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(Room 7)

14:00 - 16:00 WS #15: Eating Disorders

16:30 - 18:30 WS #20: Eating Disorders (Repeated)

GPCME Meeting 2016 South

The A B C of Eating Disorders

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Princess Margaret Hospital

Christchurch

What are we dealing with?

Eating disorders are common group of diseases affecting young women

High mortality

High physical morbidity

High psychiatric co-morbidity

Eating disorders are a group of serious conditions in which you're so preoccupied with food and weight that you can often focus on little else. Mayo Clinic

The assessment of eating disordered patients may reveal that they look sick, but they are often much worse.

What are we dealing with?

We often deal with:-

Severe starvation/malnutrition

Multiple vitamin mineral and protein deficiencies

Loss of glycogen

Loss of fat

Loss of protein

Bulimia nervosa is associated with multiple metabolic and cardiac problems

These clinical findings are not necessarily reflected in laboratory tests.

Classification (DSMIV)

- Anorexia Nervosa
- Bulimia Nervosa
- Eating Disorder NOS (EDNOS)
- Binge Eating Disorder (in DSMV)

Classification

- Anorexia Nervosa

  Significant loss of body weight

  Intense fear of gaining weight

  Body image disturbance

  Amenorrhea (excluded in DSM V)

  Restricting, Binge-eating/Purging subtypes

  Cognitive inflexibility as prevalent thinking style

Classification

- Bulimia Nervosa

  Recurrent episodes of binge eating

  Recurrent compensatory behaviour

  Distinct sense of loss of control

  Frequency 2/week for 3 months

  Self-evaluation influenced by shape/weight

  AN excluded

  Purging/non-purging subtypes

Classification

- Eating Disorder NOS (FEDNEC: Feeding or Eating Disorder Not elsewhere classified, ARFID: Avoidant Restrictive Food Intake Disorder)

Meets criteria for AN and/or BN BUT

Females have menses (excluded in DSM V)

May have significant weight loss but weight is in the normal range

Binging and purging occur less frequently than in BN

Other Types of Clinical Eating Disturbance

- Binge Eating Disorder

  Very common, 3.5% females, 2% males.

  Does not exercise control over consumption of food.

  Feels loss of control over eating during binge.

  Eats when depressed or bored.

  Eats large amounts of food even when not really hungry.

  Feels disgusted, depressed, or guilty after binge eating.

  Experiences rapid weight gain/sudden onset of obesity.

Other Types of Clinical Eating Disturbance

Generally seen in childhood :-

Pervasive refusal syndrome

Food avoidance emotional disorder

Functional dysphagia /food phobia

Selective eating/extreme faddiness

Restrictive eating/poor appetite

Demographics

Anorexia Nervosa

- Lifetime prevalence for women 0.5%
- Typically presents at 15-19 years of age
- Incidence 20/100,000 females/yr
- 10% of presentations are males
- Younger onset
- 20% mortality

Demographics

Bulimia Nervosa

Lifetime for women 1-3%

Incidence 30/100,000 females/yr

Rapid increase in diagnosis since first described in 1979

Was initially thought that the disorder was a culturally bound syndrome. (not so)

Now stable or declining rates but local experience shows an increase in male presentations

Demographics

Eating Disorder NOS

Point prevalence young women 3-5%

More than half of clinical samples

Virtually unstudied

Prognostic Factors

Good

adolescence/first episode/short duration

relatively preserved body weight

intact family

established other roles

absence of co-morbidity

Prognostic factors

Bad

purging anorexia

chronicity > 6 years

alcohol and drug use

psychiatric co-morbidity, especially personality disorder

unrelenting lack of insight

Morbidity

It is timely to remember that patients with Anorexia Nervosa have a 10 fold risk of death compared with healthy controls.

A 50 times risk with concurrent type 1 diabetes or alcohol dependence

A 20% mortality at 20 years

Causes of death

Complications of Anorexia Nervosa – malnutrition, methods of weight control	54%
Suicide	27%
Other/unknown	19%

Morbidity

Specific causes of death

Rarely documented

Dehydration

Electrolyte disturbance

Metabolic complications (renal, hepatic)

Infections (bronchopneumonia, sepsis)

Cardiac complications

Rupture of the GI tract

Pathogenesis

Eating disorders are undoubtedly complex and multi-factorial disorders.

With AN, theories abound implicating social and cultural attitudes, genetic endowment, trauma, and family and interpersonal relationships.

Research has shown that there is a familial aggregation of eating disorders phenotypes :-

- Anorexia 48 – 74%
- Bulimia 54 – 83%
- BED 57%

Risk Factors for AN and BN

Female (only 10% cases are male)

Adolescent/young adult

Western culture

Dieting

Family history of

- eating disorder
- depression
- obesity (AN and BN)

Individual Characteristics

High intelligence (AN)

Perfectionism (AN)

High achievement (AN)

Over-compliance (AN)

Excessive exercise (AN / BN)

Low self-esteem (AN / BN)

OCD/OCPD traits (AN)

Anxiety (AN / BN)

Diagnosing Eating Disorders in General Practice

Cues to Anorexia nervosa

- Unexplained weight loss
- Failure to gain weight in proportion to height
- Secondary amenorrhea
- Bradycardia
- Hypotension

Diagnosing Eating Disorders in General Practice

Cues to Anorexia nervosa

- Hypothermia
- Peripheral cyanosis
- Lanugo hair, brittle hair, hair loss
- Hypercarotenemia
- Preoccupation with additional weight loss despite thinness

Diagnosing Eating Disorders in General Practice

Cues to Binge-Purge behaviour

- Swollen or tender parotid glands
- Dental enamel erosion / many new caries
- Calloused scarred area on back of hand
- Yo-yo weight pattern
- Hypokalemia

Diagnosing Eating Disorders in General Practice

The SCOFF questionnaire.

Do you make yourself **S**ick because you feel uncomfortably full?

Do you worry you have lost **C**ontrol over how much you eat?

Have you recently lost more than **O**ne stone in a 3 month period?

Do you believe yourself to be **F**at when others say you are too thin?

Would you say that **F**ood dominates your life?

One point for every "yes"; a score of >=2 indicates a likely case of anorexia nervosa or bulimia BMJ. 1999 Dec 4;319(7223):1467-8.

Physical complications and management

Metabolic abnormalities

- Metabolic alkalosis
- Hypokalemia
- Hypochloremia
- Hyponatremia
- Hypomagnesimia

Monitor -> HCO_3, K^+, Na^+, Cl^-, Mg^{++}

Physical complications and management

Hypokalemia (muscle weakness, fatigue, constipation)

Regular monitoring of K+ if purging > 3 times per day. More so if combined with laxative abuse.

If K+ < 3.0 mmol/l -> daily monitoring initially with ECG

Treatment -> Oral K+, Slow K 1-2 tabs tds with fluids (Chlorvescent often better tolerated but is not funded)

If K+ < 2.5 mmol/l or there has been a rapid drop in levels, or progression of ECG changes -> ED dept / hospitalise.

Physical complications and management

Constipation and laxative abuse

Constipation is due to low calorie intake, chronic laxative abuse, hypokalemia

Constipation is aggravated by chronic use of stimulant laxatives (Bisacodyl, Senna, etc)

Treatment -> Education

Switch from stimulant laxatives to non-stimulant varieties (Metamucil, fibre, fluids)

Then no laxatives

Physical complications and management

Cardiovascular complications

- Small heart, hypotrophic muscle
- Fatigue, decreased exercise tolerance
- Hypotension
- Bradycardia
- Cardiac arrhythmia (increased QTc, electrolytes)
- Hypothermia

Physical complications and management

Cardiovascular complications

Cardiac risk increased by ->

- Severe and or rapid weight loss
- High purge frequency
- Drastic re-feeding and rehydration
- Excessive exercise

Physical complications and management

Cardiovascular complications

Treatment ->

Normalise electrolyte imbalances

Weight restoration

Refer severe cases to Cardiologist

Avoid drugs causing QTc prolongation

tricyclic antidepressants
antipsychotics
cisapride

Restrict activities

Physical complications and management

Osteoporosis

Due to low oestrogen, high hydrocortisone

When early onset of amenorrhea, peak bone mass won't be achieved

Diagnosis -> DEXA bone scan

Treatment -> **Weight restoration**

Calcium supplement 1g daily

Cholecalciferol 1.25mg month

? Oestrogen / Progesterone replacement

Physical complications

Medical indications to consider hospitalisation

Severe malnutrition (BMI < 13) (Mass in Kg / Height in M squared)

Rapid weight loss (> 4kg in 6 weeks)

Severe dehydration

K+ below 2.5 mmol/l

Prolonged QTc interval (>500 msec)

Dysrhythmias

Physical complications

Medical indications to consider hospitalisation

Hypothermia (< 35.0 C)

Bradycardia (< 40 b/m)

Pulse differential (> 30 b/m)

Rapidly diminishing exercise tolerance

Frequent exercise induced chest pain

Oligouria (< 400 ml/day)

Low phosphate during initial re-feeding

Treatment

Bulimia Nervosa/ BED:

- Good evidence to support the use of CBT (16-20 sessions)
- IPT could be used as an alternative to CBT
- SSRI's (if no contraindications, always script)

Anorexia Nervosa:

- Limited evidence base
  - Some evidence for Olanzapine
  - Range of drugs may be used in the treatment of co-mordid conditions.
- Limited evidence for therapy **Except FBT in those under 18**

- Adults *without* chronic conditions
  - Consider CBT and IPT, accompanied by regular monitoring of patient's physical state.
  - Aim: reduce risk; encourage weight gain, reduce eating disorder cognitions and to facilitate psychological and physical recovery

In Summary :

Patients with eating disorders present complex challenges

Treatment involves careful monitoring of physical parameters

Psychological support is needed

Weight gain must always be a priority

Case History:

MJ, 16yr old female, lives with parents, attends high school

No previous contact with specialist health services

Presentation:

8 – 12 month history of restriction of food, now 42kg

Started as diet to loose weight. “I look fat”. Wgt 61kg

Now wanting to be thinner, not happy with appearance, fear of being fat

Now eating an apple for lunch and a pottle of soy yoghurt every other day

Drinks about 800mls water daily

Case History:

MJ, 16yr old female, lives with parents, attends high-school

No previous contact with specialist health services

Presentation:

Exercises by push-mowing lawns on family farm daily for 1-2 hours

Has become less social

Teased by brothers about weight

Amenorrhea 6 months, previously had regular cycle

No binge / purge behaviours, no laxatives, no diet pills

Poor sleep patterns

Case History:

MJ, 16yr old female, lives with parents, attends high-school

No previous contact with specialist health services

Presentation:

High achiever at school

Obsessional about tasks

Often inflexible about disagreements

No insight with regard to thinness or its consequences

Still convinced she is fat

Doesn't wish to engage with EDS

Case History:

MJ, 16yr old female, lives with parents, attends high-school

No previous contact with specialist health services

Presentation:

BMI is 13.2

Height on 85th percentile

Weight lower than 5th percentile

Neutropenia

U&E's are normal

ECG shows bradycardia, QTc interval 443

Case History:

MJ, 16yr old female, lives with parents, attends high-school

No previous contact with specialist health services

Presentation:

Echocardiogram shows small heart, normal structures

DEXA scan shows 4% body fat and reduced bone density

Case History:

Treatment:

What diagnosis can you make ?

How would you formulate your diagnosis ?

What interventions would you put in place ?

What monitoring would you recommend ?

Would you use compulsory treatment ?

What longer term care is required ?