Eating Disorders
what do GPs need to know?

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May 2016
Overview

• Eating, weight and eating disorders

• Case scenario

• How to spot them

• When to refer

• Management pre and post referral
Eating and weight

• Adolescence
  o Time of change in weight, eating habits, dieting
  o Identity development
  o Dissatisfaction with body
  o Common time for ‘independence’ from family eating

• Dieting
  o Lots of people diet or are ‘obsessed’ with weight, few have eating disorder

• Obesity

• Culture & fashion

• Physical Disorders
  o and other factors can affect appetite and weight
Eating Disorders

- Morbid preoccupation with weight and shape
- Distorted or chaotic (eating) behaviours
- Can be chronic
- 90% are female...don't forget the ‘boys’
- Often present in adolescents/ young adults...don't forget the later presentation
- All ethnic groups
- Social, genetic, psychological (‘ideal weight’, temperament’) factors
- Different mechanism to food fads, food phobia, obesity
- Families and systems are important
Anorexia Nervosa

- Self induced *weight loss*, and sustained
- Body image distortion, fear of gaining weight, intrusive overvalued ideas
- Impose a low weight threshold
- Restricting type or binge/purge type (DSM)
- +/- vomiting, purging, excessive exercise, appetite suppressants, diuretics

- Undernutrition
- Metabolic/ Endocrine (hypothalamic- pituitary- gonadal axis e.g. amenorrhea)
- Disturbances of body function
- Delayed or arrested growth/ puberty

- Most common in girls and young women, 0.5% girls
- 3\(^{rd}\) most common chronic illness of adolescence

- Can have an atypical presentation:
  - E.g. weight loss and weight reducing behaviour but no dread of being fat

- Can kill
Bulimia Nervosa

• Excessive preoccupation with eating and control of body weight
• Over-concern with body shape, dread of ‘fatness’
• Overeating in short periods of time
• ...followed by vomiting, use of purgatives, starvation periods, appetite suppressants, thyroid preparations, diuretics, excessive exercise
• Purging type/ non purging type (DSM)
• Vomiting giving rise to electrolyte disturbance and physical complications
• Endocrine disturbance
• 1-3% prevalence
• Can appear similar to AN, and sometimes earlier episode of AN
• Don’t forget atypical presentations
• **AN**
  - Low weight
  - Presents early
  - Rarely seeks help
  - Often early to mid teens onset
  - Can be pre-menarcheal
  - Can affect boys
  - Can be chronic
  - No previous illness
  - Depression, anxiety, OCD
  - Poor prognosis without early intervention

• **BN**
  - Normal weight
  - Presents late
  - May seek help
  - Often late teen onset
  - Rarely pre-menarcheal
  - Usually affects girls
  - Usually fluctuating course
  - Previous AN (mthys/yr before)
  - Depression, S/H, substances
  - Up to 60% response to Tx
Others

- **EDNOS**: ED that doesn’t meet criteria for AN, BN.
  - subthreshold AN/BN,
  - mixture of AN and BN
  - Very atypical eating behaviours not characterised by AN/BN

- ‘Binge eating’:
  - some will call it a disorder
  - ...but is a pattern of episodes of uncontrollable eating
  - often hidden
  - associated shame, depressed mood

- Others:
  - Psychogenic overeating
  - Psychogenic vomiting
  - Pica in adults
Case discussion
How to spot them?
How to spot them?

• GPs likely to have some ED patients on their case load

• ...but may not have identified them as often ‘hidden’: patients’ secretive nature and reluctance to seek help

• It may be someone else who spots it for you...get the collateral history from them

• Need to spot them as early intervention very important for prognosis
How to spot them?

• Can be difficult:
  o Reluctant attender to clinic- ‘its just a lifestyle choice, not an illness’
  o Physical symptoms
  o Resists examination and observations
  o Covers body
  o Secretive/ evasive –May be distressed when asked about eating

• Risk factors (esp. if in adolescence):
  o Female…but don’t forget about boys
  o Repeated dieting
  o Early puberty
  o Temperament
  o Perfectionism
  o Teasing about weight
  o Low self esteem
  o Loss & major life events
  o Family dysfunction
What should I do?

• Take a good history – you can make diagnosis from this!

• What should I ask?
  o How do you feel about your weight?
  o Do you worry about your weight?
  o Does anyone else worry about your weight, eating or exercising?
  o Do you think you have any eating difficulties?
  o How much would you like to weigh? (and how soon?)

  o What do you think about the look of your body?
  o Have you made any changes to your diet?
  o Are you restricting your diet?
  o How often and how much exercise?
  o Have you been making yourself sick?
  o Have you been using any other drugs?
What else should I explore?

• Mental state
  o Anxiety
  o Depression
  o S/H
  o suicide
  o OCD
  o ASD
  o Psychosis

• Past Psychiatric history
  o Eating
  o Premorbid personality

• Past Medical history

• Family history

• Substances, other drugs

• Change in functioning

• Life events
  o trauma & abuse

• Systemic factors
  o Family, parents, siblings
  o School
  o Friends
  o Social media – ‘pro-ana’ ‘pro-mia’
Physical examination

Signs of malnutrition and purging
- Thinning hair
- Parotid gland swelling
- Enamel erosion
- Hypothermia
- Bradycardia
- Lanugo hair
- Dry skin
- Hypotension
- Underweight
- Cold (blue/dark) hands/feet
- Poor capillary return
- Insensitivity to pain
- Constipation
- Amenorrhoea

Measurements & investigations
- Weight
- Height
- BMI (centile)
- BP & pulse (postural drop)
- ECG
- Temperature
- Sit up/ Squat test
- Blood tests: FBC, UEs, PO4, LFT, Albumin, CK, Glucose, Mg, Ca, TFT, serum proteins, FSH, LH, GH
- Bone scan
- Pregnant?
- Diabetic?
Management
Management

• Therapeutic relationship important
• Feedback findings
• Continue to monitor risk
• Mental state examination
• Establish a weight monitoring plan
• Provide family/carers with information, encourage their involvement
• Low threshold for referral/discussions with clinicians in secondary care
• Plan to monitor whilst awaiting assessment
What happens after referral?

• Majority will be managed as outpatients/day hospital (6/12+):
  o MDT management – medical, dietician, psychology
  o Meal planning
  o Family involvement
  o Medication e.g. SSRI

• Small proportion will require inpatient admission
  o Very rapid weight loss, BMI well below 2nd centile, suicidal, physical compromise
  o Meal planning, observations,
  o Goal to establish weight gain
  o May require use of MHA
  o Family involvement, family support
  o Medication

• Discharge back to GP
  o Shared care agreement
  o Who is monitoring, how often?
  o Contingency/crisis/relapse prevention plans
Summary – key points

• Early detection/ intervention gives better prognosis

• Assess mental health, physical health…and RISK

• Have a contingency plan once referred

• What’s going on in their ‘system’?

• The most effective screening test is the GP thinking about it
Useful resources

• NICE guidance

• MARSIPAN: RCPsych

• ‘BEAT’ – UK eating disorder charity

• BMJ : eating disorders and weight problems

• ‘pro’ websites