Addison’s disease presenting as anorexia nervosa in a young man

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Summary: A young man with a long history of obsessional traits and food fads presented with anorexia, vomiting and marked weight loss. He showed little concern for his physical state and his vomiting was frequently witnessed as self-induced. A diagnosis of anorexia nervosa was made and he took his own discharge from hospital. He was readmitted one month later, severely cachectic and with biochemical abnormalities consistent with advanced Addison’s disease which was subsequently confirmed. He responded dramatically, both mentally and physically, to corticosteroid therapy. It is likely that anorexia nervosa, relatively rare in males, was a manifestation of the psychological abnormalities commonly seen in severe Addison’s disease.

Introduction

Psychological changes are common in Addison’s disease and frank psychosis is well recognized. Anorexia nervosa, predominantly a disease of young women, has never been reported in association with Addison’s disease. We report a case of anorexia nervosa, apparently precipitated by acute adrenal insufficiency, in a young man with a long history of minor psychological disturbances and its complete remission following corticosteroid replacement for Addison’s disease.

Case report

A 20 year old vegan was admitted to hospital following a visit from his general practitioner at the request of his parents. They were concerned about their son’s recent weight loss, his depressed and apathetic mood, loss of appetite and intermittent vomiting. He had lost approximately 18 kg in weight in the previous 6 months and had refused to seek medical help. He had strictly adhered to a vegetarian diet for the past two years and had numerous food fads since the age of 10 years. He was seen by a psychologist at that time because of a refusal to take food, at which stage he was showing ‘minor psychological disturbances including abnormal obsessional traits’.

He admitted to recent depression with insomnia and lack of concentration which he attributed to social isolation because of chronic unemployment. Sexual interest and potency had declined and he insisted that he was taking adequate nutrition, denying that he was underweight.

On examination, he was malnourished and dehydrated, weighing 40 kg (body mass index 14.3). He was not pigmented and blood pressure was 90/60 mmHg. Serum sodium was 126 mmol/l, potassium 3.8 mmol/l, urea 6.4 mmol/l and glucose 4.7 mmol/l.

While in hospital he refused all food, only taking water. He had episodic vomiting which was frequently witnessed as self-induced and the vomit was sometimes concealed. On formal psychiatric assessment he was considered to have classical anorexia nervosa with a typical premorbid personality. He refused further investigation and treatment and took his own discharge against medical advice. One month later, he was readmitted severely dehydrated and cachectic and now weighing only 38.5 kg. Serum sodium had fallen to 114 mmol/l, potassium was 5.0 mmol/l, urea 31.0 mmol/l and glucose 5.4 mmol/l. Other investigations were as follows: 09.00 h cortisol 124 nmol/l (normal 130–690 nmol/l) with no response to 1 mg of tetracosactrin, ACTH 1687 ng/l (normal 10–80); adrenal antibodies, Mantoux test 1:1000, sputum, urine and bone marrow aspirate for acid-fast bacilli all negative, chest and abdominal X-rays normal.

He was commenced on hydrocortisone 20 mg in the morning and 10 mg in the afternoon with
References

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