Learning Objectives

- To understand how someone may present with an Eating Disorder and learn the factors that may have influenced its 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/tOouAmEEnk

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

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

- Personal history
  - History of childhood abuse (similar rates to other psychiatric illnesses)
  - for bulimia previous obesity or anorexia nervosa (25-50%)
- Family
  - Parental style – ‘enmeshment’
  - Family traits
- Low Self Esteem
- Depression

**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

Gastrointestinal
- constipation
- slow gastric emptying
- delayed gastric emptying
- constipation
- abdominal pain
- diarrhea

Musculoskeletal
- osteoporosis
- proximal muscle weakness

Cardiovascular
- bradycardia
- hypotension
- arrhythmias
- heart failure

Reproductive System
- amenorrhea
- infertility
- loss of libido
- loss of morning erection

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.
2. Squat: patient opens their legs until parallel with the floor. Make sure the patient’s lower body is not touching the floor.
3. Stand: patient stands with their hands on their hips. Ensure proper body alignment.

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 (<35C)
- 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
they 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)