Eating Disorders

what do GPs need to know?

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Overview

- Eating, weight and eating disorders
- Case scenario
- How to spot them
- When to refer
- Management pre and post referral

Eating and weight

- Adolescence
  - Time of change in weight, eating habits, dieting
  - Identity development
  - Dissatisfaction with body
  - Common time for 'independence' from family eating
- Dieting
  - Lots of people diet or are 'obsessed' with weight, few have eating disorder
- Obesity
- Culture & fashion
- Physical Disorders
  - and other factors can affect appetite and weight


Underweight
Anorexia nervosa
Food
Eating disorders
Distorted body image
Obesity
Treatment
Health problems
Symptoms
Eating habits
Skinny
Size zero
Weight loss
Weight gain
Self-esteem
Dieting
Health
Bulimia nervosa
Body Weight
Diet pills
Medical condition
Malnutrition
Teenagers
Calories

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
- 3rd most common chronic illness of adolescence

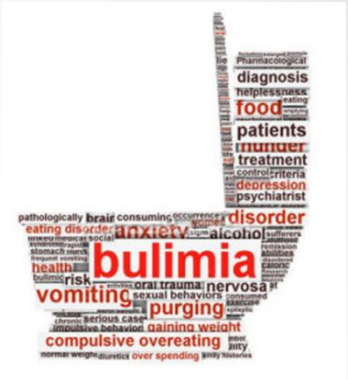
- Can have an atypical presentation:
  - E.g. weight loss and weight reducing behaviour but no dread of being fat

- 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

Vs



- 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-menarchael
  - Usually affects girls
  - Usually fluctuating course
  - Previous AN (mnths/yrs 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:
  - Reluctant attender to clinic- 'its just a lifestyle choice, not an illness'
  - Physical symptoms
  - Resists examination and observations
  - Covers body
  - Secretive/ evasive –May be distressed when asked about eating

- Risk factors (esp. if in adolescence):
  - Female…but don't forget about boys
  - Repeated dieting
  - Early puberty
  - Temperament
  - Perfectionism
  - Teasing about weight
  - Low self esteem
  - Loss & major life events
  - Family dysfunction

What should I do?

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

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

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

What else should I explore?

- Mental state
  - Anxiety
  - Depression
  - S/H
  - suicide
  - OCD
  - ASD
  - Psychosis
- Past Psychiatric history
  - Eating
  - Premorbid personality
- Past Medical history
- Family history
- Substances, other drugs
- Change in functioning
- Life events
  - trauma & abuse
- Systemic factors
  - Family, parents, siblings
  - School
  - Friends
  - 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+):
  - MDT management – medical, dietician, psychology
  - Meal planning
  - Family involvement
  - Medication e.g. SSRI
- Small proportion will require inpatient admission
  - Very rapid weight loss, BMI well below 2nd centile, suicidal, physical compromise
  - Meal planning, observations,
  - Goal to establish weight gain
  - May require use of MHA
  - Family involvement, family support
  - Medication
- Discharge back to GP
  - Shared care agreement
  - Who is monitoring, how often?
  - 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