# AFRICAN JOURNAL OF MEDICINE and medical sciences

VOLUME 29, NUMBER 2, JUNE 2000

EDITOR:
B. O. OSOTIMEHIN

ASSISTANT EDITOR:
A. O. UWAIFO

ISSN 1116 — 4077

*Afr J. Med. med. Sci.* (2000) 29, 175-177



# A case report of anorexia nervosa

***Ayo Binitie, Osaghae and +OA Akenzua**
**Department of Mental Health, University of Benin, +Psychiatric Hospital, Uselu, Benin City, Edo State, Nigeria*

**Summary**
Although there are a few reports of Anorexia Nervosa in non-white populations some authors believe that the prevalence of anorexia Nervosa is as common in African populations as it is in Western countries. A case is presented of Anorexia Nervosa in a Nigerian female with features that strictly fulfil the ICD 10 diagnostic criteria. The difficulties encountered in the treatment of such disorders as well as the recurrent nature of the disorder were also highlighted in the patient's presentation.

**Keyword:** *Anorexia, weight loss, body image disorder, depression, eating disorder*

**Résumé**
Quoique il existe quelques rares cas reporte d' Anarexia Nervosa chez les populations non blanche, Certains auteurs pensent que la prevalence d'anorexia Nervosa est ausi commune en Afrique que dans les populations des pays developes. Un cas d anorexia nervosa chez une femme Nigeriane avec des traits qui correspondent aux diagustique de type, ICDIO est ico presente. Les difficultes rencontes dans le traitment de parcil desorders autant que la nature recurrante des ce desorde avaient aussi ete illustre dans la presentation du patient.

## Introduction

The name anorexia nervosa was coined by Gull [1]. It was however Myre Sim who gave a vivid description of the condition. He stated that 'She is usually a young unmarried girl of good or average intelligence whose behaviour in other respects has hitherto been impeccable. She is usually a conscientious type with high moral code and a flair for doing good, may be in a voluntary organization such as Red Cross or Girls Guide. The domestic situation frequently records a mother who is less dominant than the father, or may be absent through death or other causes. In the immediate history there is a factor which appears significant such as anxiety over examinations, loss of friendship or affection or a variety of situations which are frequently associated with onset of depression. There is often a history of fluctuation of weight, the patient putting on and taking off weight [2].

Brusch suggested that the central psychological feature is a disturbance of body image [3]. This appears to lead the patient to a relentless pursuit of thinness. Apart from gross emaciation, a fine lanugo hair covers the body. Amenorrhoea is almost universal. The basal metabolic rate (BMR) is considerably reduced allowing the patient to subsist on a minimum number of calories. Constipation is the rule. The tenth edition of the International Classification of Diseases (ICD 10) criteria for diagnosis is clearly derived from these earlier descriptions. The criteria to be met ir clude body weight maintained at least 15% below that expected, loss of weight induced by avoidance of 'fattening food', body image distortion, and endocrine dysfunction involving the hypothalamic-pituitary-gonadal axis manifesting as amenorrhoea in females and loss of libido in males.

There are reports of anorexia nervosa in black populations of either Western on non-Western societies [4,5]. In a survey of 644 female Nigerian high school and university students using the Eating Attitudes test a prevalence rate of 14% was found. These findings were similar to those from Western Countries [6]. Soomro *et al* in a 10-year study in the UK found that the incidence of the disorder was similar in white and non-white populations' [7].

Correspondence: Dr. OA Akenzua, Psychiatric Hospital, Uselu, PMB 1108, Benin City, Edo State, Nigeria.

## The patient

This report is a case of anorexia nervosa treated at a private clinic by a team of psychiatrists and a paediatrician.

The case report is that of a single female professional aged 31 years. She is a Christian who belongs to a charismatic sect. She was brought in by the mother with the complaint that she was selectively eating in the last 3 weeks, not eating in the last week and had been fasting for 5 days. The mother complained she was thin and could hardly talk. The patient agreed she had not been eating and that she would refuse any attempts to make her fat.

The patient had been well and feeding fine until three weeks prior to presentation when she began to selectively eat. She ate little and would make excuses for not eating more. She gradually ate less until she began to refuse food. The parents were worried and so resorted to forcing her mouth open and then feeding her. She sustained bruises around the mouth as a result.

She requested her father to let her pray and fast properly for a period of five days. She believed this would restore her life to the way it was before her present situation.

She became thinner than previously, and could barely talk audibly. Thereafter, she became restless, turning and rolling on her bed, and was brought to the hospital by her mother.

Six months prior to the onset of her illness, she had had a dream, in which she had eaten food and became blind. The dream recurred on a number of occasions. She also dreamt that she was admitted in a psychiatric hospital. She interpreted this to mean she would go blind if she ate or in the alternative got admitted into a psychiatric hospital.

The first episode occurred in August 1994 and lasted till January 1995. The second and third episodes were brief, just two and one week respectively. The fourth episode, which occurred in August 1996, was most serious. She was admitted in a hospital and a diagnosis of depression

was made. She was commenced on antidepressants (Imipramine) and antipsychotics (Thioridazine). She was also given electroconvulsive therapy (ECT). She induced vomiting on one occasion while in hospital. She weighed 39 kg at presentation, which increased to 51 kg at discharge.

The father, a retired civil servant, is 63 years old. He has a dominant personality. The mother is a retired teacher. Both parents are now working together in a small business. There are 6 children, two (2) of the sibs are in America and one (1) in London.

Her menarche was at 12 years. She has never had a boyfriend, and is still a virgin. 'Boys', she said 'want only one thing'. She was not prepared for sex before marriage. She had dated as a 17-year-old student within her group of friends. The patient had been amenorrhoiec for three months before presentation. She does not socialize. She is obedient and submissive to her parents.

The mental state examination showed a skinny looking young lady, in an overflowing and oversized gown. She was co-operative but evasive. She had over-valued ideas of her dream concerning blindness if she ate. She expressed her wish to drink and eat normally. She was not happy with fat people even though she had been plump as an adolescent.

The physical examination showed a grossly emaciated young woman. She weighed 41 kg (80% of her expected weight) and was 1.65 m tall. The body mass index was 15.1. Hirsutism was evident. Her pulse rate was normal (70 beats/min) but small volume. Her blood pressure was normal (110/70 mmHg). The heart size and sounds were normal. Both lung fields were clear. She had diminished muscle power globally.

Investigation showed she was anaemic with a PCV of 30% (normal 35-50%) and a haemoglobin concentration of 9.9 g/dL (normal 11-14 g/dL). The red blood cells were microcytic and hypochromic. Total WBC was normal, 6.8 x $10^9$/L (normal 2-9 x$10^9$/L). The neutrophil count was 64% and lymphocyte count 36%. Blood chemistry revealed slightly elevated urea levels of 52 mg/dL (normal 15-45 mg/dL). Sodium, potassium, chloride and bicarbonate levels were within normal range. Chest radiograph was normal.

**Treatment**

She was admitted to hospital. In view of her refusal of food, she was tube fed with a combination of cornmeal, sugar and milk three times a day. She had equivalent of 2,000 calories or more daily. She was commenced on Chlorpromazine tablets 25 mg twice a day, this was gradually increased to 100 mg three times a day. She was given injections of iron and multivitamins. Initially, she gained 10 kg (41 kg-51 kg). Thereafter, she lost some weight. She convinced her mother that sugar was bad for her. When this came to the notice of the doctors, the sugar in her diet was restored to its former level. The patient however did not gain weight subsequently. It later transpired that she would not sleep at night but stay on her knees praying through the night. She held on to her belief that she would go blind if she fed. She was discharged to her parents whom we felt will be better able to manage her prayerfulness at night.

**Discussion**

The presentation in this case is similar to that described by Sim [2]. There is the expected intelligence, the family background of a domineering father, and refusal of food. Weight fluctuation and emaciation were evident at the time of presentation. Our patient was also not married. The over-valued idea of food causing blindness is of delusional intensity. Several authors have reported that a significant minority of patients with anorexia nervosa display psychotic symptoms at some point in the course of their illness. [8,9,10] When we consider the ICD 10 diagnostic criteria, the case is typical however there is a religious overtone to the illness. This can be accounted for by the sect she belongs to, a Pentecostal church. There is evidence that in a previous admission she was diagnosed to have depression. This does not invalidate the diagnosis. The present episode was the fifth within a space of five years. Studies have reported recovery rates as low as 23% [11]. Treatment is usually difficult as the refusal of food is invariably accompanied by all forms of subterfuge to get rid of it. Efforts to get the patient to eat were met by protestations. This patient was able to convince her mother that sugar was not good for her. Theander reported that almost all probands seemed to have a neurotic fixation on body weight and diet [12].

The patient has not been seen at follow-up clinic since discharge. This is not surprising, as a substantial number of patients have been reported to dropout from long-term treatment [13].

**References**


1. Gull WW. Anorexia Nervosa_(Apepsia hysterica, anorexia hysterica). Trans Clin Soc. Lond 1894; 7:2.
2. Sim, M Guide to Psychiatry_London: E S Livingstone 2nd Edition 1969
3. Bowden PK *et al.* Distorting Patient or Distorting Instruments? Body Shape Disturbance in Patients with Anorexia Nervosa and Bulimia. British Journal of Psychiatry 1989; 155:196-201.
4. Holden, NL and Robinson PH. Anorexia Nervosa and Bulimia Nervosa in British Blacks. British Journal of Psychiatry 1998; 152:544-549.
5. Nwaefuna A. Anorexia Nervosa in a Developing Country. British Journal of Psychiatry 1981; 138: 170-171.
6. Oyewunmi L K and Kazarian S S. Abnormal eating attitude among a group of Nigerian youths with Anorexia Behaviour. East African Medical Journal 1995;69(12):667-669
7. Soomro GM, *et al.* Anorexia Nervosa in non-white populations. British Journal of Psychiatry 1995; 167: (3) 385-386.
8. Frazier SH. Anorexia Nervosa. Diseases of the Nervous System 1965;26:155-159
9. Hsu L KG, Meltzer ES and Crisp AH. Schizophrenia and anorexia nervosa. Journal of Nervous and Mental Disease 1981; 169:273-276
10. Hudson JI, Pope HG and Jonas JM. Psychosis in Anorexia Nervosa and Bulimia. British Journal of Psychiatry 1984; 145:420-423.
11. Hall A, Slim E, Hawker F, Salmond C. Anorexia Nervosa: Long-term Outcome of 50 Female Patients. British Journal of Psychiatry 1984; 145:407-413.

12. Theander S. Anorexia nervosa – a psychiatric investigation of 94 female patients. Acta Psychiatrica Scandinavica. 1970; Suppl.214.

13. Szmukler GI *et al.* Anorexia Nervosa, Parental 'Expressed Emotion' and Dropping Out of Treatment. British Journal of Psychiatry 1985;147:265-71.