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CASE REPORT

Complications of pre-operative anorexia nervosa in bariatric surgery

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Summary It is important to recognise that patients who seek weight loss surgery may have a history of restrictive eating or anorexia nervosa. The following case report describes a woman with a history of anorexia nervosa who underwent Roux-en-Y gastric bypass surgery. Her eating disorder symptoms subsequently reappeared and were largely resistant to treatment. To the best of our knowledge, this is the first case report of a bariatric surgery patient with a prior history of anorexia nervosa. Further research is required to determine how best to select patients for weight loss surgery.
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Introduction

When evaluating candidates for bariatric surgery, surgical teams routinely consider a variety of current and past medical conditions, including eating disorders related to being obese, such as excessive weight gain and patterns of overeating. However, disorders related to being underweight, including excessive weight loss and patterns of restrictive caloric intake, are often overlooked. In this report, we describe a patient who had an undisclosed history of anorexia nervosa (AN) prior to undergoing bariatric surgery. Subsequently, the AN reemerged and treating it with standard behavioural interventions was difficult. This case illustrates why a history of AN, or a predisposition for restrictive eating, needs to be recognised pre-operatively when evaluating candidates for bariatric surgery.

Case history

After failing to gain weight at a partial hospital day treatment program, a 52-year-old woman was admitted to our specialised inpatient unit for

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individuals with eating disorders. She satisfied the diagnostic criteria for AN set forth in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (the DSM-5), which include restriction of caloric intake, fear of weight gain, and shape and weight concerns. Notably, the DSM-5 does not have a specific body mass index (BMI) threshold below which a patient must fall to qualify for a diagnosis of AN. She reported a long history of AN, as well as excessive concern regarding her weight and size. At the time of her admission, the patient was 64 in (163 cm) tall, weighed 103 lb (46.8 kg), and had a BMI of 17.6 kg/m^2.

The patient's AN symptoms first manifested at age 16, when she lost 100 lb (45.5 kg) from a starting weight of over 200 lb (91 kg) by restricting her eating, over-exercising, and using diet pills. She had no specialised care for AN at that time. Her primary care doctor, whom she saw monthly, monitored her weight and vital signs. The patient maintained a low-normal weight for six to seven years, until she became pregnant with her first child at age 24. During her pregnancy, her weight increased 100 lb (45.5 kg), returning to 200 lb (91 kg) at the time of the normal vaginal delivery of her son.

Several years later, at age 34, the patient's AN symptoms returned, and she lost approximately 115 lb (52.3 kg) over a one-year period by severely restricting her caloric intake and over-exercising, which she attributed to emotional distress from marital difficulties. She required hospitalisation for one week for weight loss and malnutrition. After being discharged from the hospital, she spent three weeks at a day treatment program, which successfully stabilised her weight in the short term.

Following her completion of the day treatment program, the patient began binge eating, which continued — with varying degrees of severity — for more than a decade, until she ultimately reached 325 lb (147.7 kg) and developed hypertension and elevated blood glucose levels. In 2010, she sought bariatric surgery to treat these conditions. When she underwent the prerequisite pre-operative psychological screening, she did not disclose her history of AN. In October of that year, she had Roux-en-Y gastric bypass surgery.

Within six months of the surgery, the patient lost 100 lb (45.5 kg). During this period and for the next six months, she was following the diet and exercise regimen prescribed by her surgeon. Then, after a difficult personal experience, she began to overly restrict her caloric intake and to exercise excessively. She was consuming only 800—900 kcal per day. While there are no specific recommendations for long-term calorie intake post-surgery, survey data compiled in one study suggest that patients consume an average of over 1700 kcal per day 30 months following the surgery [1]. The patient was also going to the gym twice daily, and taking her dog for multiple hour-long walks each day in an attempt to compensate for guilt she experienced in relation to meals. She denied self-induced vomiting, but did take over-the-counter stimulant laxatives, laxative teas, and stool softeners daily. The patient concealed this behaviour during her follow-up with the bariatric surgical team, which did not detect that her caloric intake was too low even by post-surgical standards. By the time she presented to our institution, four years following her surgery, the patient had lost approximately 210 lb (95.5 kg) and weighed 103 lb (46.8 kg). She reported that, due to her gastric bypass, she was unable to eat meat of any kind, could not eat carbohydrates except granola, and could only swallow low-fat and/or low-sugar foods. She had not menstruated for five years, since before her surgery.

On initial examination, the patient was thin. She appeared older than her stated age. There was no sign of jaundice. Her blood pressure was 116/65 mm Hg and her pulse was 60 bpm. Cardiovascular examination showed regular rate and rhythm without murmurs or jugular venous distention. Abdominal examination was notable for loose skin, but abdomen was soft and non-tender. There was no lower extremity edema.

The patient's attitude was superficially cooperative. She described her mood as ''so-so'' and demonstrated a full range of affect. Her thoughts were linear and goal-directed. She had no psychosis, suicidal ideation, or homicidal ideation. She was alert and oriented. Her insight and judgment were assessed to be poor, given her persistent attempts to restrict her food intake.

Course of inpatient treatment

Treatment included structured meals and snacks aimed at weight restoration and development of healthy eating behaviours. Our unit uses behavioural management strategies that reinforce nutritional stabilization and normalization of eating behaviours. Specifically, the psychiatrist-led, multidisciplinary treatment team uses behavioural, cognitive, and supportive therapies in a group and individual setting to help patients address their disordered eating behaviours. Treatment includes nutritional education, with a goal of decreasing

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