

ATYPICAL BULIMIA NERVOSA: A CASE REPORT

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ABSTRACT

This report describes a case of bulimia nervosa presenting with atypical features and her treatment response to SSRIs.

Key words: Eating Disorders, Bulimia Nervosa, SSRIs

Patients with eating disorders display a broad range of symptoms that frequently occur along a continuum between those of anorexia nervosa and bulimia nervosa. Weight preoccupation and excessive self-evaluation of weight and shape are primary symptoms in both anorexia nervosa and bulimia nervosa, and many patients demonstrate a mixture of both anorexic and bulimic behaviors (Bulik et al., 1997)

Atypical patients- who deny fear of weight gain, appraise their bodies as malnourished, and deny distorted perceptions of their bodies- are not uncommon among Asian patients (Khandelwal & Saxena, 1990; Lee et al., 1993). Strober et al.(1999), reported these atypical features in about one-fifth of their patients admitted to a specialty eating disorder program in United States. Anorexic patients with atypical features were found to have a somewhat better course (Strober et al., 1999). Although wide variability exists across studies, reductions in binge eating and vomiting rates in the range of 50%-75% have been achieved with active medication (APA, 2000).

To our best of knowledge, there have been

no reports of patient with atypical bulimia nervosa from Indian subcontinent. We wish to report a case of an atypical patient with bulimic behaviors, who responded to high dose of fluoxetine.

CASE REPORT

A 24-year old unmarried lady, from middle socio-economic status, was brought to us by her family members complaining that patient had repeated episodes of vomiting. She was born to a caesarian section due to premature rupture of membranes and her postnatal period was uneventful. Her motor, social and language developmental milestones were normal but she did not attain bladder control. Her enuresis persisted through out her childhood and adolescence, and it did not respond to imipramine but she had a significant improvement with desmopressin nasal spray (Dvoid). She also had a history of nail biting and of specific phobia towards fat people. According to parents, she was a child with difficult temperament in comparison to other children. There was no family history of

mental illness.

At the age of 19 years, patient was noticed to have repeated episodes of vomiting. She used to eat more than before. She started eating more chocolates, cold drinks and high calorie food items along with regular food unlike before. This pattern of excessive eating used to last for the whole day, but only 3-4 days per week. There was associated sense of lack of control over her eating during these days but were never followed by guilt, dysphoria or overconcern with weight gain. She also used to complain of heaviness in chest and epigastric discomfort, and was found to have repeated episodes of vomiting 4-5 times per day. Later it was found that these episodes of vomiting were self-induced. According to the patient, her heaviness in chest and epigastric discomfort were the reasons for her self-induced vomiting each time. Patient never attributed these self induced vomiting to excessive eating or fear of weight gain. There was no misuse of laxatives, diuretics, enemas or other medications. She was not found doing fasting or involved in excessive exercise. Over the time, there was about 13 kg increase in her body weight without any marked fluctuations. Throughout her illness, she never had any body-image disturbances. She used to deny fear of weight gain and deny any distorted perceptions of her body. There was no past or present history suggestive of anorexia nervosa. Her menstrual cycles were regular and adequate. There were no other associated psychiatric symptoms and behaviors.

Her laboratory tests including hemoglobin, peripheral blood smear, renal function tests, liver function tests and serum electrolytes were within normal limits. Upper GI endoscopy, whole abdomen ultrasound and cranial CT scan were found to be normal. After assessment, she was started on fluvoxamine 50 mg/day, which was later increased to 100 mg/day. As patient was not able to tolerate fluvoxamine, it was decreased and stopped over follow-ups. Later fluoxetine 20mg/day was started and over the next 8 weeks, fluoxetine was gradually increased to 80 mg/day. She also underwent psychotherapy including

nutritional counseling, and was advised healthy but not excessive exercise patterns. Over the next three months there was reduction in her body weight. There was significant improvement in her eating pattern and marked reduction in self-induced vomiting. No side effects were reported or noticed at fluoxetine 80mg/day.

DISCUSSION

Atypical patients with anorexia nervosa denying fear of body weight and denying body image disturbances have been exclusively reported from the Asian subcontinent in the last decade (Khandelwal & Saxena, 1990; Lee et al., 1993). These cases were associated with anorexia and amenorrhea. Their presence of atypical features was explained on the basis of cultural factors and excessive preoccupation of western societies with slimness and body image. To our best of knowledge, this is the first case report of an atypical patient with bulimia nervosa (without anorexia nervosa) from Indian subcontinent.

As per definition, binge eating is defined as eating an amount of food definitely larger than most people would eat in that similar discrete period of time (e.g., within any 2-hour period) under similar circumstances (APA, 1994). This patient had recurrent episodes of excessive eating but these episodes were not limited to few hours and were spread over the whole day. They were associated with sense of lack of control over eating during these episodes suggesting binge eating. Various recurrent inappropriate compensatory behaviors in order to prevent weight gain have been reported in patients with bulimia nervosa (APA, 1994). Self induced vomiting was present in this patient but it was attributed to heaviness in chest and epigastric discomfort, and not to fear of weight gain. Abdominal bloating, loss of appetite, no hunger or distaste for food has been the various reasons used by anorexics of Asian extraction for food refusal in contrast to Western population who refuse food for fear of weight gain. Also this patient had no fear of weight gain or body image disturbance. Absence of fear of

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fatness and body image disturbances in patients with anorexia nervosa in Asian population has been well documented (Khandelwal & Saxena, 1990; Lee et al., 1993; Goh et al., 1993). This patient had excessive weight gain unlike patients with bulimia nervosa who tend to have upper end of normal weight range. Only about 10% of them have been reported markedly overweight.

Lee et al. (1993) supported the existence of non-fat phobic anorexic nervosa as a heterogeneous group with regard to reasons used for food refusal. Attempting to remedy the problems of the overtly culture-specific DSM criteria for anorexia nervosa, Lee (1993) proposed a set of revised "culture-free" criteria for anorexia nervosa for a more culture-free diagnosis. Presence of binge eating associated with self-induced vomiting but absence of fear of weight gain and body image disturbances in our patient suggests that these atypical features observed in Asian anorexics may also be applicable to people with bulimic behavior from Asia.

To date, the only medication approved by the Food and Drug Administration for bulimia nervosa is fluoxetine. Fluoxetine at doses higher (60-80 mg/day) than those used for depression has been found to be more effective for bulimic symptoms (APA, 2000). There is evidence that treatment programs that include nutritional counseling and management as part of the program are more effective than those that do not (Laessle et al., 1987). Our patient when treated with combined nutritional counseling and high dose fluoxetine (80mg/day) had a marked improvement in her eating pattern and self-induced vomiting.

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