Case Report

Case Report on Anorexia Nervosa

Preeti Srinivasa, Chandrashekar M., Nikitha Harish[1], Mahesh R. Gowda, Sumit Durgoji[2]

ABSTRACT

Anorexia nervosa is an eating disorder characterized by excessive restriction on food intake and irrational fear of gaining weight, often accompanied by a distorted body self-perception. It is clinically diagnosed more frequently in females, with type and severity varying with each case. The current report is a case of a 25-year-old female, married for 5 years, educated up to 10th standard, a homemaker, hailing from an upper social class Hindu (Marvadi) family, living with husband's family in Urban Bangalore; presented to our tertiary care centre with complaints of gradual loss of weight, recurrent episodes of vomiting, from a period of two years, menstrual irregularities from 1 year and amenorrhea since 6 months, with a probable precipitating factor being husband's critical comment on her weight. Diagnosis of atypical anorexia nervosa was made, with the body mass index (BMI) being 15.6. A multidisciplinary therapeutic approach was employed to facilitate remission. Through this case report the authors call for the attention of general practitioners and other medical practitioners to be aware of the symptomatology of eating disorders as most patients would overtly express somatic conditions similar to the reported case so as to facilitate early psychiatric intervention.

Key words: *Anorexia nervosa, BMI, eating disorder, somatic complaints multidisciplinary therapeutic approach*

INTRODUCTION

Eating disorder is defined as a persistent disturbance of eating behavior or behavior intended to control weight, which significantly impairs physical health or psychosocial functioning, often turning out to be chronic psychiatric conditions.[1] Anorexia nervosa is an eating disorder as recognized by both ICD-10 and DSM-IV-TR. It is characterized by excessive restriction on food intake and irrational fear of gaining weight, often accompanied by a distorted body self-perception. It typically involves excessive weight loss and is usually found to occur more in females than in males.[2] An individual with anorexia nervosa may exhibit a number of signs and symptoms that may be present but not readily apparent. The type and severity may vary in each case.[3-5]

Access this article online	
Website: www.ijpm.info	Quick Response Code
DOI: 10.4103/0253-7176.155655	

Clinically they may present with symptoms of

- Distorted body mass index range; of less than 17.5.[6]
- Amenorrhea.[6]
- Fearful of even the slightest weight gain.[6]
- Cooking elaborate dinners for others, but not eat the food themselves.[7]
- Hypotension orthostatic hypotension, bradycardia, or tachycardia.
- May frequently be in a sad, lethargic state.[8]
- Swollen joints, hair loss or thinning.[9]
- Constipation,[10] electrolyte imbalance.[11]
- Lanugo.[12]

The causes for Anorexia nervosa have been attributed to risk factors such as, family history, obesity, weight

Consultant Psychiatrist, Spandana Nursing Home, [1]Psychiatric Rehabilitator, Spandana Health Care, [2]DNB Resident, Spandana Nursing Home, Bangalore, Karnataka, India

Address for correspondence: Dr. Mahesh R. Gowda
Spandana Health Care, No. 236/2, 29th Main Road, 5th Block, Nandini Layout (Coconut Garden), Near Ring Road, Bangalore - 560 096, Karnataka, India. E-mail: maheshrgowda@yahoo.com

concerns, psychiatric comorbidity, and substance abuse.[13-16] Although anorexia nervosa is widely described in the Western literature, it is rather rare in nonwestern cultures. In India, the information regarding these disorders is very limited.[17] In most Indian clinical settings, patients chiefly present with refusal to eat, persistent vomiting, marked weight loss, amenorrhea, and other somatic symptoms, but rarely show over activity or disturbances in body image.[18] However, the management of the disorder does not markedly vary irrespective of the cultural and ethnic variations in the clinical picture. It calls for the involvement of a multidisciplinary approach.[19]

In this article, the authors report a case of atypical anorexia nervosa in an attempt to contribute to the Indian literature of eating disorders that currently lacks clinical reports on the same.

CASE REPORT

Case of Mrs S, a 25-year-old female, married for 5 years, educated up to 10th standard, currently a homemaker, hailing from an upper social class Hindu (Marvadi) family, living with husband's family in Urban Bangalore; presented to our tertiary care center with complaints of gradual loss of weight, recurrent episodes of vomiting, from a period of 2 years, menstrual irregularities from 1 year and amenorrhea since 6 months, with a probable precipitating factor being husband's critical comment about her weight. Patient was reported to be dull and inactive most of the times since her marriage able to carry out her activities of daily living adequately. With symptoms of weight loss and amenorrhea, she was evaluated by a physician. A series of investigations were conducted in the background of suspected tuberculosis, anemia for evaluation and abdominal tumors. However, all the investigations were well within normal limits except low hemoglobin.

She was further evaluated by a gastroenterologist; an intestinal biopsy was done to rule out malabsorption syndrome. Gynecological opinion was taken in the background of amenorrhea and infertility, and was advised endometrial biopsy. Endocrinologist was seen and investigations conducted were normal. Thus, no clear cut cause could be established to the loss of weight. The patient was referred to psychiatric consultation by her treating physician as she appeared less cheerful, dull, and inactive and decreased interest in sex.

During psychiatric interview it was difficult to establish rapport and Mrs S was uncooperative. With persistent probing, she expressed low mood, easy fatigability, apathy, decreased attention and concentration, bleak, and pessimistic ideas about future. No suicidal ideas or unusual perceptual experiences were reported. Attempt to establish the cause of above symptoms were futile.

Information was elicited by Mrs S' husband, revealed an incident during their early days of marriage when he had casually remarked of her being slightly heavy near her flanks and thighs and that she would look more beautiful if she reduced it. Since then her intake of food decreased. She followed a change in the diet pattern with complete avoidance of all foods with high caloric value. She gradually began to skip breakfast and would have minimal lunch. She began to avoid eating in front of other family members. At times hide and eat, and/or would secretly go into the bathroom and induce vomiting.

After repeated sessions, the patient opened up to the clinician. When questioned about her purging behavior, she reported of being unable to tolerate the guilt associated with eating excessively. Patient was re-evaluated and probed about her eating habits. Premorbid personality assessment revealed an over concern about physical appearance, inspired by skinny models. She reported of wanting to impress her husband with her beauty as he was fond of thin looking girls. She recalled that her husband would repeatedly compare her with thin looking girls on television and magazines. She eventually developed a morbid fear of looking fat and ugly, began eating a handful of fennel seeds to facilitate digestion. She would use soap water enema and would occasionally use laxatives. Her weight dropped from 59 to 30 kg.

During clinical examination, her weight was 30 kg in relation to her height being 5.4 ft and a BMI of 15.6. She had lanugo hair on her face and looked emaciated. Vitals were stable and systemic examination was normal. Her thyroid function was normal, serum electrolytes were normal, her hemoglobin was 8 gm/dl. Clinical depression was ruled out and a diagnosis of atypical anorexia nervosa was made (according to ICD-10). The general health questionnaire (GHQ) and the eating disorder examination questionnaire (EDE-Q) were administered. She was admitted for inpatient care and started immediately on IV fluids. Initially she developed facial edema that gradually reduced with fluid redistribution. A multidisciplinary team approach was employed. Psycho education with regard to the disorder was given. Nutritional rehabilitation was planned, where she was asked to maintain a dairy about her intake of food. She was encouraged to eat food with high caloric value.

Post sessions with the family, husband was involved in the therapeutic process and was asked to keep a watch on her purging behavior. The patient was simultaneously given Cyproheptadine and low dose Olanzapine. Her weight gain after 1 week was 2 kg. Mrs S gradually became cooperative for treatment process. Supportive

psychotherapy was planned that provided a maximum understanding of the patient perspective. Techniques of insight-oriented psychotherapy and cognitive behavioral therapy were structured to address the cognitive distortions. She was subsequently discharged and a follow up for every 2 weeks was done. Her weight gain at the end of 1 month was 4 kg. At the end of 6 months, there was a weight gain of 15 kg. At the end of 1 year, there was a relapse in symptoms with patient reported of decreased intake of food and purging tendencies. The symptoms were addressed through Psychotherapy only. Mrs S' symptoms remitted. At the end of 2 years, her weight was 55 kg with no fresh complaints.

DISCUSSION

Though the cases of anorexia nervosa are reported greatly in the grey literatures of the western countries, the number of clinical cases in India is on the rise. The age of onset for most cases ranges between 12 to 20 years.[20] Most cases are brought to clinical attention only when there are severe somatic complaints.[18] In this case, Mrs S was taken to the physician by her husband with symptoms of weight loss and amenorrhea. Multiple specialist opinions were taken to ascertain the cause of symptomatology. With no clear cut causal factor, the case as referred for psychiatric evaluation. The clinical picture led to the diagnosis of anorexia nervosa. There were no other potentially fatal medical consequences as the case was referred at the earliest by the physician. By reporting the particular case, the authors call for the attention of general practitioners and other medical practitioners to be aware of the symptomatology of eating disorders as most patients would overtly express somatic conditions similar to the reported case. Such awareness would have called for an earlier psychiatric intervention and curbed other unnecessary investigations.

Ethical considerations

- The confidentiality of the identity of the patient has been ensured.
- The patient has been informed of the publication of the case.
- The case report is in the best interest of the community and to create awareness among mental and general health professionals.
- A copy of the article has been submitted to the ethical committee for clearance.

ACKNOWLEDGMENT

The authors thank Dr. M. Srinivasa, Director Spandana Nursing Home for his valuable guidance. We thank Dr. S. Kanchana for her clinical guidance and Mr. H. D. Harish for his ardent support. We also thank the treating team and the nursing staff at the Spandana Health Care for their minute yet valuable support.

REFERENCES

1. Fairburn CG, Walsh BT. Atypical eating disorders (Eating disorder not otherwise specified). In: Fairburn CG, Brownell KD, editors. Eating Disorders and Obesity: A Comprehensive Handbook.London: Guilford; 2002. p. 171-7.
2. Hockenbury D, Hockenbury S. Psychology. New York: Worth Publishers;2008. p. 593.
3. Abell TL, Malagelada JR, Lucas AR, Brown ML, Camilleri M, Go VL, *et al*. Gastric electromechanical and neurohormonal function in anorexia nervosa. Gastroenterology 1987;93:958-65.
4. Ulger Z, Gürses D, Ozyurek AR, Arikan C, Levent E, Aydoğdu S. Follow-up of cardiac abnormalities in female adolescents with anorexia nervosa after refeeding. Acta Cardiol 2006;61:43-9.
5. Støving RK, Hangaard J, Hagen C. Update on endocrine disturbances in anorexia nervosa. J Pediatr Endocrinol Metab 2001;14:459-80.
6. Attia E, Walsh BT. Anorexia nervosa. Am J Psychiatry 2007;164:1805-10;quiz 1922.
7. Pietrowsky R, Krug R, Fehm HL, Born J. Food deprivation fails to affect preoccupation with thoughts of food in anorectic patients. Br J Clin Psychol 2002;41:321-6.
8. Lucka I. Depression syndromes in patients suffering from anorexia nervosa. Psychiatr Pol 2004;38:621-9.
9. McClure GM, Timimi S, Westman A. Anorexia nervosa in early adolescence following illness — the importance of the sick role. J Adolesc 1995;18:359-69.
10. Chiarioni G, Bassotti G, Monsignori A, Menegotti M, Salandini L, Di Matteo G, *et al*. Anorectal dysfunction in constipated women with anorexia nervosa. Mayo Clin Proc 2000;75:1015-9.
11. Olson AF. Outpatient management of electrolyte imbalances associated with anorexia nervosa and bulimia nervosa. J Infus Nurs 2005;28:118-22.
12. Walsh JM, Wheat ME, Freund K. Detection, evaluation, and treatment of eating disordersthe role of the primary care physician. J Gen Intern Med 2000;15:577-90.
13. Strober M, Lampert C, MorrellW, Burroughs J, Jacobs C. A controlled family study of anorexia nervosa: Evidence of familial aggregation and lack of shared transmission with affective disorders.Int J Eat Disord 1990;9:239-53.
14. Råstam M. Anorexia nervosa in 51 Swedish adolescents: Premorbid problems and comorbidity. J Am Acad Child Adolesc Psychiatry1992;31:819-29.
15. Halmi KA, Eckert E, Marchi P, Sampugnaro V, Apple R, Cohen J. Comorbidity of psychiatric diagnoses in anorexia nervosa. Arch Gen Psychiatry 1991;48:712-8.
16. Stern SL, Dixon KN, Sansone RA, Lake MD, Nemzer E, Jones D. Psychoactive substance use disorder in relatives of patients with anorexia nervosa. Compr Psychiatry 1992;33:207-12.
17. Patel DR, Phillips EL, Pratt HD.Eating disorders. Indian J Pediatr 1998;65:487-94.
18. Khandelwal SK, Sharan P, Saxena S. Eating disorders: An Indian perspective. Int J Soc Psychiatry 1995;41:132-46.
19. Chakraborty K, Basu D. Management of anorexia and bulimia nervosa: An evidence-based review. Indian J Psychiatry 2010;52:174-86.
20. Mammen P, Russell S, Russell PS. Prevalence of eating disorders and psychiatric comorbidity among children and adolescents. Indian Pediatr 2007;44:357-9.

How to cite this article: Srinivasa P, Chandrashekar M, Harish N, Gowda MR, Durgoji S. Case report on anorexia nervosa. Indian J Psychol Med 2015;37:236-8.

Source of Support: Nil, **Conflict of Interest:** None.