CASE REPORT

Unexplained weight loss in an 80-year-old woman

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Accepted 8 January 2015

SUMMARY

An 80-year-old woman presented with long-standing history of weight loss and malnutrition, which had caused her to become reliant on the use of a wheelchair. Her symptoms were initially attributed to her medical comorbidities, however, during admission it became apparent that she had been suffering from depression and had gone on to develop an eating disorder. Eating disorders are most common in young adults but can affect all age groups, including the elderly population. The diagnosis is rarely considered in such patients and easily overlooked, especially when in the presence of chronic conditions and cognitive decline. A pre-existing psychiatric issue, most often depression, may also be present in this age group. There are no current treatment methods targeting patients in this population, who may not respond as effectively to the available strategies directed at young adults. It is important to always consider an eating disorder as a contributor or direct cause of unexplained weight loss in elderly patients.

BACKGROUND

Our 80-year-old patient's low mood and eating disorder had gone undetected by her general practitioner (GP). The case demonstrates how easily these issues can be missed because of a patient's advanced age and comorbidities.

We believe that heightening awareness of eating disorders in this age group could lead to earlier diagnosis and a reduction in the associated mortality rate.

CASE PRESENTATION

A quiet, 80-year-old woman was referred to our hospital by her GP for weight loss and malnutrition. She had lost 8 kg in the previous 9 months and now had a body mass index of 11.5 kg/m^2. She was accompanied by family members who reported that her oral intake was poor and that she had become a wheelchair user in recent weeks.

Her history included hypertension and chronic obstructive pulmonary disease (COPD). She had been widowed 10 years before and now lived with an elderly friend who also acted as her carer.

The patient was severely cachectic and appeared dehydrated. She had a grade 2 pressure sore over the coccyx and minimal ankle oedema. The rest of her examination was normal.

INVESTIGATIONS

Initial investigations revealed albumin 23 and C reactive protein 81. The results of a chest X-ray and ECG were unremarkable.

DIFFERENTIAL DIAGNOSIS

The potential causes of our patient's frailty were considered to be malnutrition, malignancy or weight loss secondary to undertreated chronic lung disease.

TREATMENT

The patient received an urgent dietetic review. She admitted to often missing breakfast and lunch and having only a saucerful of food for dinner. When told her weight she expressed surprise as if she ought to weigh much more. She was started on dietary supplementation and intravenous fluids, and her COPD medications were optimised. Nursing staff also referred her to the mental health team because of her odd eating habits and the suspicion that she was concealing food.

OUTCOME AND FOLLOW-UP

Eleven days into her admission, the patient had not gained weight despite a daily intake of 2200 kcal. Her family had had suspicions of her having an eating disorder, but had not formally raised this with the healthcare team earlier. They disclosed that the patient had suffered with low mood and an abnormal attitude to food for many years and had had a mental breakdown with significant weight loss 17 years previously.

The patient was stubborn, never wanting to talk about her weight, and was very reluctant to see her GP. When challenged about her diet, she would speak fancifully about the dozens of items of foodstuff she had eaten that day and would excuse herself from eating more. She would wear three jumpers at a time and hide her gauntness with make-up. The family had contacted the GP on several occasions in the past year, but perhaps because of a lack of continuity between the patient's different GPs and limited awareness of her history, her weight loss had not been investigated. One GP commented that she was 'looking rather thin' but did not weigh her or explore this further.

On discussing this with her, the patient said that following the loss of loved ones she had become depressed and had made a decision to stop eating in an attempt to feel in control of her life. She agreed to start antidepressants. She started to gain weight and was happy at the prospect of going home and receiving follow-up from a community mental health dietician.

Unfortunately, the patient developed hospital-acquired pneumonia and was unable to fight it. She died shortly afterwards.

DISCUSSION

This patient was found to be depressed and to have developed a coexisting eating disorder most closely

To cite: Taylor IA, Gill I, Harripaul A. *BMJ Case Rep* Published online: [*please include* Day Month Year] doi:10.1136/bcr-2014-206847

resembling anorexia nervosa. Her case highlights the serious consequences of dangerously low weight and malnutrition, and the fact that the prognosis in this age group is particularly poor.[1]

The majority of the literature focuses on young adults with eating disorders. However, this and many other case reports[2–5] indicate that it remains a salient issue across the life span.

Many explanations have been proposed for why older people develop abnormal eating behaviours: biological changes leading to body dissatisfaction and reduced appetite; the influence of the media with their focus on the young and thin; or the need to find a coping mechanism following traumatic life events.[6] Stressful life events and depression are common precipitants of late-onset eating disorders.[6 7] Widowhood and bereavement may be especially frequent triggers.[6]

The exact prevalence is uncertain, but the 2007 British National Psychiatric Morbidity Survey found 2.1% of adults aged 60–69 and 1.1% of adults aged 70 or older screened positive for an eating disorder.[8] In studies of Canadian and Austrian communities, 1.8–3.8% of older women met the criteria for an eating disorder.[9 10] The figure may in fact be much higher since the clinical features of poor appetite and low weight may be attributed to pre-existing medical problems, and the diagnosis missed. The figure may also be increasing, given our progressively ageing population.

When encountering a patient with significant weight loss, a careful history regarding diet, physical and psychological symptoms must be taken. Any previous abnormal eating or psychiatric issues should be noted, together with the timing of the weight loss and its relation to life events. History-taking may be more difficult in patients who are lonely, unsociable or depressed, and as this case demonstrates, a collateral history from family members can be vital to making the diagnosis.

Several screening tools for eating disorders are available; most simple is the SCOFF questionnaire.[11] This may be used to identify a possible eating disorder, however, there are concerns about the SCOFF's validity in different populations and we could find no study focusing on its validity in older adults.

Controlled trials investigating the best treatment approach for eating disorders in older patients are also lacking. We are currently relying on a combination of behavioural and pharmacological methods employed for younger patients, though this may not be appropriate.

For example, one study of 193 patients found that older women gained more benefit from therapy targeting grief and loss than did younger patients.[12] Scholtz *et al*[7] also found there to be great dissatisfaction with provision of services for older patients with eating disorders. Patients felt they received poor follow-up and that related websites were aimed at younger people. Relatives of our patient reported that they could not find adequate information about eating disorders in the elderly and that their local support groups would not cater for older patients.

Within Essex, elderly patients with eating disorders are seen by the Adult Eating Disorders Service, who are referred to via a single point of access for mental health. However, there are currently only one or two elderly patients receiving treatment for eating disorders in a population of over one million. Although not common in elderly patients, the very few patients currently known to this team may reflect under-recognition of eating disorders in this age group.

Learning points

- Anorexia is a well-recognised condition in young adults; however, in the elderly population it remains underdiagnosed.
- Eating disorders must be kept in mind in the differential diagnosis of unexplained weight loss in the elderly. One should ask about a patient's previous mental health issues and seek a collateral history from their family.
- Though the reasons for developing eating disorders in this age group may differ from young adults, the symptoms will be the same.
- Greater awareness among healthcare providers is needed to prevent significant mortality and morbidity in this group of patients.
- There is an unmet need for provision of services for older patients with eating disorders that warrants urgent action.

Acknowledgement Ian Lea, Clinical Lead and Team Manager of the North Essex partnership NHS Foundation Trust, provided information regarding service provision for eating disorders in the Essex region.

Contributors The authors jointly conceived the idea for the article, and gained consent from the patient and relatives. IAT wrote the first draft and rewrote the article based on input from coauthors. All authors read and approved the final manuscript.

Competing interests None.

Patient consent Obtained.

Provenance and peer review Not commissioned; externally peer reviewed.

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