Anorexia Nervosa in a Nigerian – A Case Report

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SUMMARY

Background: Anorexia Nervosa has been reported to be uncommon among the non-western populations. However the frequency of its presentation has increased world-wide.

Method/Result: The case of a 19year old secondary school leaver with 2 year history of refusing food, claiming that she is too fat and progressive weight loss is presented.

Conclusion: Anorexia Nervosa is frequently seen among the western population. However it may not be as rare in non-western societies as previously reported.

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Key words: Prophylactic Ceftriaxone, Pacemaker Surgery

INTRODUCTION

Prevalence of eating disorder such as anorexia nervosa and bulimia nervosa are lower in non-western countries than that of western countries[1]. Eating disorders may present differently in different cultures and diagnostic criteria based on western norms may not always be appropriate[1].

Socio–cultural factors have been reported to be associated with the development of anorexia nervosa[2]. The western cultural ideal of thinness is now being adopted by non-western girls for the purpose of feminine beauty [3]. However, in some subjects the ideas of self control and denial of hunger may be the underlying factors for anorexia nervosa[4]. In Nigeria, three cases of anorexia nervosa have been reported so far[5, 6] and in Zimbabwe Buchan and Gregory reported one case[7].

Anorexia Nervosa is frequently associated with comorbid psychiatric disorders notably affective disorder, obsessive compulsive disorder (OCD) and social phobia[8, 9] and there is significantly high morbidity and mortality [10].

CASE REPORT

Miss AA is a 19year old secondary school leaver brought to our hospital by her elder sister on account of a 2 year history of refusing food, inducing vomiting, claiming she is too fat and progressive weight loss. She was apparently in a good state of health until about 2 years prior to presentation when she complained that she is too fat. Subsequently, she started skipping lunch and later she started eating once in a day. Sometimes she takes 'pap' which she specially prepared 'watery' without milk or sugar and at times she can take only one orange throughout the day. She maintained that she was too fat even when it was obvious that her shirts, blouses, skirts and wrist watch were appearing too big for her. She had to use belt or 'safety' pins to hold her skirt.

About 8 months later she was caught in the toilet inducing vomiting with her finger. Her sister had earlier noticed that patient would immediately go to the toilet to "ease" herself whenever she was forced to eat. Few months later she was seen taking some white tablets which were later confirmed by a pharmacist to be lasix (frusemide). AA confessed to have been using the tablets for more than 8 months – which she claimed was given to her by a patent medicine dealer when she complained that she had too much water in her body. The sister confirmed that since the onset of "these" strange behaviours AA has been unusually cautions of what she eats, preferring to take Schweppes bitter lemon (a bitter non-alcoholic drink) instead of coke, fanta or maltina because she believes that Schweppes contains less sugar. She was also noticed to have involved herself in vigorous physical exercise.

AA admitted that her menstruation has been irregular in the previous 6 months and her last menstrual period was 2 months from the time of presentation, but she was not bothered because she has not had sexual intercourse in the last one year (prior to presentation). There were no features suggestive of depression, anxiety, mania or psychosis. She has no previous history of mental illness and there is no family history of mental illness.

AA completed her secondary school education in 2005 and has since been making attempts to get admission into the higher institution. She does not use any psycho-active substance. She had good premorbid adjustment.

Mental state examination was normal except her strong belief that she is too fat.

Physical Examination revealed

Prominent zygomatic, clavicular, scapular, vertebral and iliac bones

Weight = 42.0kg,
Height = 1.56m
BMI = 17.3kg/m^2

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BP = 95/60mmHg (sitting position)
Pulse rate = 78pm, regular, good volume
Systemic examination was essentially normal. Axillary and pubic hairs are well distributed.
Investigations: Essential findings include;
Negative retroviral and pregnancy tests.
Normal Full Blood Count and Electrolyte & Urea.
Random blood sugar = 3.2mmol/l
AST (SGOT) = 36mmol/l
ALT(SGPT) = 41mmol/l
Urinalysis – Ketonuria^{+}

Patient attended weekly sessions of counseling, which focused on identifying the psychosocial factors that may have precipitated or perpetuated her behaviour, the need to understand the dangers associated with her habit and helping her to arrive at realistic ways of balancing her wish not to be too fat with healthy living. She was placed on multivitamin tablets.

By the fourth week of commencing therapy she made a marginal improvement in her weight which increased from 42.0kg to 42.8kg. However patient defaulted few weeks after.

DISCUSSION

Anorexia Nervosa is commoner in females. The onset is usually in adolescent or early adult life. It is an eating disorder characterised by deliberate weight loss induced and/or sustained by the patient. The body weight is maintained at least 15% below that expected or Quetelet's body mass index is 17.5 or less [11]. Other features include; avoidance of "fattening foods", self induced vomiting, self induced purging or use of diuretics and excessive execise[11]. Our subject had many of the above features.

Some of the neuro-endocrine disorders described in patients with anorexia nervosa include; increased growth hormone, corticotrophin releasing hormones, cortisol and reverse triiodothyronine, and decrease luteinizing hormones, follicle stimulating hormones and thyroxin[12]. Our subject did not do hormonal assay before she defaulted. Anorexia nervosa may also be associated with biochemical changes such as electrolyte renal and liver dysfuncaiton[13]. AA had only slight elevation of SGOF and SGPT. Ketonuria may be secondary to self-induced starvation.

Anorexia Nervosa may not be as uncommon as previously thought. This probably is the 4th case reported in Nigeria. However many cases may have existed (or even existing) without recognition. It is possible that many don't seek orthodox intervention. Our patient had been taken to a religious healer and a herbalist prior to presentation in our facility. This is common in our society where abnormal or strange behaviors are understood to be spiritually induced and spiritual/religious healers reinforce this belief [14]. It is also possible that the Nigerian extended kinship system is protective or it may be due to the customary passion for plumpness as an attribute of beauty [5].

Treatment of Anorexia Nervosa should include physical and psychological investigations. resuscitation and correction of electrolyte imbalance. Comorbid psychiatric disorders must be treated. Patients with Anorexia Nervosa must have psychological treatment. These include individual and family therapy, behaviour therapy and cognitive behaviour therapy [12]. Some pharmacological agents have shown some benefits in the treatment of Anorexia Nervosa. These include cyproheptadine (an anticholinergic with some antiserotonergic properties), antidepressants and antipsychotics. Recently Olanzapine was found to improve obsessional symptoms and lead to weight gain in some Anorexia Nervosa Patients [15].

REFERENCES

1. Makino M., Tsuboi K., Dennerstein L. Prevalence of Eating Disorder: A comparison of Western and Non-western countries. *Medscape Gen Med.* 2004; **6(3):** 49.
2. Willemsen E. M., Hock H. W. Sociocultural factors in the development of anorexia nervosa in a black woman. *Int. J Eat Disorder* 2006:353–5
3. Iancu I., Spivak B., Ratzoni G., Apter A., Weizman A. The socio-cultural theory in the development of anorexia nervosa. Psychopathology 1994: **27(1-2)**: 29–36.
4. Bennett D., Sharpe M., Freeman C., Carson A. Anorexia nervosa among female secondary school students in Ghana. *Br. J. Psychiatry* 2004; **185:** 314–317.
5. Famuyiwa O. O. Anorexia nervosa in two Nigerians. *Acta Psychiatr Scand* 1988; **78(5):** 550–4.
6. Binite A., Osagbe, Akenzua O. A. A case report of anorexia nervosa. *Afr J. Med Sci.* 2000; **29(2):** 175–7.
7. Buchan T., Gregory L. D. Anorexia Nervosa in a black Zimbabwean. *Br J. Psychiatry* 1984; **145:** 326–330.
8. Steiger H., Leung F., Puentes-Neuman G., Gottheil N. Psychosocial profiles of adolescent girls with varying degrees of eating and mood disturbance *Int J. Eat Disorder* 1992; **11:** 121–131
9. Kaye W. H., Bulik C. M., Thornto H., Barbarich N., Masters K. Comorbidity of anxiety disorder with anorexia and bulimia nervosa. *Am J. Psychiatry* 2004; **16(12):** 2216–21.
10. Hoek H. W. Incidence, prevalence and mortality of anorexia nervosa and other eating disorders Curr. *Opin Psychiatry* 2006; **19(4):** 389–394.
11. ICD –10 international classification of Disease and Disabilities, World Health Organization, Geneva, 1993.
12. Sadock B. J., Sadock V. A. Pathology, Laboratory examination and treatment of anorexia nervosa*:* In Kaplan and Sadock Synopsis of Psychiatry 10th ed. Lippincott Williams and Wilkins Philadelphia US. 2007 pp. 731–734.
13. Turner M., Shapiro C. The biochemistry of anorexia nervosa. *Int J Eat Disorder* 1992; **12:** 179–193.
14. Ohaeri J. U., Campbell O. B., Dare L. O. The emotional predisposition of terminally ill Nigerian patients to their condition. *Orient J Med* **5(40):** 115–117.
15. Bissada H., Tasca G. A., Barber A. M., Bradwejin J. Olanzapine in the treatment of low body weight and obsessive thinking in women with anorexia nervosa. A randomized, double blind, Placebo-controlled trial. *Am J Psychiatry* 2008: 16C ahead of Print)