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Letter to the Editor

MORBID OBESITY IN A TWENTY ONE YEAR OLD BEGGAR: A CASE REPORT

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INTRODUCTION

Though obesity is said to be common in the developed world[1], developing countries like Chile and China[2] recorded the greatest increase in obesity, particularly in childhood. Adults in the developing countries are not entirely left out[3]. There has been an increase in the prevalence of obesity in England and Wales; from 6% and 8% respectively for men and women in 1980 to 8% and 12% in 1990 and to over 21% for both in 2000[4]. In the United States, the figure are not different. It is estimated that 34% of adults aged 20 to 74 yrs are overweight and an additional 24% are obese[5]. These percentages are higher in African Americans. Native Americans and Mexican Americans[5]. There are no established figures from our local community.We present here a case of morbid obesity in a beggar in whom it is most unexpected.

Case Report

M.L is a 21-year-old male beggar. He is Hausa by tribe and Moslem by religion. He hail from Mareri area in Gusau and was referred to the Medical Consultants Clinic of Usmanu Danfodiyo University Teaching Hospital (UDUTH) Sokoto on the 10th of may 2004 through the General Outpatient department. He was brought to the clinic by one of the Zamfara state government house nurses supported with fund from the governor of the state. His presenting complaints were excessive eating and uncontrollable weight gain for 12 years and leg ulcer for 9 years. Patient admitted to eating four times a day. He also takes snacks between the meals. He stated that the quantity of food consumed per meal was at least double that of his peers and is made up of local meals and other Nigerian dishes. There was no associated polydypsia or polyuria. There was however associated dyspnoea on exertion and easy fatiguability, which were not associated with orthopnoea, and paroxysmal nocturnal dyspnoea. He could not remember how the ulcer on the lateral aspect of the right sheen developed. Attempts at treating the ulcer at other hospital earlier were unsuccessful. There was no associated history of recurrent boils. He has never experienced weight loss in the past.

He was the first of the father's three children. Other siblings were not obese. There was no family history of hypertension or diabetes mellitus. He lost his father at the age of three years and his mother at the age of 12 years. His attempt at trading early in life failed; hence he resorted to begging ever since then. He smoked four and half pack years. He does not take alcohol and never took alcohol in the past.

He was 1.67 meters tall and weighed 150.4kgs. He was extremely obese (see fig 1-3).

Figure 1

Figure 2

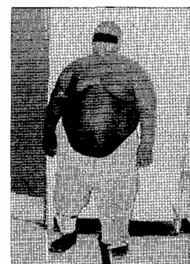
Figure 3

His body mass index (BMI) was calculated to be 53.7kg/m^2. He was not pale or jaundiced and had no peripheral oedema. His blood pressure was 120/80 and pulse rate was 76 beats/min, regular, full volume. Apex beat could not be palpated. The neck veins were not distended and the heart sounds were normal. No abnormalities were detected on chest examination. There were no areas of tenderness in the abdomen. No organs were palpably enlarged and ascites was not detected clinically.

His waist circumference was 180cm while his hip circumference was 140cm given a waist/hip ratio of 1.3. No neurological abnormalities were detected.

An ulcer on the lower lateral aspect of the right leg measuring 6cm x 6cm and discharging serosanguinous fluid was seen.

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A diagnosis of morbid obesity with chronic leg ulcer was made. We entertained the differentials of Cushing's syndrome and Hypothyroidism.

The following investigations were requested for among others: Fasting Blood Sugar 4.6mmol/I.

Thyroid function test	T3 - 2.90nmol/I
	T4 - 84.04nmol/I
	TSH- 2.77microiu/ml.
Serum Cortisol	11.77 microgam/dI

Dexamethasone suppression test was requested for but was not done because of lack of facilities to carry it out. Electrolyte, urea and creatinine, chest x-ray, full blood count, urinalysis, 2 hour post prandial glucose were all done and the results were within normal limits. Wound swab was taken for microscopy, culture and sensitivity but did not grow any organism. Wound dressing was started first with salvon and Eusol and later with sofratulle and cicatrin powder. In addition, Tabs Vitamin C 200mg tds and Tabs Ciprofloxacine 500mg bd were prescribed for one week each.

The dietician was invited to start him on a graded weight reduction diet using the locally available food. He was then referred to the physiotherapy department to start him on steady dynamic exercises. Wound was beginning to granulate and was showing signs of healing when patient stopped cooperating with the hospital staff. He refused dressing of his wound as prescribed and would not adhere to any exercise Programme or dietary advice. His BMI increased to 54.5kg/m^2.

After seven weeks on admission, he was discharged for outpatient follow up but never showed up.

DISCUSSION

Obese patients have an unhealthy amount of fat. These contrasts with athletes whose high body densities are contributed to by muscles. Our patient was extremely obese. The aprons of fat seen from the figures are supportive of this fact. He ate too much while he did little or nothing to burn of excess calories. The readiness of the physically fit in this environ to give alms as a religious duty ensures that he got enough to enable him indulge himself with food. In England it has been demonstrated that physical inactivity contributed more to obesity then food intake[6]. Our patient was grossly inactive and rebuffed all attempt to get him to exercise. Genetic factors are estimated to explain 30-50% of heritability of obesity[4]. Our patient has no family history of obesity. We are of the opinion that loneliness could have contributed to his over eating. We had no facilities to survey hypothalamic lesions. With respect to characterisation[1], our patient falls into grade 111 android obesity even though he does not have any associated complications apart from occasional breathlessness probably because he is very young.

The treatment of obesity is difficult. The expectations of the doctor from the patient and vice versa are unrealistic. Our patient showed no interest in the outlined treatment programmes. He was rather treatment programmes. He was rather interested in the money he got from the government and from begging. We lost his cooperation when the ulcers in his leg were getting healed. This probably was one of the facts that attracted human sympathy for him and he was not to loose it. He failed to comply with our feeding plan and gained weight instead of loosing weight, as was the plan.

We feel that all should be mobilized to prevent obesity from becoming a national problem since management of the full-blown case may be disappointing.

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