EATING DISORDER: BULIMIA NERVOSA

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ABSTRACT
A 30 year old female medical undergraduate presented with the poor eating habits of insidious onset for 9 years. During her 11th class, she developed liking for a boy in her class who rejected her calling fat. Though, she managed to move on; however, developed dissatisfaction for her body image, and would consider herself fat in front of the mirror and started looking for means to reduce weight. With gradually increasing concern over growing fat, she started skipping two meals and would take only one meal and salads in class 12th. She tried to induce vomiting also once or twice. She started exercising for 1-2 hours in order to compensate weight gain out of binging. Though she knew that her Body Mass Index (BMI) was well within normal range, she started taking one tablet of Orlistat daily secretly along with skipping meals and rejoining gymnasium. At the time of consultation in the Psychiatry out-patient department, her BMI was 22.5, which is within normal range. Her laboratory investigations including, complete hemogram, liver, and renal function tests, serum electrolytes, plasma blood glucose levels were normal. She was put on Fluoxetine 40 mg and Cognitive Behavior Therapy. She is under regular OPD follow-up with sustained improvement since last 16 weeks.

KEYWORDS: Psychiatry, Eating disorders, Bulimia nervosa.
INTRODUCTION

There is so much influence of culture on the development of eating disorders such as anorexia nervosa (AN) and bulimia nervosa (BN). These syndromes are more prevalent in Western cultures and far more common among females than males, mirroring cross-cultural differences in the importance of thinness for women.\textsuperscript{[1]} Increased prevalence of BN is observed in the western countries during the current century, and the recent point prevalence of BN is around 1% of young western women.\textsuperscript{[2,3]} with another 3-5% suffering from similar eating disorders, known as Eating disorder not otherwise specified (EDNOS) in the Diagnostic and Statistical Manual-IV (DSM-IV).\textsuperscript{[4]} Only few classical cases are described in the Asian countries, particularly having more western influence. Atypical case of BN has recently been reported from India.\textsuperscript{[5,6]} To our best knowledge, a classic case of BN had never been reported from India.

CASE REPORT

A 30 year old unmarried female medical undergraduate, belonging to a Hindu extended nuclear family of the middle socio-economic status from a metropolitan city, with predominantly narcissistic trait and family history of recurrent depressive disorder in paternal grandmother, presented with the poor eating habits of insidious onset for 9 years. During her 11\textsuperscript{th} class, she developed liking for a boy in her class who rejected her calling fat. Though, she managed to move on; however, developed dissatisfaction for her body image, and would consider herself fat in front of the mirror and started looking for means to reduce weight. With gradually increasing concern over growing fat, she started skipping two meals and would take only one meal and salads in class 12th. Over next 6-7 month period, she lost up to 12 kg and looked thin, although she would consider it inadequate and would find herself flabby, in front of the mirror, although at other times, she could appreciate that her clothes had become loose. However, she never had symptoms of micronutrient deficiency or menstrual irregularity. At the same time, she also developed intense liking for the high calorie foods. She would binge on them 3-4 times a month and would regret afterwards. She tried to induce vomiting also once or twice. She started exercising for 1-2 hours in order to compensate weight gain out of binging. This pattern continued for next few months when she gave up working out unwillingly, to focus more on studies, and she gained about 4-5 kg. She would be distressed with it. She passed class 12\textsuperscript{th} with expected marks and qualified for MBBS course. She restarted dieting; however, within few months she again started having increased craving for the high calorie foods and binging, which would be more when she
would deny food in parties. Though she knew that her Body Mass Index (BMI) was well within normal range, she started taking one tablet of Orlistat daily secretly along with skipping meals and rejoining gymnasium in order to reduce her weight to below 50 kg, which was below normal for her height. She would often consume isaphgul husk for purging after binging. She sold her precious ornaments without informing the family members to undergo liposuction. She could undergo a single session after which it came to the knowledge of a family member, who refrained her. During last 3 year, she would compare herself with every female she met or read about in novels, would feel better on seeing obese females, and feel let down if they were slim. She could not spend an hour without fear of becoming obese. In recent times, she would avoid parties, going out with friends and would spend hours in the gymnasium.

At the time of consultation in the Psychiatry out-patient department, her BMI was 22.5, which is within normal range. Her laboratory investigations including, complete hemogram, liver, and renal function tests, serum electrolytes, plasma blood glucose levels were normal. She was put on Fluoxetine 40 mg and Cognitive Behavior Therapy. She is under regular OPD follow-up with sustained improvement since last 16 weeks.

**DISCUSSION**

This case is a typical case of BN with obvious presence of body image dissatisfaction and setting a sharply defined weight threshold and binging associated with compensatory behavior. Rapid and sustained improvement with the low-dose Fluoxetine and Cognitive Behavioral Therapy as observed in this case is usually not seen. Despite influence of western values world-wide, body dissatisfaction is remarkably lower in non-western countries.\(^7\) Cases reported earlier from India was lacking fear of fatness.\(^5,6\) Study on Indian medical students by the Srinivasan et al. found 15% of the 210 students had a form of distress and disorder in attitude towards eating habits and body weight, which are milder or subtle than AN or BN.\(^8\) The author termed this as Eating Distress Syndrome.\(^9\) The authors stated that the current severe form of eating disorder such as AN, BN might have emerged form of this archaic form. This historical evolution of major eating disorder from older form had been observed in studies carried out across different culture and region over different periods of time. So it is possible that eating disorder might be in evolution phase in developing countries like India, and largely present here in its archaic form. However, this case may be taken as an
indicator of emergence of BN in the context of rapidly increasing western influence in India. Well-designed systematic studies might be able to find out more cases.

CONCLUSION
There is so much influence of culture on the development of eating disorders such as anorexia nervosa (AN) and bulimia nervosa (BN). More common among females than males, mirroring cross-cultural differences in the importance of thinness for women. Only few classical cases are described in the Asian countries, particularly having more western influence. However, this case may be taken as an indicator of emergence of BN in the context of rapidly increasing western influence in India.

REFERENCES