

Anorexia Nervosa with Binge Eating : A Case Report

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ABSTRACT:

Anorexia nervosa is regarded as a typical culture bound syndrome, and its existence is negligible in nonwestern countries due to protective biological and socio-cultural factors. Most of the cases reported from nonwestern countries are atypical in presentation with lack of body image disturbances. Recent studies showed that anorexia nervosa is no more culture bound, in fact it is a "culture change syndrome" due to westernization and no differences are seen in the phenomenology of anorexia nervosa between the two cultures. We report a typical case of anorexia nervosa of binge eating and purging type associated with body dysmorphophobia in an adolescent girl.

Key words : Anorexia Nervosa, Culture bound syndrome, binge eating

Anorexia nervosa has been reported rarely from the third world countries before the 20th century. Recently, however, several reports have been published from 1977 onwards notably from China, Hong Kong, Malaysia, Pakistan and India (Hsu et al., 1996). As has been found in various studies done in the Asian population, the fear of fatness or body image distortion or weight phobia were typically not found in the patients purported to be anorexics. Till recently, negligible number of patients of these countries actually fulfilled all the diagnostic criteria according to the DSM-IV or the ICD-10 to achieve a diagnosis of anorexia nervosa.

To our knowledge, this is probably the first case report from Indian subcontinent in which an adolescent girl exhibited all features of anorexia nervosa including binge eating and purging type behavior.

CASE

Ms. B was a 20 year old, single Hindu female. She was a graduate student in her 2nd year and

had a four and a half year duration of illness when she presented to us. Her premorbid weight was 47 kg.

Her illness started during a course of fashion designing that she was pursuing. For this course she had to shift to an aunts house in a different city. The aunt was quite particular about her own food intake and would keep a strict watch over her own daughters caloric intake. At her college, MS.B was the youngest student and was in the company of weight and figure conscious elders. In this environment B remembered that a remark by a friend that she looked obese prompted her to decrease her diet and start exercising regularly. She decreased intake of fat and carbohydrates and started taking only salads, fruit and juices. This was accompanied by vigorous workout everyday. The aim was to get thin. She reportedly "felt fat". Her weight dropped to 38 kg in the next 4 months and she developed amenorrhoea. She would cook for herself and did not eat any food cooked by anyone else and would clean out all the utensils to clear the last vestiges of cooking oil or fat. She reportedly used to feel that she was still obese, that her body was swollen and disfigured due to her obesity. She was apparently unaware of the relationship of height and appropriate weight for health. Over the next two years MS. B returned to her hometown and for a few months increased her food intake marginally and then decreased it again reporting

that if she kept eating all the "fatty food" her body would be disfigured and that she felt herself to be ugly. Eventually her diet included only boiled vegetables, soups and limited fruits.

Two and a half years after the onset of illness, a physician explained to her about the relationship between adequate weight for her age and height and how it was important for her to be in a particular weight range to be healthy. That was the first time, MS.B remembered, that she became aware of her weight. At that time she reportedly weighed 35 kg and the appropriate weight for her was calculated by a physician as 45 kg. Since that time till presentation to us, MS.B had kept close watch on her weight and her total caloric intake everyday. From this time onwards, (i.e. 2 years) she also started having bingeing episodes where she would eat large quantities of sweet and fried foods on one day and then have no solids or even semi-solid at all for the next several days. She also started using laxatives like isabgol 4 teaspoon after her periodic binges, which would occur approximately once in a 2 weeks.

MS.B's weight remained in the range of 32 - 36 kg in these two years and she was 34.5 kg when she presented to us after a four and half year of illness. Her height was 5 ft 2 inches and her Quetelet's body mass index was less than 17.5, she gave her reason for not eating as discomfort in the abdomen when she ate a slightly larger than usual quantity and reported that she did not at that time have an attractive figure. She would prefer redistribution of her body fat in a more attractive manner and felt that she was large at her waist. She drew her figure as she saw herself on paper with a paunch, flat chest and extremely thin legs. On the other hand, she acknowledged that she was underweight for her age by atleast 10 kg and expressed a desire to achieve a target weight of 45 kg. She was eager, in fact to increase her diet in special category of fat free food to become "healthy".

On examination, she had lanugo hair on her face and had signs of emaciation, poor nutrition and poorly developed secondary sexual characters. Pulse was 54 /minute, blood pressure was 88/60 mm of Hg. An opinion from gastroenterologist was sought and appropriate investigations were conducted including endoscopy, barium swallow and meal, abdominal ultrasound and X-Ray chest. All investigations were within normal limit except Hb, which was 8 gm%. Her anemia was corrected by giving iron and B-Complex preparation (Hb=10.5 gm%)

At follow ups, she could not steadily improve her weight due to parental conflict and severe pressure from mother to eat solid foods. Her poor interpersonal relationship and parental conflicts were expounded in detail and tackled by conducting

5 sessions of family therapy. On a supervised dietary programme she stopped laxative and emetic use and started taking a more balanced and nutritious diet.

Her weight after 6 months follow up was 38 kg but she still had a fear of fatness and felt that she was swollen and bloated in terms of body shape. She continued to have amenorrhoea and there was not much change in her bulimic behavior. At the end of one year, she started showing improvement in all symptoms. Her weight was 41 kg and had scanty but regular menstrual cycle. However she would express fear of fatness.

DISCUSSION

Our patient fulfilled all the criteria of anorexia nervosa mentioned in the both classificatory systems. From the case description there is no doubt that she is a classical case of binge and purging type of anorexia nervosa.

Earlier studies on eating disorder have routinely been known as typically culture bound syndromes but it was apparently did not exist in Indian population. Srinivasan et al (1995) found no typical cases of anorexia nervosa in their screening study though 15% had "eating distress" syndrome but the symptoms were less in severity and fewer in numbers. Chandra et al (1995) viewed anorexia as a commonly occurring symptom rather than syndrome, presentation being atypical, and they commented that anorexia is a family disorder, reflecting pathology therein. Lee et al. (1989) made a statement that anorexia nervosa is unlikely to reach nonwestern countries due to protective biological and socio-cultural factors. Subsequently the same author in 1993 made a note that nonfat phobia is not

a western culture bound syndrome, but it may evolve into its fat phobic manifestation under the growing influence of westernization. Khandelwal et al (1995) described five cases of young women with atypical eating disorder who did not exhibit over activity or body image disturbances. The proposition was made by Khandelwal et al (1995) and Hsu et al (1996) separately that this could be due to the pathoplastic effects of the cultural differences among the western and Asian cultures. Asian and African cultures do not emphasize thinness as attractiveness, which may be the protective factor that prevents emergence of this phenomenon. In Indian culture, little importance has traditionally been given to slimness. Eating well is considered to be a symbol of nurturance and good family life style (Chandra et al 1995). But our case has shown that pathoplastic effect of particular culture is no longer an immune against the development of a typical eating disorder.

An adolescent girl pursuing fashion design course with more emphasis on thinness, strict watch on her calories intake and company of figure conscious girls may be a few predisposing factors to develop this illness. Intense fear of becoming fat even though she was under weight was the most striking feature of this case, which is not commonly seen in non western countries. We have come across only one case report from India where typical manifestation of anorexia was noticed (Chaudhury & John 2001).

We have reported a case of atypical presentation of bulimia nervosa in which binge eating was not prominent (Mendhekar et al, 2002).

Over contention is that it is a culture

change syndrome, might hold well in this light. This case report leads us to cautiously suggest that it may not be surprising if we see an increase in the number of 'typical' anorexia cases in our culture.

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