ANOREXIA NERVOSA AND DEPRESSION — RECONSIDERING DIAGNOSTIC CRITERIA

SIR:

Shared clinical symptoms and features in major depressive disorder and anorexia nervosa have long been recognized. Dysphoric mood, sleep disturbance, and diminished libido are frequently encountered in anorexia nervosa and starvation. Indeed, weight loss, a common symptom of depression, is the hallmark of anorexia nervosa (AN).

Given the overlap of symptoms, one may presume it enormously difficult to diagnose major depression in a patient with AN, particularly if primary depression cannot be diagnosed prior to the onset of AN.

Although many investigators report depressive symptomatology when an AN patient presents for treatment (Hendren, 1983), age of onset and course of depression prior to presentation are rarely identified. This information is necessary to discern primary versus secondary depression in the anorexia nervosa patient.

Distinguishing primary vs secondary depression becomes increasingly important depending on the diagnostic criteria used for AN. Feighner *et al* (1972), exclude any "known psychiatric disorder with particular reference to primary affective disorder . . ." Although most frequently cited by AN investigators, Feighner criteria appears to discriminate against patients with a concurrent affective disorder diagnosis, especially if a depression diagnosis precedes a diagnosis of AN. Halmi *et al* (1977), permitted the diagnosis of depression in AN subjects in instances where depression was not present prior to onset of AN symptoms. Criteria proposed by Rollins & Piazza (1978) allow a diagnosis of "secondary depression" in anorexia nervosa subjects. Finally, DSM-III disregards the issue of concurrent affective disorder when considering the diagnosis of AN.

Clearly, diagnostic criteria used by Drs Feighner, Halmi, and Rollins do not permit a diagnosis of AN with a pre-existing history of depressive illness and, of these, Feighner criteria may be the most restrictive. Nonetheless, investigators using these criteria have cited a significant incidence of depression in their AN populations. Although it may be assumed that no premorbid or primary depression existed in these patients, the reader is never sure since this issue typically is not addressed.

However, Cantwell *et al* (1977) have addressed the issue of premorbid affective histories in AN patients. They found significant depressive symptomatology prior to the development of AN in their sample. Interestingly, the criteria used to make an AN diagnosis in Cantwell's population were those of Feighner, *et al*. Thus, one cannot be certain whether previous AN investigators rigidly adhered to their diagnostic criteria.

Cantwell also found a significant incidence of major depression in their AN subjects at follow-up despite an absence of current AN symptoms. Other studies finding a significant family history of affective disorder in relatives of AN patients (Gershon *et al*, 1983) supplement Cantwell's suggestion that AN is an affective variant.

Indeed, it is possible that a portion of AN patients have either premorbid depression and/or depression following resolution of AN symptoms. It remains unclear whether patients with premorbid depression differ in clinical features or treatment response. Consequently, it may be premature to exclude patients with depression who otherwise meet diagnostic criteria for anorexia nervosa.

Whether AN is a depressive variant, as Cantwell proposes, or another association exists between AN and affective disorder is unknown. Moreover, the two disorders may simply coexist. In any event, the otherwise specific diagnostic criteria for AN lend little risk to falsely identifying a patient as anorexic who concurrently meets diagnostic criteria for primary depression.

We would recommend that the AN diagnostic criterion excluding other psychopathology be eliminated until it is demonstrated that AN and primary depression cannot coexist or are not associated. Further investigation is needed to elucidate the premorbid and post-recovery affective status of AN patients. Additional neuroendocrine, polysomnographic and family history data will assist our understanding of the correlation between anorexia nervosa and other psychopathology.

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References

CANTWELL, D. P., STURTZENBERGER, S., BURROUGHS, J., SALKIN, B. & GREEN, J. K. (1977) Anorexia nervosa — an affective disorder? *Archives of General Psychiatry,* **34,** 1087–93.

FEIGHNER, J. P., ROBINS, E., GUZE, S. B., WOODRUFF, R. A., WINOKUR, G. & MUNOZ, R. (1972) Diagnostic criteria for use in psychiatric research. *Archives of General Psychiatry,* **26,** 57–63.

GERSHON, E. S., HAMOVIT, J. R., SCHREIBER, J. L., DIBBLE, E. D., KAYE, W., NURNBERGER, J. I., JR., ANDERSON, A. & EBERT, M. (1983) Anorexia nervosa and major affective disorders associated in families: a preliminary report. In *Childhood Psychopathology and Development* (eds S. B. Guze, F. J. Earls & J. E. Barrett) New York: Raven Press.

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HALMI, K. A., GOLDBERG, S. C., ECKERT, E., CASPER, R. & DAVIS, J. M. (1977) Pretreatment evaluation in anorexia nervosa. In *Anorexia Nervosa* (ed. R. A. Vigersky). New York: Raven Press.

HENDREN, R. L. (1983) Depression in anorexia nervosa. *Journal of American Academy of Child Psychiatry*, **22**, 59–62.

ROLLINS, N. & PIAZZA, E. (1978) Diagnosis of anorexia nervosa. *Journal of American Academy of Child Psychiatry*, **17**, 126–37.

COMPLICATIONS OF BULIMIA NERVOSA

DEAR SIR,

The clinical features of bulimia, bulimia nervosa and binge eating are now well documented (Russell, 1979, Pyle *et al*, 1981, Abraham & Beumont, 1982, Fairburn & Cooper, 1984). Physical complications may be caused by binge eating, self induced vomiting, or purgative abuse (Fairburn, 1982). I report here, and comment on, two further complications of self induced vomiting.

Mrs A., a 31 year old housewife, was admitted to hospital with a 4-day history of haematemesis and melaena. She was treated conservatively, transfused with 4 units of whole blood and had no further bleeding. Barium meal examination showed normal oesophagus, stomach and duodenum. The attending doctors failed to elicit a history of longstanding weight preoccupation, dieting, binge eating, and self induced vomiting since the age of 17. She had induced vomiting many times a day in the week prior to presentation. Two years later, she re-presented elsewhere for management of her eating disorder.

Miss B., a 17 year old schoolgirl, was extensively investigated for vomiting accompanied by nausea and vague abdominal pain, after each meal. Barium meal and follow through examination revealed congenital malrotation of her bowel. This was confirmed at exploratory laparotomy, but was thought not to be responsible for the vomiting. Referal to a psychiatrist elicited a history of food and weight preoccupation, binge eating and consequent vomiting.

These two complications, upper gastrointestinal tract haemorrhage presumably due to a Mallory Weiss mucosal lesion (Foster *et al*, 1976), and illadvised surgical intervention, have not been reported previously. In neither case was sufficient enquiry made into patterns of eating. Mrs A., certainly, was anxious to reveal and seek help for her problem.

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References

ABRAHAM, S. F. & BEUMONT, P. J. V. (1982) How patients describe bulima or binge eating. *Psychological Medicine*, **12**, 625–35.

FAIRBURN, G. C. (1982) Binge eating and bulimia nervosa. *SK&F Publications*, **1** (4), 1–20.

—— & COOPER, P. J. (1982) Self induced vomiting and bulimia nervosa: an indetected problem. *British Medical Journal*, **284**, 1153–5.

—— —— (1984) The clinical features of bulimia nervosa. *British Journal of Psychiatry*, **144**, 283–46.

FOSTER, D. N., MILOSZEWSKI, K. & LOSOWSKY, M. S. (1976) Diagnosis of Mallory-Weiss lesions. *Lancet*, **ii**, 483–5.

PYLE, R. L., MITCHELL, J. E. & ECKERT, E. D. (1981) Bulimia: a report of 34 cases. *Journal of Clinical Psychiatry*, **42**, 60–4.

RUSSELL, G. (1979) Bulimia nervosa: an ominous variant of anorexia nervosa. *Psychological Medicine*, **9**, 429–48.

PRESCRIBING PSYCHOTROPIC DRUGS

DEAR SIR,

In their survey of prescribing patterns, Morgan and Gopalaswamy (*Journal*, March 1984, **144**, 298–302) criticise the value of drug surveys which fail to look at the patients' individual clinical details. Though this seems correct when a choice of drug or drug group is being criticised, I feel that there is still information to be learned from general surveys of prescribing. These serve to underline the need for rational pharmacotherapy, for instance, as set out by Ayd (1973).

This is illustrated by a review of patients' medication in the long-stay wards of a large psychiatric hospital, which I carried out without reference to individual diagnosis. There were 313 patients in these wards: 174 could be broadly classified as chronic psychogeriatric patients, and 134 as chronic psychotic. Their placements on these wards could be regarded as effectively permanent.

The findings as relevant to their discussion were as follows: 33% of patients were on more than three different drugs and 18% were on more than four. 55% of the patients were needing more than two drug rounds per day, and 21% were on four times daily medication. Most drugs can be given in a once or twice daily dosage.

In the chronic psychotic group, 84% were receiving neuroleptic medication. 37% were on two or more types at once, 11% on more than two, and 2% on four types. Only 8% of these patients received depot neuroleptics alone, and 25% received both depot and oral forms. There are few good reasons for chronic patients to be on more than one neuroleptic at once.

In the same group, 56% were receiving anticholinergic anti-parkinsonian agents, with 95% of

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