undereating, and is a physiological perpetuating factor of anorexia nervosa (Robinson, *Journal*, March 1989, **154**, 400–405). In the study of Stacher *et al* where gastric symptoms were specifically measured, it is noteworthy that all the anorexic patients showed varying degrees of gastric fullness, pain, belching, and bloating.

In those Asian cultures where a permeative cultural fear of fatness is inconspicuous, stomach affliction may be a more admissible means of adopting the sick role and negotiating change in interpersonal worlds than complaints of fatness or depression. Among Hong Kong Chinese, we see a phenomenological mixture of anorexic patients, some of whom used epigastric bloating and/or pain rather than the fear of fatness to legitimate food refusal and emaciation (Lee, 1991). Delayed gastric emptying may conceivably contribute to their culturally amplified gastric complaint, which should not be presumed to be a purely psychological defense. Stacher *et al* have shown that the enhancement of gastric emptying may be therapeutically useful, and perhaps more meaningful than confronting anorexic patients about their body image distortion. If the finding can be substantiated in the long-term treatment of a larger group of anorexic patients, the implications for the often difficult treatment of both Western and non-Western anorexic patients may be considerable.

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Blood-letting in bulimia nervosa

SIR: Parkin & Eagles (*Journal*, February 1993, **162**, 246–248) reported three cases of blood-letting in association with bulimia nervosa, and noted this association had not previously been described. We would like to report a similar case.

Case report. Our patient, in her 20s, described an uneventful early childhood but recalled lifelong difficulty socialising, associated with lack of self-confidence. She did well academically at university, but had a limited social life with no sexual relationships. She had a period of in-patient treatment eight years ago for anorexia nervosa and was treated as an out-patient two years ago following episodes of self-mutilation. There was a positive family history, her younger sister having been treated for anorexia nervosa and trichotillomania.

She was referred, on this occasion, because of episodes of self-mutilation, blood-letting, bingeing, and depressed mood. She described cutting herself, after which she sutured the wound without anaesthetic. On one occasion she sutured a self-inflicted cut on her leg while engaged in a telephone conversation. She also described two episodes of performing venisection on herself. On each occasion she withdrew approximately a pint and a half of blood which she then poured down the sink. She described excessive intake of alcohol of 60 units per week, and depressive symptoms which met DSM – III – R criteria for dysthymic disorder. She had previously met DSM – III – R criteria for bulimia nervosa, although she currently did not. She weighed 57.2 kg and her height was 1.7 m.

She was on fluoxetine, 20 mg daily, and this was increased to 60 mg daily. She was also referred to a Day Hospital Group for assertiveness training. Less than one month later she required admission to the general hospital having venisected herself again. Her haemoglobin was 4.6 g/l and she required a blood transfusion.

Three months after presentation she was euthymic, she had returned to work, and she felt no desire to cut or venisect herself. Her eating pattern was normal and she had successfully completed assertiveness training. She remained on fluoxetine, 60 mg daily. She reported that she had not obtained any relief from cutting or venisecting. Her cutting had started two years earlier and although initially this relieved tension, it no longer did. She was unable to identify any urge to venisect, and after venisecting she described feeling 'numb'. The venisection had not been accompanied by any suicidal intent or performed in the hope of weight loss.

There are a number of similarities between this case and the three previously described. Our patient is a veterinary surgeon with access to instruments, and has knowledge of blood-letting. She had previously engaged in acts of self-harm, and in the past had met DSM – III – R criteria for bulimia nervosa. However, a notable difference is the fact that this patient does not derive any apparent psychological benefit from blood-letting and was 'mystified' as to why she did it.

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Abuse of the nasogastric tube in patients with eating disorders

SIR: The case reports by Parkin & Eagles (*Journal*, February 1993, **162**, 246–248) describing blood-letting in bulimia nervosa highlight the self-abusive

behaviour patterns that can occur in patients with eating disorders.

A behaviour involving abuse of medical equipment occurred in two of our patients with eating disorders who used a nasogastric tube and syringe to aspirate their stomach contents.

Case reports. Case A, a 22-year-old nurse with an eight-year history of bulimia nervosa fulfilling DSM – III – R criteria, had severe bulimia, binging and vomiting up to three times each day. She also had a history of abusing aspirin to induce gastritis, and to decrease her appetite. She went to the accident and emergency department, having swallowed a nasogastric tube, and an oesophagoscopy was performed to remove the tube. She had used the nasogastric tube to empty her stomach after meals and binges, as she considered it more effective than vomiting. (Six months later, she again swallowed the nasogastric tube and spigot which was removed by gastroscopy.)

Case B, a 20-year-old student of Indian origin, was admitted to the Eating Disorder Unit with a two-month history of self-starvation and weight loss to 36 kg (30% below standard body weight). The diagnosis was of abstaining anorexia nervosa. Initially she refused to eat and, after other treatment options had failed and because of her deteriorating physical state, she was treated with nasogastric-tube feeding for four weeks. She was found to have been inserting a nasogastric tube and using a syringe to aspirate her stomach contents, thus controlling her food intake. She denied self-induced vomiting.

The abuse of a nasogastric tube is a behaviour that one should be aware can occur in patients with an eating disorder, particularly if they have medical or nursing experience, or in those patients who on rare occasions may require tube feeding as part of in-patient treatment.

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CORRIGENDUM

Journal, May 1992, **160**, 671. The legend for Figure 2 should read "Number of panic attacks per hour".

A HUNDRED YEARS AGO

Homicidal insanity

A wave, so to speak, of homicidal insanity has been passing over the North of England lately. At Middlesborough a lunatic shot a policeman, who was trying to secure him, through the heart; and at Durham, last week, a lunatic shot at two bank clerks with a revolver and wounded them – happily, it is hoped, not dangerously – and then shot himself fatally. From some writing found upon the suicide it appears that he brooded over some supposed wrong, for he had an entry that "bank clerks and post-office clerks were all the same".

Reference

Lancet, 6 May 1893, 1098.

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