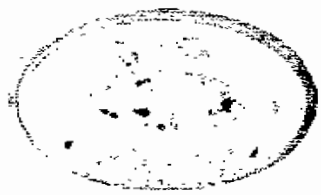
A REVIEW OF
ANOREXIA NERVOSA AND BULIMIA

(Thesis for Partial Fulfilment of M.Sc. in Psychological Medicine and Neurology)



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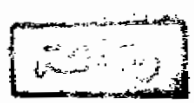

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Preface

ACKNOWLEDGEMENT

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Nevertheless I won't miss to take this opportunity to express my indebtedness thank, to the role played by W.H.O. for offering me the fellow-ship, as part of its endeavour to promote mental Health services in my dear country. I also, pay tribute to my publishers for their skill and for bearance.

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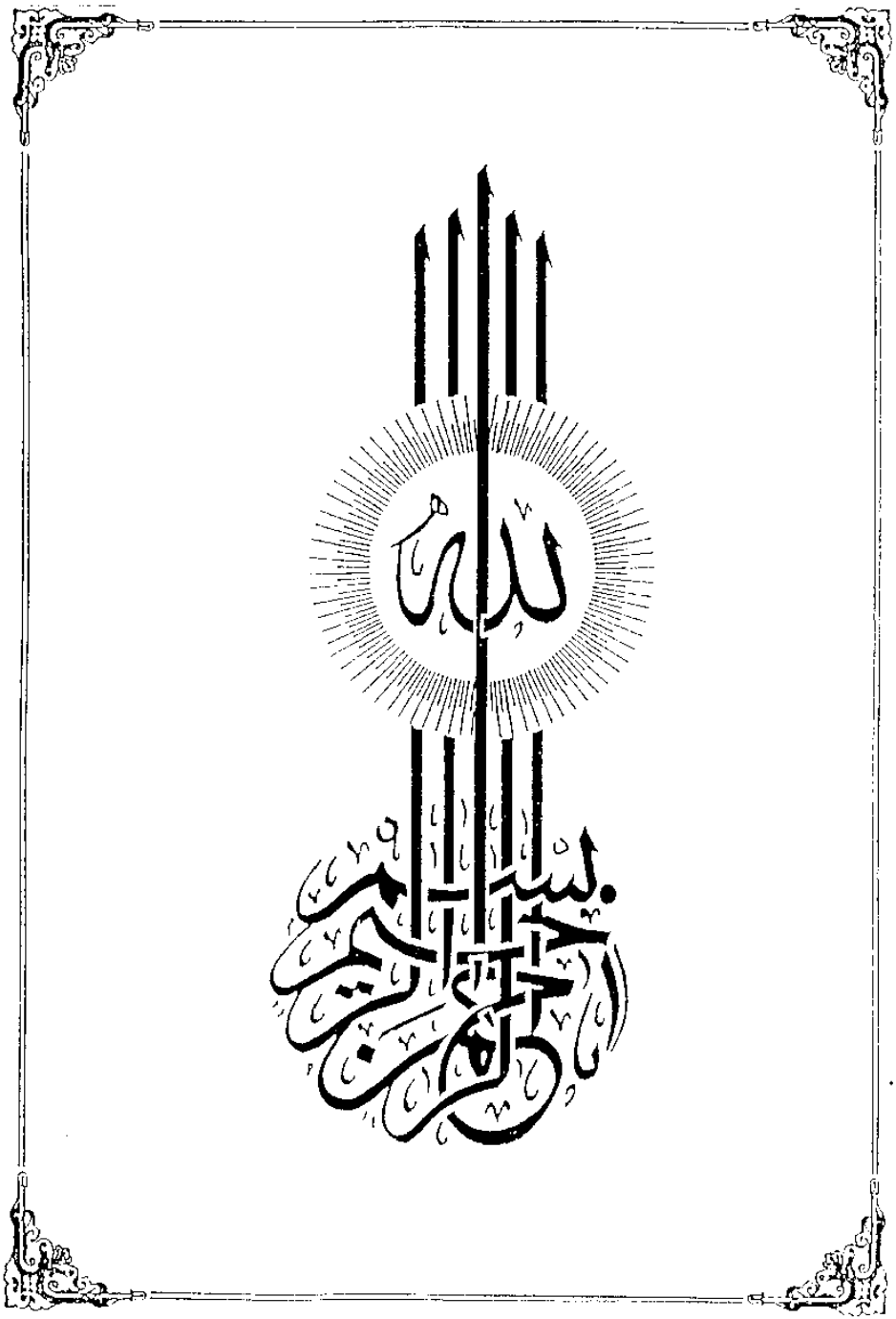


FIGURES

INTRODUCTION

Anorexia nervosa and Bulimia, are two types of eating disorders, which have attracted a great deal of attention over the last decade or so. The former is characterized by active refusal to eat and marked loss of weight (Kaplan Harold, Benjamin J. 1981), and the latter is characterized by recurrent episodes of binge-eating and fear of not being able to stop eating voluntarly (Halmi, Katherine, 1985).

Aim of the Work:

Is to draw a comparative study in these specific disorders, which have attracted a great deal of attention over the last decade or so. This review will emphasize those areas in which progress has been made and in particular biological, psychosocial and epidemiological studies which approach the question of the nature of the disorder. (Palmer Robert L. 1982). Also to answer the question of whether Bulimia is a syndrome itself or both as a syndrome and a symptom in anorexia nervosa or obesity (Paul E. and associates 1983).

Method of the Work:

Is based on review of literatures.

Charles Laséque invoked the protean and then fashionable on a paper in 1873, idea of hysterical anorexia, and emphasized that anorexia ought to be replaced by the term "inanition" (Kaufman, 1964) it was William Withey Gull's 1873 (Gull, 1964) paper that gave the entity the name "anorexia nervosa" by which it is generally known. Another vivid and accurate description of the syndrome was presented in 1908 by Dejerine and Gaunkler (Kendell, 1985). In 1914, Simmonds, a German physician, described a total case of cachexia and gave it the name of pituitarycachexia (Palazzol 1974).

Because of this and two later reports, from 1916 through the 1930, many if not most cases of anorexia nervosa used to be treated with hormonal extracts and pituitary grafts (Palazzoli, 1974). Dubois (1949) attempts to characterize anorexia as simply an extreme form of compulsion neurosis with cachexia as a leading symptom. Decourt (1954) described as anorexia Mentale which is the term being used till the present time in France. King (1963) was perhaps the first writer to set out a classification in terms of primary and secondary anorexia nervosa, this has been important in resolving these difficulties.

Indeed, within formal classificatory systems cases of the secondary type are diagnosed under whatever disorder is judged to be primary, because of its poorly definition and little studied ragbag.

Crisp (1967) has suggested the term weight phobia is appropriate to the primary anorexia's avoidance of normal body weight; which serves to define a recognisable and relatively homogenous primary group. Russell (1970) described as a morbid fear of being fat.

Anorexia nervosa is the occurrence of anorexia and emaciation without detectable organic diseases, (Kay, 1953, Kay and Leigh, 1954).

II. CLASSIFICATION OF ANOREXIA NERVOSA

(1) Primary and Secondary anorexia nerova

(a) Primary anorexia nervosa is defined not only by low weight and eating disorder, but more specifically by the subject's attitude to her state.

(b) Secondary anorexia nervosa is diagnosed under whatever disorder is judged to be primary, because of its poorly definition and little studied ragbag.

(2) Dally's (1969) classification

Dally attempted to divide his anorectic population into three distinct groups according to character traits, on the clear assumption that there were three different types of anorexia.

(a) **The first group "O"**

Is an obsessional like group characterised by presence of appetite; conscious refusal of food, occasional bulimia; interest in cooking and preoccupation with food; activity voluntarily increased; expression of concern about health and amenorrhoea; and labile mood.

(b) Group "H"

Is an hysterical-like group characterised by absence of appetite and hunger; fear of food denied; no interest in cooking; no over eating; concern about health and amenorrhoea denied; denial of depression, and anxiety.

(c) Group "M"

Is a miscelleneous group of anxiety hysterics, conversion, and schizoid reactions.

Blitzer and his colleagues (1961) noted the same constellations of traits in a sample of 15 preadolescent and child anorectics.

(3) Bruch (1973) classification:

He adopted the same classification of primary and secondary anorexia nervosa; and gave his definition for the primary anorexia nervosa as follows.

(a) A disturbance of delusional proportions in the body image and body concept" the define anorexic identifies with his skeleton like appearance denies its abnormality, and actively maintains it, in contrast for the typical anorexi who deplores the weight loss but feels helpless to change it.

(b) A disturbance in the accuracy of the preception or cognitive interpretation of stimuli arising in the body, with failure to recognise signs of nutritional needs as the most pronounced deficiency... and the characteristic manifestation... is hyperactivity and denial of fatigne.

(c) A paralyzing sense of ineffectiveness, which prevades all thinking and activities of anorexic patients. The experience themselves as acting only in response to demands coming from other people in situations, and not as doing things because they want to.

(4) Atypical Anorexia Nervosa:

Andersen (1977) has discussed the different types of atypical anorexias and pointed out the difficulty of recognizing and classifying

the atypical Syndromes. He suggests that there are four possible presenting pictures in anorexia.

(i) Typical presentation, typical syndrome (classic primary anorexia)

(ii) Atypical presentation, typical syndrome (problem of recognition)

(iii) Typical presentation, atypical syndrome.

Quantitative by atypical: mild or in complete. Quantitatively atypical (Problem of classification)

(iv) Atypical presentation, atypical syndrome. (Problem of weight loss of unknown origin)

Andersen's formulation suggests some of the difficulties of using research diagnostic criteria in studies such as those reviewed (Johnson Craig and Colleagues, 1984) for example an older woman who has had the disorder for more than 20 years or an atypical syndrome that is only atypical by virtue of being mild (less than 25% weight loss), or of being incomplete (only having one rather than two of the following manifestations requires: amenorrhoea, lanugo hain bradycardia, overactivity, bulimia and vomiting).

In writing this thesis I will avoid using this classification for avoidance of confusion.

EPIDEMIOLOGY AND PREVALENCE

Anorexia nervosa is not a common illness. Anorexics are often reluctant patients, and either avoid medical care or else present only part of their problem and baffle their physicians (Palmer Robert L. 1982). Further more not all people with eating problems turn to medically qualified therapists, when they want help, and certainly amongest doctors psychiatrists do not have a monopoly of the condition (Bhanji, 1979).

Prevalence:

While no figures are available regarding its prevalence in the general population, on the basis of data from three separate community psychiatric case registers, in Scotland, England, and the United States, the average annual incidence appears to be low, in the range of one case per 100,000 population (Crisp, A.H., and colleagues 1976 and Kendell, R.E., and Colleagues, 1973).

Jones et al (1973) reported from Monroe country a substantial increase in numbers. However, amongest white females aged 15 to 24 there was a dramatic rise in incidence rates from 0.55 per 100,000 per year for the 1960-1969 to 3.26 per 100,000 per year for 1970-1976 (Palmer Robert, 1982). Jones, D.J. and Colleagues (1980) reported an increase in incidence, from their studies.

Case register studies and special case note researches provide onset of abservations as follows:

- Kidd & Wood (1966): reported age incidence 15 or over in three cases out of 1240 new female patients, seen by psychiatrists

as inpatients or out patients in a year in Aberdeen and the North East of Scotland.

- Theander (1970): Arrived at figure of 0.24 per 100,000 population, having studied the in-patient records for psychiatric and medical treatment over a thirty year period (1931-1960) for a defined area in sweden.

- Kendell et al, (1973) reported from three psychiatric case registers (Aberdeen, Camberwell and Monroe Country, New York. See Table 1.

Table 1:

Prevalence	Year	Male and Female	Female aged (15-24)
Monroe County (U.S.A.)	1960-69	0.37 per 100,000 per year	0.8 per 100,000 per year
Camber well (U.S.A.)	1965-71	0.66 per 100,000 per year	4.1 per 100,000 per year
Aberdeen (Scotland)	1966-69	1.6 per 100,000 per year	10.8 per 100,000

Age:

- Anorexia nervosa usually occurs between 12 years of age and the mid-30 years, with the bimodel age of onset at 13 to 14 years and at 17 to 18 years (Halmi, K.A., and Eckert, E.D., et al., 1979).

- Anorexia nervosa and Bulimia affect as many as 5 to 10 percent of adolescent girls and young women (Pope, H.G., and Colleagues 1984, Pope, H.G.. and Colleagues 1984).

- Warren (1968) reported anorexia nervosa in 10 to 15 years. ie 8 pre-pubertal. Blitzer et al (1961) reported age of 7 to 14 years among 3 females who not reached the age of menarche.

Race:

- The absence of non-white victims has been remarked upon by observers on the three continents-Bruch (1966) in the United States, Hall (1976) in Australia and Norris (1979) in South Africa. While Norris notes the occurrence of some cases in Indian and coloured patients (the latter being those of mixed racial descent) in South Africa.

Crisp (1980)recorded cases in Arab States There are few reports of anorexia nervosa specifically or of anorexic-like behaviour amongest people of African Origin.

- Robinson-P and Andersen-A (1985) found five cases of anorexia nervosa in black American patients, who had a first or second degree retative with affective disorders.

A black child patient mentioned briefly by Warren and Vande Wiele (1973) and a more detailed report by Nwaefuna (1981) of the first case recorded in a black. A Zimbabwean girl in a developing country, was reported by (Buchan T. and Gregory L.D., 1984).

- However, the racial distribulation may reflect socioeconomic States rather than racial characteristics (Herzog David B. 1985).

Sex:

Anorexia nervosa occurs much more frequently in girls than in boys. Probably 90% of cases are girls (Hay, G.G., and Leonard,

J.C., 1979), incidence more than ten to one (Palmer robert 1982).

Social Class:

Some authors believe anorexia nervosa is mainly an illness of middle-class and upper-class girls, but there are no controlled data to support this hypothesis (Kendell, R.E., 1985).

It appears to exist and occurs in one of every 100 middle class adolescent girls (Kalucy, R.C., and Colleagues, 1977). Robinson-Rand Anderson-A, (1985), report four anorexia nervosa in black Americans, class III and V.

Group at Risks:

- Appears to be the middle class females in their late teens and early twenties of western Europe and North America, or of caucasian descent in Southern Africa, who are under social pressure to remain unrealistically slim, despite the increasing weight norms for this age group (Garner et al., 1980).

- It has been reported in men who are in training for competitive activity while restricting their weight (Smith, N.J., 1980).

- The prevalence rate of anorexia nervosa (treated and untreated cases) has been estimated by Crisp et al. to be 1% in British Secondary-School populations (Crisp, A.H., and Associates, 1976).

- It is apparently over represented among professional dancers and modeling students, usually developing after the students have begun their studies (Frisch, E.D., and Associates, 1980) 6.5%.

- Fries (1974) found a number of unrecognised cases in gynaecological outpatient clinics, presenting with secondary amenorrhea.

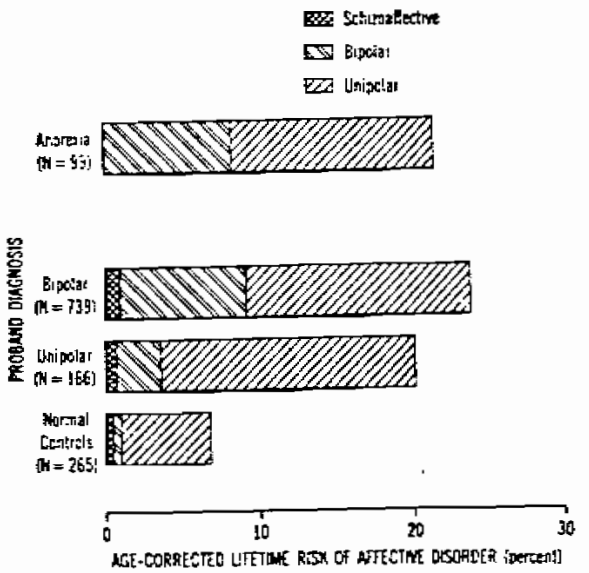
Relative risk:

(a relative risk refers to the ratio of the prevalence in relatives of patients to the prevalence in relatives of control Gershon Elliots and Colleagues (1984). See figure 2.

Figure 2:

(Gershon, Elliots, and Colleagues, 1984) study of platients with anorexia nervosa and affective illness in relatives.

FIGURE 1. Affective Disorders in the Parents, Siblings, and Adult Offspring of Probands With Anorexia Nervosa[a]



[a]The numbers in parentheses are the numbers of relatives. From the data of Gershon et al. (3).

AETIOLOGY

There is no doubt that anorexics differ physically from their healthy peers. The cause of the illness is not known. though hypothesis involving biological, hypothalamic and psychosocial factors (Garfinkel, P.E., and Colleagues, 1980; Russell, G., 1979). there has been much recent research of this kind, but controversy continues as to how these observations should be interpreted (Palmer Robert, 1982).

I. BIOLOGICAL FACTORS

(A) Endocrine Studies:

The changes in other endocrine systems are less consistent and clearly defined (Palmer Robert, 1982).

1. **Ovarian Horomones:** (The brain-Pituitary-gonad axis).

Amenorrhea may begin before, with. or after the disturbance of appetite (Falk, J.R.; and Halmi, K.A., 1982) A shift of oestradiol metabolism from 16-&-hydroxylation to 2-hydroxylation and, consequently, a dispropationate increase in catechol-oestrogens, occurs in anorexia nervosa (Wooley, S.C., and Colleagues, 1980).

If weight loss occurs prior to amenorrhoea; the patient may present with primary amenorrhoea (Warren, Michelle P., 1985).

Amenorrhoea is a crude index of the changes in hormonal patterns which have been observed in the disorder, oestrogens and progesterone are produced by the ovaries in response to the pituitary gonadotrophins, Luteinizing hormone (LH) and Follicular Stimulating hormone (F.S.H) (Palmer Robert, 1982). These hormones tend to be present in lower than usual quantities in the circulation of anorexic subjects at low weight (Marshall and Fraster, 1971; Crisp et al., 1973;