



CASE REPORT A CASE OF EATING DISORDER

KEYWORDS

Eating Disorders, Anorexia, Bulimia, Academic decline, Amenorrhoea, Fluoxetine

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ABSTRACT

This is a case of Eating Disorder, which is described in a teenage girl who presented with intractable vomiting, hydropneumothorax and pulmonary Koch's. The patient's initial presentation was marked preoccupation with body shape and image, restrictive eating, which progressed to episodes of vomiting after every meal, and led to academic decline followed by amenorrhoea and deterioration of general medical condition. She was managed with nutritional restoration, ATT and Olanzapine with Fluoxetine, to which she responded poorly.

Introduction:

The term "eating disorders" refers to anorexia nervosa and bulimia nervosa and their variants. These disorders typically develop in adolescence or early adulthood but in some cases they start earlier. They are not distinct conditions; they share much the same psychopathology and many patients migrate between them.

The first descriptions of anorexia nervosa in the Western world date from the 12th and 13th centuries, most famously Saint Catherine of Siena, who denied herself food as part of a spiritual denial of self. By the sixteenth century, ascetics were considered witches and burned at the stake. There are several other clinical descriptions of "wasting disease" in the 17th-19th century, and in the early 20th century, anorexia was considered an endocrine disorder and treated with pituitary hormones.

In 1973, Hilde Bruch published a book with a number of case studies, called Eating Disorders: Obesity, Anorexia Nervosa, And The Person Within. As the disorder reached public awareness in the 1970s, cases increased, spreading beyond the upper class.

Bulimia is first reliably described among some of the wealthy in the Middle Ages, who would vomit during meals so they could consume more. Apparently this behavior did not happen in ancient Rome despite a common conception otherwise. The first clinical paper on bulimia was published in 1979—Bulimia nervosa, an ominous variant of anorexia nervosa.

The cases of anorexia and bulimia escalated in the 1970s and 1980s. While most scholars will point to cultural pressures for thinness, increasing depression and obsessive compulsive behavior, and increased dieting behaviors as precipitants for eating disorders, it is impossible to ignore the fact that the 1970s and 80s is when the rates of obesity in the United States began to increase at an unprecedented rate, and low fat eating began its popular progression through the mainstream (1).

Cardinal features of eating disorders include overvaluation of shape and weight, attempts to maintain unduly low body weight in the form of restrictive eating and excessive physical exercise in Anorexia, and binge eating with purging in Bulimia nervosa. The criteria of Amenorrhoea is no longer considered, as it is inconsistent and leads to exclusion of boys with Eating Disorders from the clinical population (2).

Additional features found in these patients include asceticism and competitiveness. Co-morbid Psychiatric conditions that may be present include Depression, Anxiety and other sub-syndromal symptoms of irritability, impaired concentration, mood swings, emotional lability, reduced libido and obsessional symptoms. Social withdrawal is commonly found. These

features tend to improve with weight gain (3).

Females are primarily affected, but not exclusively. The disorders generally develop in adolescence, and in contrast with the normal preoccupation with maintaining low weight and thinness and associated dieting behaviours seen in teenagers, the eating habits of patients with eating disorders are particularly rigid, persistent and extreme. Family history of eating disorders, depression and substance use and childhood adverse events such as abuse are common, as is pre-morbid negative self-evaluation and perfectionism. Genetic predisposition as well as environmental factors play a role in causation. 5-HT receptor polymorphism has been implicated and is under study as a risk-factor (4).

Medical complications include fluid and electrolyte disturbance, dental damage, growth retardation and short stature in case of childhood onset, pubertal delay, osteopenia and osteoporosis, increased risk for pathological fracture, nutritional deficiency diseases, endocrine abnormalities and ECG abnormalities.

Management is centred around management of physical life threatening conditions and nutritional restoration followed by psychotherapy aimed at maintaining a healthy body weight. Focused Family Therapy based on Maudsley approach, CBT, IPT and supportive psychotherapy are among the options available. Antidepressants such as Fluoxetine may be added to maximize the benefit with CBT and to address co-morbid Psychiatric illnesses. Once response to treatment is established, it is important to continue follow up and rehabilitative measures (5,6).

Prognosis is better for adolescent onset disease rather than adult onset disorder (7).

Case report:

An 18 yrs old school dropout from middle socio-economic background in Pune, with h/o excessive concerns about body weight in mother, with pre-morbid perfectionist traits, was brought by family members on 30 Mar 2016 with c/o intractable vomiting and weight loss for the last 02 yrs and fever with cough for the last one week. History revealed onset of symptoms two years ago with excessive preoccupation with maintaining a very low body weight and gradual reduction of meal frequency and size, followed by self-induced episodes of vomiting after every meal, which were initially surreptitious, but later became known to family members.

She would admire those with very thin bodies and aspired to become like them. Although she was a bright student and secured 95% marks in Class X, she was not satisfied with her performance and sought appreciation from teachers and peers

for her low weight. Gradually over the next one year, she lost about 17 kg weight and from 46 kg, reached a weight of 29 kg. Her academic performance declined and she failed in Class XI. She had to drop out of school due to her poor general medical condition. She developed hypomenorrhoea followed by amenorrhoea. Concerned by this, her parents took her to a physician.

Evaluation in Dec 2014 revealed Hb : 13.4 mg%, TLC : 4800/cu mm, DLC : N49L32, MCV : 84.1 Fl, MCHC : 36.7, MCH : 30.9, Plt : 2.67×10^3 /cu mm, ESR : 40 mm/hr, S. B12 : 171 pg/ml, TSH : 1.83 microU/L, FBS : 88 mg/dl, S. Bil : 1.5 mg/dl, OT/PT : 20/10 IU/L, ALP : 47 U/L, Total Protein : 8.0 g/dl, Alb : 4.5 g/dl, Glb : 3.5 g/dl, Creat : 0.8 mg/dl, Urine (specific gravity : 1.015, WBCs : 3.4 cells/hpf, epithelial cells : 6.8/hpf), UGI endoscopy : WNL, Barium meal follow through : WNL, USG(abd) : WNL, 2D Echo : Normal study, NCCT(Head) : NAD

She was referred for Psychiatric evaluation by her Physician who suspected a functional cause for her vomiting. She was diagnosed with Eating Disorder NOS and was started on Fluoxetine, Chlorpromazine and Olanzapine. Her response to medication was poor and she continued to deteriorate. She received 05 sessions of ECT in Mar 2015. In addition, she has been treated by a number of faith healers in the last 02 yrs.

She was admitted in a civil hospital in Jan 2016 with c/o giddiness; managed in ICU for bradycardia and hypotension. During that admission :Hb : 10.6%, TLC : 17651/cu mm, Plt : 1.93×10^3 /cu mm, K⁺ : 1.8 mEq/L, Ca²⁺ : 7.6 mEq/L. Managed with inotropes, antibiotics and other supportive measures. In the last one week before her hospitalization, she developed low grade, continuous fever associated with cough with scanty expectoration, which she found painful, and had difficulty bringing out sputum. She had generalized weakness and giddiness on standing up from sitting position. Any attempts to eat were followed by episodes of vomiting, and she was on exclusively liquid diet, which her family members coerced her to take.

On evaluation during current admission, she was conscious, alert and oriented. Pulse : 80/min, BP : 100/60 mm Hg, Temp : 98.3 degree F, Wt : 23 kg, Ht : 157 cm, BMI : 9.33 kg/m². She appeared severely cachexic with generalized wasting and pallor. There were chemosis at pressure points and i/v sites.



There were no other signs of nutritional deficiency in the form of cheilitis, fissuring of tongue, pigmentation/scaling of skin, pityriasis alba.

Respiratory system examination revealed reduced chest movement on rt side, b/l reduced air entry R>L (poor effort), absent resp sounds on rt infrascapular/infraxillary, and mammary region, hyper-resonant note on rt mammary region, TVF/TVR increased in rt interscapular region. No creps/wheeze.

Other systems were WNL.

MSE revealed a thin individual who was unable to sit on her own and kept lying in the bed, talked slowly with effort, in a reduced tone and volume, with depressed affect, thinking dominated by denial regarding her eating behavior and superstitious beliefs with no depressive cognition, suicidal ideation or perceptual abnormalities in a clear sensorium with grossly reduced appetite and energy and increased sleep.

Hb : 7.6 mg%, TLC : 5900/cu mm, DLC : N86L13, MCV : 71 Fl, Plt : 1.86×10^3 /cu mm, Bld urea : 13 mg/dl, S. Creat : 0.6 mg/dl, Na⁺ : 124 mEq/L, K⁺ : 2.4 mEq/L, Ca²⁺ : 6.5 mEq/L, Phosphate : 2.8 mEq/L, Corrected Ca²⁺ : 8.6 mEq/L, Total protein : 5.0 g/dl, Alb : 1.3 g/dl, ESR : 46. CXR-PA view revealed rt hydro-pneumothorax, cavitation RUZ and LLZ, NHO RUZ, suggestive of Pulm Koch's. Sputum was positive for Tubercular Bacillus.

She was started on ATT as a case of Pulm Koch's. Chest tube drainage was planned, but was refused by the patient's NOK. She was started gradually on oral feeds with initial aim of 1000 cal intake. Upon stabilization of her electrolytes, she was discharged for follow up in OPD.

Discussion :

Eating disorders like anorexia nervosa and binge eating disorder are complicated psychiatric illnesses and most of them have comorbid psychiatric illnesses. Their attitude surrounding weight, food intake, self esteem and their control of their own emotions and physical problems make the condition far complicated to treat.

Serious malnutrition will become a life threatening condition that every psychiatrist must be aware to, while managing such cases as history will not be forthcoming initially. Strong index of suspicion, timely intervention, cognitive behavioural therapy introduction, medications and supportive psychotherapy go a long way in not only managing such cases but also promoting increased self esteem and self confidence.

In this case, the patient did not meet criteria for Anorexia nervosa or Bulimia Nervosa, and had presented with mixed features, leading to a diagnosis of Eating Disorder NOS. Among all eating disorders, there has been least research on the management of Eating Disorder NOS, and symptomatic treatment based on whether the clinical picture resembles Anorexia more or Bulimia, is given.

Importance of Psychotherapy requires to be emphasized in this case, as pharmacological management has little place in literature. Also, contrary to popular belief, Eating disorders are neither rare nor restricted to high socio-economic status or to Western countries. However, lack of data and under-diagnosis probably due to associated stigma may underlie the distorted figures that we see (8).

In conclusion, there is a need to identify and aggressively treat eating disorders in the community in addition to enhancing awareness and reduce stigma. Psychotherapy is the cornerstone of management of these cases, and therefore, facilities for the same must be made available to the patients across all socio-economic strata.

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