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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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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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