EATING DISORDERS

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Learning Objectives

• To understand how someone may present with an Eating Disorder and learn the factors that may have influenced it’s onset.
• To recognise the psychological and physical manifestations of an Eating Disorder.
• To know how to undertake an assessment, make a formulation and treatment plan.
Definition of Eating Disorders

• psychological illnesses defined by abnormal eating habits involving either insufficient or excessive food intake to the detriment of an individual’s physical and mental health.
Types of Eating Disorder

- Anorexia nervosa (10%)
- Bulimia nervosa (40%)
- Eating disorder not otherwise specified (EDNOS)
- Binge eating
Eating Disorder Statistics - BEAT

• c725 000 in UK
• number being diagnosed and entering inpatient treatment increased at average 7% year on year since 2009
• 11% male

• symptoms first recognised under age of 16 in 62% of cases

From ‘The Costs of Eating Disorders- Social, health and economic impacts’ February 2015
Lifetime Prevalence

- Anorexia Nervosa 0.6%
- Bulimia Nervosa 1.0%
- Binge Eating Disorder 2.8%
Eating disorders are a life threatening illness

- Highest mortality rate of all psychiatric illnesses (up to 15%)
- 3rd highest morbidity and mortality rate after RTA and childhood cancers
- Early Identification improves Prognostic Outcomes
Presenting Features
Katie’s Story

https://youtu.be/tOouAmEEnlc
ICD 10 Anorexia Nervosa F50.0

Deliberate weight loss induced and/or sustained by patient via:-
• Grossly inadequate, irregular, or restricted food intake
• Overuse of laxatives, dietary suppressants or diuretics and self purging

Body weight maintained at least 15 % below expected or BMI < 17.5

Body image distortion

Morbid preoccupation with weight and shape

Endocrine dysfunction (HPA axis)
• amenorrhoea, loss of sexual interest, impotency in men
ICD 10 Bulimia Nervosa F50.2

Persistent preoccupation with eating and irresistible craving for food

Repeated bouts of overeating

Excessive preoccupation with control of body weight with morbid dread of fatness and sharply defined weight threshold

Adoption of extreme measures to mitigate the ‘fattening effects’ of ingested food

• self induced vomiting, purgative abuse, alternating periods of starvation, appetite suppressants, if diabetic misuse of insulin
Aetiology
Aetiology

• Genetics – heritability 60%

• Gender - more common in females, increasing in males

• Personality
  • Perfectionist
  • Conscientious
  • Wish to please
  • High Achievers
Aetiology

- Sociocultural
  - Media pressure
  - Occupations; ballet dancers, models, athletes, jockeys
Aetiology

- Personal history
  - History of childhood abuse (similar rates to in other psychiatric illnesses)
  - for bulimia previous obesity or anorexia nervosa (25-50%)

- Family
  - Parental style – ‘enmeshment’
  - Family traits

- Low Self Esteem

- Depression
ASSESSMENT
Figure 1.0
Treatment, recovery and relapse – the 6 year cycle

63% relapse rate

Symptoms emerge → Seeking help → Diagnosis

Average of 9 months

Relapse → Waiting for treatment → Recovery

Average of 9 months

Multiple relapses with an average total duration of 6 years

Lasting impacts
Assessment

1. Eating Disorder Symptoms
   - calorie restriction and preoccupation with food
   - distorted body image
   - fear of fatness
   - excessive exercise
   - Purging

2. Duration of Symptoms and history of weight loss
3. Any recognised Co-Morbidity
   - OCD
   - depression
   - Aspergers
   - Anxiety
   - self-harm

4. Current Weight, Height and BMI – (historical if possible)
5. Menstrual history - LMP
6. Past Medical History
7. Medication History
8. Family Structure
9. Current diet and eating pattern
10. Mental State Examination
11. Risk History
12. Physical examination including standing BP and pulse
SCOFF questionnaire (Morgan et al)

- Sick?
- Control?
- One stone weight loss in 3 months
- Fat?
- Food dominates your life?
Behavioural Features

- Food preoccupation
- Hiding food
- Secretiveness
- Vomiting
- Exercising
- Laxative abuse
- Withdrawal
- Irritability
Sophia

16 year old girl
attends local grammar school- top grades at GCSE
enjoys sports- in school netball team, recently started cross country

brought to GP by mother who is concerned that becoming a ‘fussy eater’.

you are seeing Sophia on her own during morning surgery

Ask Sophia questions to reach a differential diagnosis
PHYSICAL HEALTH
Physical Complications - AN

**Blood**
- anaemia
- leucopenia
- thrombocytopenia
- electrolyte disturbances

**Skin**
- lanugo hair

**Cardiovascular**
- bradycardia
- hypotension
- arrythymias
- heart failure

**Gastrointestinal**
- constipation
- abdo pain
- delayed gastric emptying

**Reproductive System**
- amenorrhoea
- infertility
- loss of libido
- loss of morning erection

**Musculoskeletal**
- osteoporosis
- proximal muscle weakness
Clinical Presentation - BN/purging

- Signs of malnutrition
- Arrhythmias
- Tender abdomen
- Erosion of dental enamel
- Dental caries
- Parotid swelling
- Electrolyte disturbances
What sign is this?

Russell’s sign
SUSS Test

- **Sit-Up – Squat – Stand**

1. Sit-up: patient lies down flat on the floor and sits up without, if possible, using their hands.

   Scoring (for Sit-up and Squat–Stand tests separately)
   0: Unable
   1: Able only using hands to help
   2: Able with noticeable difficulty
   3: Able with no difficulty

2. Squat–Stand: patient squats down and rises without, if possible, using their hands.
Blood Chemistry

- Full Blood Count;
- Anaemia,
- low white cell count
- Ferritin
- Urea & Electrolytes
- Hypokalaemia from vomiting/Diuretic use
- Hyponatraemia from water loading
• Abnormal renal function
• raised urea
• Liver Function Tests
• Total protein and albumin
• Calcium and magnesium Potassium
• Hypophosphataemia
• Glucose
• Hypoglycaemia
TREATMENT
Treatment Anorexia

Food is ultimately the treatment

NICE Guidelines Recommendations;
1. Psychoeducation
2. Young people and their families worked with together – empowerment of parents to take back control
3. Individual Therapy
4. Family Therapy
5. Regular Medical Overview; Physical complications
6. Do not use medication as sole or primary treatment
Very Low Weight and BMI

Always consider physical health first - consult MARSIPAN guidelines

BMI <13 = high risk

Other risk factors include
- bradycardia (<40bpm)
- hypotension
- hypothermia (<35°C)
- reduced muscle power
- low sodium
- low potassium
- hypoglycaemia
- raised transaminases
- raised urea or creatinine
- prolonged QTC (>450ms)
Mental Health Act

Tests for compulsory admission and treatment are:

the presence of a mental disorder

inpatient treatment is appropriate, necessary and available

such treatment is necessary for the health and safety of the patient
MHA and Eating Disorders

may be putting their lives at risk and require inpatient treatment

ey can be detained under the MHA and treated against their will, this should be last resort but will need to be considered if refusing treatment

under the MHA refeeding is recognised as treatment and can be done against the will of a patient as a life-saving measure
Treatment Bulimia

NICE guidelines suggest;
1. Psychoeducation
2. CBT-BN
3. Family therapeutic work
4. Potential for psychotropic medication - fluoxetine (SSRI)
Prognosis at 10 years

In anorexia:
- 50% recover
- 40% chronic eating disorder
- 10% die

In bulimia:
- 70% recover
- 29% chronic eating disorder
- 1% die
Helpful Websites

- NHS Choices
- BEAT
- National Centre for Eating Disorders
- RCPsych leaflets for patients and carers
Key References

• MARSIPAN guidelines (RCPsych, 2014)
• ICD-10 (WHO, 1992)