Diogenes syndrome: a case report

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INTRODUCTION

A rare syndrome, variously known as Diogenes syndrome (Clarke et al, 1975), senile breakdown (MacMillan and Shaw, 1966) and senile squalor, is characterized by extreme self-neglect, domestic squalor, social withdrawal, apathy, tendency to hoard rubbish and a blissful unconcern about one's living condition. It is periodically encountered among the elderly, and debate continues regarding the exact cause of the condition. A typical case with severe frontal lobe atrophy is presented.

DISCUSSION

The annual incidence of this condition has been estimated as 0.5 per 1000 of population over the age of 60 years. The term was originally suggested by Clarke et al (1975) and gets its name from Diogenes, the ascetic Greek philosopher of the 4th century BC. Diogenes lived as a vagabond beggar and advocated the principles of self-sufficiency and contentment unrelated to material possessions (there is no evidence that people living in senile squalor hold these core values).

Several case series of the syndrome has been described in the past (MacMillan and Shaw, 1966; Clarke et al, 1975; Orrell et al, 1989; Shah, 1992; Wrigley and Cooney, 1992) and multiple hypotheses have been advanced to explain the condition. There is a consensus that at least half of the cases do not suffer from a diagnosable mental illness, while the rest have been diagnosed with personality disorders, alcoholism, dementia or mild depression. Orrell and Sahakian (1991), in their case report, demonstrated frontal lobe dysfunction on neuropsychological testing and hypothesized that Diogenes syndrome is a manifestation of frontal lobe dementia.

It is not yet clear why the patients remain so oblivious to the tremendous stench around them, something that is unbearable to the nostrils of an average person. To the best of the author's knowledge, this is the first time that a specific inability in identifying the smell of excrement has been demonstrated by clinical test, and it is tempting to relate this to atrophy of frontal lobe (damage to which is known to cause disorders of olfaction).

Whatever the cause, it is agreed that prognosis of such cases are poor, something that became obvious in this case within a month of discharge from hospital.

CASE REPORT

The liaison psychiatry unit of University Hospitals Aintree received a referral from the maxillo-facial surgery unit for a 72-year-old man. He had been admitted in January 1998 under Section 47 of the National Assistances Act 1948 with a large fungating tumour on his forehead.

The admission was initiated by his downstairs neighbour who called the GP after failing to elicit any response from the man, especially after noticing a foul smell coming from his flat. The patient had not been seen outside since November 1997 after a burglary in his flat. The neighbour had been pushing in some food through his letter-box for the last 6 months.

The flat was cluttered with rubbish, infested with vermin, and excrement was smeared over the furniture, walls and the floor. The sink was overflowing with urine and the stench emanating was unbearable. When the appalling conditions were pointed out to him, he remained blissfully unconcerned and could not understand why all the fuss was being made about him.

He was anaemic and grossly malnourished with a body mass index of 14. Two units of blood were transfused before the tumour (basal cell carcinoma) was successfully excised.

Psychiatric examination revealed an elderly man, who had been living alone for the last 40 years after an acrimonious divorce because of his alcohol-related problems. He had 5 children but did not have any contact with them and had led a reclusive and solitary life since the divorce.

Mental state examination revealed no psychopathology. He scored 28 out of 30 on mini mental state examination. However, he exhibited several signs of frontal lobe dysfunction on bedside testing. A computed tomography scan showed severe frontal lobe atrophy. Clinical tests of olfaction revealed no abnormalities in detection of smell of common objects (coffee, tea, onion, ginger, orange, vanilla), except that the patient could not identify the smell of excrement from a soiled pad.

After recovering from the surgery, he was transferred to a general residential home. After a month he started relapsing again and then had to be transferred to a elderly mentally infirm (EMI) nursing home where he is presently doing well.

CONCLUSIONS

This case demonstrates almost all the typical features of Diogenes syndrome. Frontal lobe atrophy and the peculiar abnormality of smell may give some clues to the aetiology, but more neuroimaging, neuropathological and neurophysiological (evoked potential) studies are required in the future for a clearer understanding of the aetiology of the syndrome. HM

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