95% CI 10.0%-36.0%	Subgroup estimate; substantial heterogeneity. The 7,159 participants belong to the full 22-study review.
Kaleeny and Janis 2024 [4]; 65 studies; 17,107 participants	Heterogeneous instruments and clinical settings	18.6% 95% CI 15.1%-22.4%	Mixed aesthetic, reconstructive, and related settings; not a uniform diagnostic-interview estimate.
Lekakis et al. 2016 [6]; 116 aesthetic rhinoplasty patients	BDDQ-AS screening rule	47% 55/116	Screening positivity; reference comparison used a symptom-severity threshold.
Ramos et al. 2016 [7]; 80 rhinoplasty candidates	BDSS symptom threshold	46% 37/80	Selected validation sample; symptom classification is not a population diagnostic estimate.
Rabaioli et al. 2022 [8]; 131 rhinoseptoplasty candidates	BDDE symptom threshold	38% 50/131	Previous BDD diagnosis was an exclusion criterion; diagnostic confirmation was not established by the threshold.
Kuehl et al. 2026 [9]; 95 functional septorhinoplasty patients	BDDQ-AS; 82 valid results	36.6% 30/82	Denominator is the subgroup with valid screening data, not all 95 participants.

TABLE 1: Selected prevalence and screening estimates grouped by assessment approach

Percentages reproduce the authors' reported rounding. These estimates describe different constructs and populations and have not been pooled.

BDD, body dysmorphic disorder; BDDE, Body Dysmorphic Disorder Examination; BDDQ-AS, Body Dysmorphic Disorder Questionnaire-Aesthetic Surgery; BDSS, Body Dysmorphic Symptoms Scale; CI, confidence interval

A consistent assessment process gives every patient an opportunity to disclose symptoms that may be missed in an unstructured consultation. Its findings must then be interpreted for that individual. A pooled prevalence estimate supplies context for case finding; it cannot substitute for the patient's history or diagnostic assessment.

Rhinoplasty evidence also requires particular restraint. Patients attending a tertiary rhinology service, those seeking an aesthetic change alone, and those seeking relief of obstruction are not equivalent populations. Findings should not be transferred automatically to breast surgery, body contouring, genital aesthetic surgery, or reconstructive indications [8,9].

Psychiatric morbidity and safety

Depression is common in clinically diagnosed BDD. In Crerand et al.'s 200-person BDD cohort, lifetime major depressive disorder was present in 149 participants (74.5%), calculated from the reported subgroup counts of 33 and 116. This is a lifetime estimate in a psychiatric research sample, not the prevalence of current depression among screen-positive aesthetic patients [10].

Assessment must address distress, functional restriction, comorbid depression, self-harm, and suicidal thoughts. NICE recommends suicide and self-harm risk assessment in diagnosed BDD, particularly with depression, and specialist mental health assessment for suspected or diagnosed BDD in people seeking cosmetic treatment. Acute safety concerns require timely clinical escalation rather than continuation of elective planning [11].

A technically feasible operation does not resolve an immediate psychiatric safety problem. Conversely, an elevated questionnaire score alone should not be used to assign an individual the suicide risk observed in a psychiatric cohort. The clinical response depends on what direct assessment establishes.

Screening instruments and the limits of validation

Screening has value only when the result is linked to assessment and an appropriate response. The BDDQ organizes questions around appearance concern, preoccupation, consequences, and time occupied. The BDDQ-DV adapts this approach for dermatological practice and introduces graded ratings of distress or impairment. Published forms can count blocks, subquestions, and free-text prompts differently; the instrument version and scoring rule should therefore accompany a reported result [3,12].

The COPS contains nine scored items, sometimes preceded by an unscored prompt identifying the features

of concern. In its original development study, 97 people with BDD and 108 community participants seeking cosmetic change were compared. The design supports discrimination between those groups; it does not validate COPS as a prediction rule for benefit from surgery. Its nine scored items each range from 0 to 8, producing a total of 0-72, with a referral threshold of 40 or above in the original report [13].

The BDDQ-AS contains seven items and was studied in 116 aesthetic rhinoplasty patients. Its reported sensitivity of 89.6% and specificity of 81.4% were calculated against a threshold on the Yale-Brown Obsessive-Compulsive Scale Modified for Body Dysmorphic Disorder (BDD-YBOCS), a symptom severity measure, rather than an independent structured diagnostic interview. Those figures should not be presented as unrestricted diagnostic accuracy for BDD across aesthetic procedures [6].

Table *2* compares six instruments used or discussed in aesthetic practice and distinguishes the strength and scope of their supporting evidence. The BDSS has psychometric evidence for a Brazilian-Portuguese adaptation; this does not validate every language version or establish universal thresholds. The BDD-ST should not be described as equivalently validated merely because its component questions originated in established instruments [3,7].

Instrument	Number and type of items	Principal content	Evidence and limitations
Body Dysmorphic Disorder Questionnaire [3]	Four question blocks, commonly counted as nine questions or subquestions; binary responses and a time category	Appearance concern, preoccupation, weight-related differential, distress, functional impact, avoidance, and time occupied	A screen requiring clinical interpretation; report the exact version and rule. Its content differs from the dermatology adaptation.
Body Dysmorphic Disorder Questionnaire-Dermatology Version [12]	Seven core symptom questions; binary and graded distress or impairment responses, with explanatory free-text prompts	Appearance concern and preoccupation; severity of distress and effects on social or occupational functioning	Adapted for dermatological settings. A Polish study assessed translation and reliability in 26 patients, not diagnostic accuracy against an independent interview.
Body Dysmorphic Disorder Questionnaire-Aesthetic Surgery [6]	Seven items: three binary and four 5-point items	Concern, preoccupation, distress, interference in daily roles, and avoidance	Rhinoplasty-specific development; reported accuracy used a BDD-YBOCS severity threshold as the comparator. It is not a diagnostic interview.
Cosmetic Procedure Screening Questionnaire [13]	Nine scored 0-8 items; some forms add an unscored feature-identification prompt	Checking, perceived unattractiveness, distress, avoidance, preoccupation, relationships, work or study, social life, and appearance's importance to identity	Total 0-72; the original referral threshold was at least 40. Group discrimination and reliability do not establish individual surgical benefit.
Body Dysmorphic Symptoms Scale [7]	10 yes/no items	Appearance beliefs, checking or avoidance, camouflage, expectations of cosmetic treatment, and safety-related symptoms	The Brazilian-Portuguese adaptation showed psychometric properties in 80 candidates. Its threshold and performance cannot be assumed for every language or procedure.
Body Dysmorphic Disorder Screening Test [3]	20 questions combining BDDQ-DV and BDDE content	Mixed questions about appearance preoccupation, distress, functioning, and related symptoms	As described in the cited full-text review, nine questions were drawn from BDDQ-DV and 11 from BDDE. The combined approach lacks equivalent validation against an independent diagnostic interview.

TABLE 2: Content and interpretation of six body dysmorphic disorder assessment instruments

Question counts follow the described instrument versions; totals can differ when question blocks, subquestions, and free-text prompts are counted separately. A severity measure, a screening questionnaire, and a diagnostic interview serve different purposes. None of these tools independently determines suitability for surgery.

BDD-YBOCS, Yale-Brown Obsessive-Compulsive Scale Modified for Body Dysmorphic Disorder

Sensitivity and specificity concern classification against a particular reference standard. Predictive values

also depend on prevalence in the population tested. Neither a satisfactory reliability coefficient nor a correlation with another symptom scale demonstrates that screening improves surgical outcomes. A negative result remains subject to incomplete disclosure and does not override concerning history or behavior; a positive result requires clarification rather than automatic diagnostic labelling [14,15].

Surgical outcomes requiring distinct populations and endpoints

Crerand et al. evaluated a cohort with established BDD using retrospective accounts of cosmetic treatment. Among 87 surgical or minimally invasive procedures received by 42 participants, only two procedures (2.3%) were associated with reported longer-term improvement in overall BDD symptoms. Outcomes were counted by procedure, not by patient. Retrospective recall and psychiatric recruitment limit causal and generalizable conclusions, but the study distinguishes improvement in a treated feature from improvement in the disorder [10].

Lekakis et al. found lower postoperative nasal satisfaction in the BDDQ-AS-positive group at 12 months. This supplies prognostic information about a selected surgical cohort, while its screening-based grouping and lack of a nonoperative comparison prevent conclusions about the effectiveness of surgery for diagnosed BDD [6].

Rabaioli et al. followed 131 rhinoseptoplasty candidates, of whom 50 met the study's preoperative symptom threshold. Crucially, the study excluded a previous BDD diagnosis, unrealistic surgical motivations, and technically unattainable objectives. Symptom scores and nasal outcomes improved after surgery, but outcome questionnaires were available for 75 patients at six months. This selected, diagnostically unconfirmed cohort cannot establish remission of pre-existing diagnosed BDD. The group with the highest initial symptom scores also had lower absolute postoperative aesthetic satisfaction despite improvement from baseline [8].

A 2026 prospective functional septorhinoplasty study by Kuehl et al. adds a different outcome perspective. Among 95 participants, 82 had valid BDDQ-AS data, and 30 screened positive. Screening positivity was associated with greater improvement in a nasal quality-of-life score in univariate analysis, but it was not independently associated with improvement in the multivariable models. The endpoint was nasal health-related quality of life, not BDD remission. The study illustrates how baseline burden, functional indication, and adjustment can change the interpretation of an apparent association [9]. Table *3* summarizes the surgical outcomes.

Study and design	Population and assessment	Principal finding	What the finding establishes
Crerand et al. 2010 [10]; retrospective treatment accounts	200 participants with BDD; 42 received 87 surgical or minimally invasive procedures	Reported longer-term global BDD improvement followed 2/87 procedures (2.3%).	Procedure-level retrospective outcomes distinguish local change from global illness. Psychiatric recruitment and recall limit generalizability.
Lekakis et al. 2016 [6]; prospective validation and outcome study	116 aesthetic rhinoplasty patients; BDDQ-AS-defined groups	Screen-positive patients had lower nasal satisfaction at 12 months.	Prognostic association in a surgical cohort; no demonstration of a treatment effect for diagnosed BDD.
Rabaioli et al. 2022 [8]; prospective cohort	131 baseline candidates; 75 six-month outcome questionnaires; previous BDD diagnosis excluded	Symptoms and nasal outcomes improved, but the highest-symptom group had lower final aesthetic satisfaction.	Selected, diagnostically unconfirmed population; attrition and combined functional indications limit inference about psychiatric remission.
Kuehl et al. 2026 [9]; prospective functional septorhinoplasty cohort	95 patients; 82 valid BDDQ-AS results; nasal quality of life at 12 months	Screening positivity related to improvement in univariate analysis, but was not an independent predictor in multivariable models.	Association depends on adjustment and baseline burden. Nasal quality of life is distinct from BDD remission.

TABLE 3: Selected full-text studies and the limits of surgical outcome interpretation

These studies have different populations, denominators, and endpoints. Their sample sizes are not combined, and postoperative improvement is not interpreted as proof that surgery treats BDD.

BDD, body dysmorphic disorder; BDDQ-AS, Body Dysmorphic Disorder Questionnaire-Aesthetic Surgery

These studies answer different questions. A reduction in symptom score after surgery, an association between preoperative symptoms and satisfaction, and improvement in global BDD are distinct outcomes. Even improvement from baseline may coexist with a poorer final outcome than that of a lower-risk group. Without suitable comparison groups, postoperative change cannot be attributed wholly to surgery; concurrent care, natural fluctuation, regression toward the mean, and selection of patients considered suitable remain plausible influences.

Screening-positive cohorts must not be relabeled uniformly as subclinical: some participants may have undiagnosed BDD. Equally, they must not be assumed to have a confirmed disorder. The appropriate description is screening-defined or diagnostically unconfirmed unless the study demonstrates otherwise. Current evidence does not establish elective aesthetic surgery as treatment for BDD or supply validated criteria identifying patients with active BDD who will benefit safely [16].

Clinical assessment beyond the questionnaire

Assessment should establish the requested anatomical change, its technical feasibility, and the patient's expected outcome. The history should explore time spent thinking about appearance, checking, comparison, camouflage, reassurance seeking, avoidance, and interference with work or relationships. Repeated consultations, dissatisfaction migrating between features, or requests for unattainable perfection warrant exploration in context. No isolated feature establishes a diagnosis [15].

Expectations should be specific enough to discuss against the operation's limits. A request to reduce a dorsal hump describes an anatomical objective; a belief that surgery will guarantee relationship success or remove all fear of judgement describes a broader psychological expectation. Neither statement alone diagnoses BDD, but the latter requires further assessment before consent can be considered adequate [17].

Previous dissatisfaction must also be investigated fairly. A patient may have a genuine complication, functional problem, or communication concern. Psychiatric explanations should not displace examination of an objective surgical problem. Mental health assessment and appropriate physical care can proceed together [15].

Consent professional responsibility and referral

A BDD diagnosis does not by itself establish incapacity. The UK General Medical Council's consent guidance requires a presumption of adult capacity and assessment for a particular decision at a particular time; application must follow the relevant legal framework. Assessment should address understanding, retention, use of relevant information, and communication of a decision [18]. The discussion should include the proposed change, limitations, complications, alternatives, and possible persistence of distress. A patient's preference does not oblige a surgeon to offer an intervention whose likely net benefit is unfavorable [17].

Consent should distinguish anatomical improvement from psychological treatment and should address residual asymmetry, uncertainty of satisfaction, and the additional physical risks of revision. Deferral or refusal should be explained respectfully and linked to appropriate assessment, rather than communicated as a judgement about the legitimacy of the patient's suffering. Neither diagnostic assessment nor mental health referral is a guarantee of a satisfactory surgical outcome [15,17].

Professional guidance and implementation

The Medical Board of Australia's guidance, effective from 1 July 2023, requires the practitioner who will perform cosmetic surgery to assess psychological suitability using a validated BDD screening tool and document the process and outcome. Significant underlying psychological concerns that may make surgery unsuitable require referral to an independent psychologist, psychiatrist, or general practitioner. These are Australian requirements, not a universal international rule [1].

NICE provides a complementary clinical recommendation: people with suspected or diagnosed BDD seeking cosmetic surgery or dermatological treatment should be assessed by a mental health professional with specific BDD expertise. Screening and referral systems should be agreed between relevant services [11].

Implementation evidence should be interpreted separately from diagnostic accuracy. Haines et al.'s 2026 Australian survey received 136 responses, a 27% response rate. Respondents reported low confidence in screening tools and variable referral experience. These self-reported practice data cannot estimate patient-level sensitivity, determine the true prevalence of BDD, or establish whether screening prevents harm. They identify practical questions about training, referral access, and consistent use of instruments [19].

Digital images and appearance expectations

Social media exposure and edited self-images can shape the material a patient brings to consultation. Mironica et al.'s systematic review describes associations with body dissatisfaction and consideration of cosmetic procedures, but heterogeneous and predominantly observational evidence cannot establish that

social media causes BDD [20].

A filtered photograph is therefore relevant to the discussion of expectations, not a diagnostic test. Examination and standardized clinical photographs should help determine whether the desired change is stable and anatomically achievable. Whether newer synthetic images alter long-term dysmorphic symptoms or revision requests remains a research question rather than an established causal explanation.

Evidence-based care when surgery is deferred

Referral should explain that the distress deserves treatment and that an operation cannot be relied upon to address the underlying disorder. BDD-specific cognitive behavioral therapy (CBT) and serotonin reuptake inhibitors are established treatment approaches; medication selection and monitoring belong within an appropriate mental health treatment plan. There is no equivalent evidence base establishing cosmetic surgery as a psychiatric treatment [16].

Randomized evidence provides a useful comparator to uncontrolled surgical observations. Enander et al. randomized 94 adults with diagnosed BDD to therapist-guided internet CBT or online supportive therapy. At treatment completion, three months from baseline, the symptom-scale difference favored CBT by 7.1 points (95% CI, 4.4-9.8 points). At six months from baseline, 56% versus 13% were classified as responders. Response was defined as a reduction in symptoms and was distinct from no longer meeting diagnostic criteria. Participants were selected for trial suitability, including psychiatric safety; these results do not justify internet treatment as a substitute for urgent care [21].

Wilhelm et al.'s smaller randomized study of modular CBT also supports a structured treatment approach addressing appearance beliefs, avoidance, and rituals. Its waitlist comparison and small sample limit the precision of treatment-effect estimates. The relevant message for the surgeon is that deferral can lead to active, evidence-based care rather than an unexplained denial of treatment [22].

Implications and limitations

The review supports assessment that connects a screening result to diagnosis, treatment needs, and a reasoned surgical decision. Services need an agreed referral route, documentation of the anatomical indication and psychological expectations, and a plan for follow-up. A low screening score alone is insufficient justification to proceed when the consultation identifies clinically important concerns. A positive score alone is insufficient justification to diagnose BDD.

The strongest unresolved issue is whether any clearly defined group with confirmed, treated BDD can later undergo elective aesthetic surgery with acceptable long-term psychological outcomes. A past diagnosis need not imply unchanged symptoms, but symptomatic improvement is not surgical clearance. Reconsideration requires individual surgical and specialist mental health assessment; no validated symptom score or universal period of stability establishes safety [15,16].

Research should recruit consecutive candidates, including patients whose surgery is deferred or declined, and document diagnostic assessment, severity, insight, treatment exposure, and reasons for selection. Outcomes should distinguish function, appearance satisfaction, global BDD symptoms, depression, symptom migration, revision requests, and adverse events. Longer follow-up and appropriate nonoperative comparisons are needed to test clinical benefit rather than simply describe postoperative change.

This narrative review is limited by purposive selection, one bibliographic database, English-language eligibility, absence of independent duplicate selection or formal risk-of-bias scoring, and incomplete access to some original reports. Excluding abstract-only evidence improves the basis of study-level interpretation but may omit relevant literature and introduce availability bias. The retained evidence is heterogeneous, often observational, and concentrated in selected nasal surgery populations. Evidence syntheses may contain overlapping primary studies and have not been treated as independent patient cohorts. These limitations preclude a universal surgical eligibility rule.

Proposed practical framework for surgical decision-making

Table *4* translates the preceding assessment and referral principles into an author-proposed clinical framework [1,11,15,16]. It has not been prospectively validated and should not be used as a score-based eligibility algorithm. A specialist opinion informs the surgical decision but does not transfer the surgeon's responsibility for indication, consent, and expected benefit.

Clinical presentation	Assessment priority	Suggested clinical response
Screen-negative with a discrete anatomical concern and realistic expectations	Complete the history, physical examination, and routine assessment of indication and consent.	Continue ordinary surgical assessment while investigating any concerns arising despite the negative result.
Screen-positive or concerning dysmorphic symptoms without a confirmed diagnosis	Clarify impairment, repetitive behaviors, insight, expectations, comorbidity, and safety.	Arrange appropriate diagnostic assessment when BDD is suspected; follow applicable referral requirements. Do not decide from the score alone.
Diagnostic uncertainty or unresolved expectations that compromise the assessment of benefit	Establish whether the proposed anatomical change can address the patient's stated problem.	Defer elective intervention while assessment and treatment needs are clarified; provide a documented referral and follow-up plan.
Confirmed active BDD	Specialist BDD assessment and treatment, including comorbidity and risk.	Defer elective aesthetic surgery directed at the dysmorphic concern and prioritize evidence-based mental health care.
Active self-harm, suicidal intent, or another acute psychiatric safety concern	Prompt assessment of immediate safety and appropriate escalation.	Pause elective planning and arrange urgent care through appropriate local clinical services.
History of treated BDD with apparent sustained improvement	Individual assessment of current symptoms, stability, anatomical indication, expectations, and relapse concerns.	Consider any renewed request jointly with relevant mental health expertise. There is no validated clearance threshold or guarantee of benefit.

TABLE 4: Author proposed framework for assessment and elective surgical decisions

BDD, body dysmorphic disorder

This framework is proposed by the authors from the reviewed evidence and guidance [1,11,15,16]. It is not prospectively validated, a diagnostic instrument, or a prediction model. It addresses elective aesthetic decisions; a psychiatric diagnosis does not remove the need to assess genuine physical disease or surgical complications.

The framework gives priority to psychiatric safety, diagnostic clarification, and a coherent anatomical indication. When surgery is deferred, the patient should receive an explanation, a referral route, and clarity about follow-up. Urgent physical problems and genuine surgical complications require appropriate assessment irrespective of the elective aesthetic decision.

Conclusions

BDD assessment belongs within aesthetic surgical care because a technically successful anatomical change may leave the disorder's preoccupation, rituals, and impairment unresolved. Screening can support recognition, but screening status, diagnostic confirmation, severity, and surgical suitability are different judgements.

Selected rhinoplasty studies show postoperative improvement in some screening-defined populations. Their diagnostic limitations, selection processes, outcome definitions, and follow-up prevent interpreting those observations as evidence that aesthetic surgery treats BDD. Suspected or diagnosed BDD requires appropriate mental health assessment before elective aesthetic intervention. Deferral should lead to an explained pathway to evidence-based care. Future research must evaluate durable psychological and functional outcomes across the whole assessment pathway, including patients who do not undergo surgery.

Appendices

Supplementary search details

The following PubMed queries were executed on 30 October 2026. They document the targeted update and are not presented as an exhaustive systematic-review strategy. No language filter was applied at search; English-language full-text eligibility was applied during selection. The publication date boundary was 30 October 2026.

Surgery and Surgical Outcomes

("body dysmorphic disorder"[Title/Abstract] OR "body dysmorphia"[Title/Abstract]) AND (rhinoplasty[Title/Abstract] OR "cosmetic surgery"[Title/Abstract] OR "aesthetic surgery"[Title/Abstract] OR "plastic surgery"[Title/Abstract]) AND ("1900/01/01"[Date - Publication] : "2026/10/30"[Date - Publication])

Screening and Assessment Instruments

"body dysmorphic disorder"[Title/Abstract] AND (screening[Title/Abstract] OR BDDQ[Title/Abstract] OR "BDDQ-DV"[Title/Abstract] OR "BDDQ-AS"[Title/Abstract] OR COPS[Title/Abstract] OR "Body Dysmorphic Symptoms Scale"[Title/Abstract] OR "BDD-ST"[Title/Abstract] OR Vulink[Author]) AND ("1900/01/01"[Date - Publication] : "2026/10/30"[Date - Publication])

Psychiatric Morbidity and Treatment

"body dysmorphic disorder"[Title/Abstract] AND (depression[Title/Abstract] OR suicidality[Title/Abstract] OR "cognitive behavio*"[Title/Abstract] OR fluoxetine[Title/Abstract] OR "serotonin reuptake"[Title/Abstract]) AND ("1900/01/01"[Date - Publication] : "2026/10/30"[Date - Publication])

Reference tracing and targeted retrieval additionally addressed professional guidance, consent, social media, and named studies in the submitted manuscript. Official guidance was checked through the Medical Board of Australia, NICE, and the UK General Medical Council. Full reports were retrieved from publishers, PubMed Central or Europe PMC, and institutional or author repositories. Reports unavailable in full text were not used for independent study-level interpretation. Search-result totals are not reported as a PRISMA flow because selection was purposive and the overlapping searches were not managed as an exhaustive systematic review.

Additional Information

Author Contributions

All authors have reviewed the final version to be published and agreed to be accountable for all aspects of the work.

Concept and design: Daniel Gravino, Kyle Attard

Acquisition, analysis, or interpretation of data: Daniel Gravino, Kyle Attard

Drafting of the manuscript: Daniel Gravino, Kyle Attard

Critical review of the manuscript for important intellectual content: Daniel Gravino, Kyle Attard

Supervision: Daniel Gravino

Disclosures

Conflicts of interest: In compliance with the ICMJE uniform disclosure form, all authors declare the following: **Payment/services info:** All authors have declared that no financial support was received from any organization for the submitted work. **Financial relationships:** All authors have declared that they have no financial relationships at present or within the previous three years with any organizations that might have an interest in the submitted work. **Other relationships:** All authors have declared that there are no other relationships or activities that could appear to have influenced the submitted work.

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