alists in the fields of audiological assessment and mental health. Such a project is currently under way at this centre.

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ANOREXIA NERVOSA, FOLLOWING TERMINATION OF PREGNANCY

DEAR SIR,

We would like to report a case of anorexia nervosa following termination of pregnancy. Such a syndrome has not been described previously in the literature.

The lady was a 38-year-old nurse in her second marriage. She had three children and her husband had undergone vasectomy 8 years before. The pregnancy was recognized in its tenth week. Two days later, she underwent termination of pregnancy and bilateral tubal ligation.

Three months later, she was referred to a psychiatrist with depression, severe guilt feelings, loss of appetite, loss of weight, (from 62–50 kg), loss of libido, amenorrhoea and early morning waking. She was admitted to hospital and prescribed clomipramine 100 mgs at night. During psychotherapy, her guilt feelings were explored and these centred around the termination. At this stage, she also expressed hostility towards her husband, who had insisted upon this procedure. It was in this setting that suicidal ideation became more prominent and a course of four electroconvulsive treatments (ECT) were given. Following this, her mood became less depressed and her guilt feelings disappeared.

However, she continued to lose weight. It was at this stage one of the nurses discovered her taking 5 cascara tablets. Further enquiry revealed that she had regularly purged herself, taking up to 9 cascara tablets a day. She occasionally binged, when she would stuff herself full of food. This was followed by induced vomiting. Her diet was otherwise very strict and she had a rigid hierarchy of foodstuffs that she could eat based upon their calorific value. She also exhibited distortion of the body image, feeling disproportionately fat, particularly over her shoulders and buttocks, and expressed the desire to reach the weight of 38 kg.

Eighteen years ago, at the time of her first pregnancy, she experienced bulimia and her weight rose to 96 kg. Her score on the Eating Attitudes Test (Garner *et al*, 1979) was well within the range of anorexia nervosa. Treatment was carried out with simple behavioural techniques and chlorpromazine and her weight rose to 50 kg (her admission weight). She is now back in full employment, and anxious to be free of medical involvement, even though she still vomits and purges herself to maintain her weight at 45 kg.

There are three features in this case that deserve attention. Firstly, using Feighner's criteria (1972) she would be too old to be included in his diagnostic category for anorexia nervosa.

Secondly, Crisp (1980), has pointed out that when this illness presents in later life, careful enquiry of the past should be made. In this case, it revealed an episode of bulimia and disproportionate weight gain at the time of her first pregnancy, and frequent dieting since then. Thirdly, there is an overlap in the biological constellation of symptoms found in depression and anorexia nervosa. In such cases, patients may initially present with what appears to be a depressed state, (as indeed happened in our case), before the true diagnosis is reached.

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