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Bulimia Nervosa: A Case Report

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Abstract
Bulimia nervosa is a serious psychiatric disorder that is often underdiagnosed, particularly among middle-aged individuals and in non-Western populations. This case report describes a 46-year-old Indian woman presenting with classical features of bulimia nervosa, including recurrent episodes of binge eating followed by self-induced vomiting. The patient also exhibited functional decline, depressive symptoms, and comorbid type 2 diabetes mellitus. Clinical improvement was observed with fluoxetine, low-dose antipsychotic therapy, and cognitive behavioural therapy. The case is notable for its late onset, chronicity, and rarity in the Indian context. Recent literature supports increasing recognition of eating disorders in midlife, especially in women, where hormonal transitions and psychosocial stressors may act as triggers. This case underscores the importance of considering bulimia nervosa in the differential diagnosis of eating disturbances in older adults. Early recognition and a multidisciplinary treatment approach are crucial for recovery and prevention of long-term complications.

Keywords: Bulimia nervosa, middle-aged woman, fluoxetine, cognitive behavioural therapy, late-onset eating disorder, India

Introduction

Bulimia nervosa was first formally described by Gerald Russell in 1979 [1]. The term "bulimia" literally translates to "ox hunger" [2]. The influence of sociocultural norms on eating disorders such as bulimia and anorexia nervosa is well-documented, particularly in Western societies [3]. The point prevalence of bulimia nervosa is estimated at around 1% among young women in the Western population [4]. However, Indian literature on the subject remains scarce. A study by Bhugra D. et al. identified a 0.4% prevalence rate among North Indians, with higher incidence observed in the eastern and northern regions of the country [5,6,7]. This report aims to highlight a rare and classical presentation of bulimia nervosa in a middle-aged Indian woman.

Case Report

A 46-year-old woman was brought to the psychiatry outpatient clinic by her son, who reported behavioural changes persisting for over five years. The patient experienced repetitive cycles of overeating followed by self-induced vomiting. Functional decline was evident, including reduced self-care, withdrawal from social interactions, and inability to engage in routine activities.

Patient's Account

The patient acknowledged an increase in appetite over the past five years, consuming food 5–6 times a day. These episodes were followed by deliberate vomiting. She frequently awoke early in the morning with intense hunger and believed that her food digested too quickly. Her reduced involvement in household responsibilities was attributed to persistent fatigue. The onset of her symptoms coincided with her younger son's premature departure from school. Previous psychiatric consultation had yielded partial symptom relief with medication, but treatment discontinuation led to relapse. Sleep disturbances, nocturnal eating, and a history of type 2 diabetes were also noted. There was no significant family history apart from paternal alcohol dependence.

On Examination

- BMI: 31 kg/m² (95 kg body weight)
- Hyperpigmentation over knuckles and dental staining
- Stable vital signs; systemic examination normal
- Mental Status: Oriented; cooperative; moderately kempt; decreased psychomotor activity; preoccupied thoughts centered on eating; mood was subjectively and objectively low with no hallucinations or delusions

Hospital Course

The patient was admitted and commenced on fluoxetine 20 mg/day and clonazepam 0.5 mg/day. Fluoxetine was titrated up to 60 mg/day, while clonazepam was gradually discontinued. Cognitive Behavioural Therapy (CBT) was initiated with focus on psychoeducation, nutritional guidance (glycemic index, neurotransmitter influence on hunger), and establishment of regular eating patterns (three meals and two snacks daily).

Biochemical investigations revealed hyperglycemia and dyslipidemia. A general medicine consultation led to initiation of metformin 500 mg and glimepiride 2 mg twice daily, along with atorvastatin 20 mg. Due to persistent sleep disturbance despite benzodiazepines, low-dose quetiapine (25 mg/day) was introduced, leading to improved sleep hygiene.

At discharge, the patient demonstrated significant symptomatic improvement: mood stabilized, eating patterns normalized, and self-care resumed. No perceptual disturbances were noted, and rapport was well established.

Discussion

Bulimia nervosa, though commonly associated with younger populations, is increasingly recognized in middle-aged and older adults. This case of a 46-year-old woman aligns with findings from recent literature indicating late-onset presentations are not uncommon.

Mulchandani et al. (2021) found that over half of elderly eating disorder cases had onset after age 40, with most improving through a combination of pharmacotherapy, psychotherapy, and hospitalization.[8] Similarly, Mangweth-Matzek et al. (2023) reported prevalence rates of 2.1–7.7% among older women, noting midlife hormonal changes—especially menopause—as a key risk factor, paralleling our patient's timeline.[9] Lapid et al. (2010) also highlighted that late-onset cases outnumbered early-onset ones in those over 50, with depression as a frequent comorbidity.[10] Our patient presented with mood symptoms and disordered eating, both of which improved with fluoxetine and structured therapy.

Pharmacological management is well supported by the Fluoxetine Bulimia Nervosa Collaborative Study (1992), which demonstrated that 60 mg/day fluoxetine significantly reduced binge and purge behaviours and improved mood symptoms.[11] Our patient's response mirrored these findings. This case reinforces the need to consider bulimia nervosa in adults of all ages. Early recognition and tailored multidisciplinary care can lead to significant clinical improvement, even in chronic, underreported cases.

Conclusion

Bulimia nervosa, though rarely reported in India, is increasingly relevant amidst changing sociocultural norms. Early diagnosis and multidisciplinary management are key to favourable outcomes. This case emphasizes the necessity for greater clinical vigilance and incorporation of psychiatric screening into routine medical practice.

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