A Classic Case of Bulimia Nervosa from India

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ABSTRACT
A classic case of the bulimia nervosa in a young Indian female is reported. This is in the context of the impression that due to increasing western influence, and change in cultural concepts of beauty and thinness among women, illnesses previously considered rare in Indian subcontinent might be becoming more prevalent. Many of the established pre-disposing factors such as female gender, metropolitan domicile, family history of depressive disorder have conglomered in this case. Rapid and sustained improvement with the low-dose Fluoxetine and the Cognitive Behavioral Therapy is also worth paid attention.

Key words: Classical bulimia nervosa, eating disorder, morbid dread of fatness

INTRODUCTION
The influence of culture on the development of eating disorders such as anorexia nervosa (AN) and bulimia nervosa (BN) has been long appreciated. These syndromes are more prevalent in industrialized, and often Western cultures and are far more common among females than males, mirroring cross-cultural differences in the importance of thinness for women.[1] These patterns indict current cultural beauty ideals in the etiology and maintenance of eating disorders. A secular trend of increased prevalence of BN is observed in the west during the current century, and the recent point prevalence of BN is around 1% of young western women,[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).[4] Only few classical cases has been reported so far from the Asian countries, particularly having more western influence, such as Japan, Hongkong.[1] Atypical case of BN has recently been reported from India.[5,6] To our best knowledge, a classic case of BN had never been reported from India.

CASE REPORT
A 22-year-old, unmarried female medical undergraduate, belonging to an urban Hindu extended nuclear family of the upper socio-economic status from a metropolitan city, with predominantly narcissistic and a histrionic traits and family history of recurrent depressive disorder in paternal grandmother, presented with the poor eating habits of insidious onset for 9 years. During her 8th 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 on 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 10th. 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 5-6 times a month and would regret afterwards. She tried to induce vomiting also once or twice. She started exercising for 1-1½ h in order to compensate weight gain out of binging. This pattern continued for next 1-1½ 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 12th 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 isaphghul husk for purging after binging. She sold her gold necklace 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 5 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 feeling of becoming obese. In recent times, she would avoid parties, going out with friends, standing for photos, and would spend hours in the gymnasium.

At the time of consultation in the Psychiatry out-patient department, her BMI was 23, 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 was started. She is under regular OPD follow-up with sustained improvement since last 18 weeks.

**DISCUSSION**

This case is a typical case of BN with obvious presence of a morbid dread of fatness, 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 ongoing adoption 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.\(^9\) Pary-Jones, referring to the historical evolution of eating disorder have mentioned about its ‘archaic form, a less severe and benign form of AN or BN.\(^10\) 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. Hence, it is possible that major eating disorder might be in evolution phase in 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.

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