Late-onset anorexia nervosa

SIR: I read the paper on late-onset anorexia nervosa by Boast *et al* (*Journal*, February 1992, **160**, 257–260) with great interest. This well-established service gives the opportunity to review cases over a 16-year period, generating numbers suitable for statistical analysis. Six women with late-onset anorexia nervosa (over 25) presented to the Leicestershire Eating Disorders Service between 1983 and 1991 (age of onset: mean 31 years, s.d. 3.5). Of patients over 16 presenting with this diagnosis, 6% were late-onset cases. This is consistent with the findings of Garfinkel & Garner (1982).

The paper identifies older patients as losing more weight than the younger group. The authors suggest this may be a possible referral bias. For our service, taking patients mainly from Leicestershire, the mean body mass index at presentation was higher for the late-onset group (17.5 kg/m^2 compared with 14.8 kg/m^2 for case-matched controls under 20).

It is pertinent to ask why women become eating disordered only later in life. Anorexia nervosa developing in the context of a depressive illness appears a sound proposition. Three of our six late-onset cases had a history of depression before the onset of anorexia nervosa. An additional two became markedly depressed during out-patient treatment. They had the associated symptoms of depressive illness which responded to antidepressant medication. Two of the Leicestershire late-onset cases developed anorexia nervosa soon after childbirth. Literature on the association between pregnancy, motherhood and eating disorders has been prominent recently (Fahy & O'Donoghue, 1991).

Conceptualising anorexia nervosa as a disorder of adolescence may deter older women from coming forward. Eating disorders in older women deserve a higher profile; perhaps then a more accurate indication of the true prevalence could develop.

FAHY, T. A. & O'DONOGHUE, G. (1991) Eating disorders and pregnancy. *Psychological Medicine*, **21**, 577–580.

GARFINKEL, P. E. & GARNER, D. M. (1982) *Anorexia Nervosa: A Multidimensional Approach*. New York: Brunner and Mazel.

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Sexual abuse and referral bias

SIR: Waller (*Journal*, November 1991, **159**, 664–671) clearly demonstrated an excess of bulimic patients with a history of sexual abuse compared with their anorexic counterparts. There is an explanation which was not explored in the study. There may be a bias on the part of the patient or the referrer to seek specialist treatment for bulimia when a history of sexual abuse is an additional factor. A higher relative rate of disclosure of sexual abuse to the referring agent among the bulimic patients might point to such a process.

I investigated a similar phenomenon as part of a case-note study of 190 women referred to the Nottingham Puerperal Mental Illness Unit between July 1989 and July 1990. Previous work had shown that women presenting in the year following childbirth are more severely ill than men and women in the same age group and are more likely to be suffering from manic–depression (Oates, 1988). I found that minor depressive episodes and adjustment disorders, although not normally referred to psychiatric services, accounted for the large majority of diagnoses associated with the childhood sexual abuse (CSA). The overall rate of reported CSA was 8%. Of the 16 women referred in pregnancy 44% reported CSA, as compared with 4.7% of post-natal women (8 of 174). Of those reporting a history of CSA, a higher proportion of those referred in pregnancy disclosed to the referrer as compared to the post-natal group. The difference was not significant because of the small numbers involved. However, since only a small proportion of mild disorder in pregnancy is referred to the Puerperal Mental Illness Unit, the data suggests that disclosure of CSA lowers the threshold for specialist referral in pregnancy.

This raises the possibility that a similar process might operate in eating-disordered patients. Fairburn & Cooper (1984) have shown that only a minority of women with bulimic symptoms seek specialist treatment, so that if the referral threshold was lowered by the disclosure of sexual abuse, this would account for Dr Waller's findings.

FAIRBURN, C. G. & COOPER, P. J. (1984) Binge-eating, self-induced vomiting and laxative abuse; a community study. *Psychological Medicine*, **144**, 401–410.

OATES, M. (1988) In *Motherhood and Mental Illness*. vol. II, (eds R. Kumar & I. S. Brockington), pp. 133–158. Guildford: J. Wright.

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Screening for depression in the medically ill

SIR: Meakin (*Journal*, February 1992, **160**, 212–216) advocates response to treatment with tricyclic antidepressants for validating paper and pencil tests