Section of Eating Disorders
Institute of Psychiatry

Eating Disorders Unit
South London and Maudsley NHS Foundation Trust

A GENERAL PRACTITIONER'S GUIDE TO EATING DISORDERS

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What are eating disorders?

Eating disorders are a range of illnesses characterised by psychological and behavioral disturbances associated with food and weight. Traditionally there are three main types:

- Anorexia nervosa
- Bulimia nervosa
- Obesity

Viewed as a spectrum:

Adolescent preoccupation ..... Dieting .....Eating disorders with food and weight

What is anorexia nervosa?

Triad of:

1. Weight, measured as Body Mass Index (BMI) < 17.5kg/m2 due to controlled eating.
2. Distorted body image and abnormal attitudes to food and weight.
3. Amenorrhoea and often other signs of starvation.

What is bulimia nervosa?

Triad of:

1. Binge eating real or perceived excessive amounts of food with loss of self-control.
2. Desire for thinness and preoccupation with food and weight.
3. Strategies aimed at weight reduction – vomiting, laxative and /or diuretic abuse, excessive exercising

What is binge eating disorder?

Binge eating real or perceived excessive amounts of food with loss of self-control. No use of extreme weight control strategies therefore often associated with obesity.

What is my case load?

On your list you are likely to have:
• 1-2 patients with anorexia nervosa
• 18 patients with bulimia nervosa
• About 5-10 per cent of the adolescent girls in your practice will have used weight-reducing techniques other than dieting, i.e. vomiting, laxative or diuretic abuse, excessive exercising.

4 per cent of younger women will have an eating disorder in their lifetime.
Women with eating disorders outnumber men by 10 to 1.

What outcome should I expect?
30 per cent of cases of anorexia nervosa have a chronic course. The morbidity and mortality of this group is considerable.

Patients who have suffered with anorexia/bulimia nervosa for than 20 years stand a 20 per cent chance of dying from their illness, either by suicide or emaciation

How may a patient with an eating disorder present?

Eating disorders can present in a wide variety of ways and it may be the patient or a member of her family who first expresses concerns.

Physical
1. Loss of weight
2. Amenorrhoea
3. Other physical complications

Psychological
1. Low mood
2. Anxiety/irritability
3. Obsessional symptoms, particularly related to food and weight

Social
1. School or work problems
2. Problems in the family and /or with relationships
3. Arrests (usually for stealing) or other police contact

When should I be worried about someone's loss of weight?

In assessing someone's weight loss, the Body Mass Index (BMI) is a useful tool as shown below.

BMI = weight in kg / (height in m)^2

However on its own, this is insufficient and we have a short risk assessment tool, available to download from *www.eatingresearch.com*, on the *for health professionals* page.

Aside from weight loss, there is a range of questions that you may want to ask someone who you suspect has an eating disorder to further clarify the diagnosis and to plan management.

What questions should I ask?

The SCOFF questionnaire was developed by John Morgan at Leeds Partnerships NHS Foundation Trust to aid early detection of eating disorders and is available to download from *www.eatingresearch.com*, on th*e for health professionals* page.

1. Eating and anorexic behavior
• Do you avoid eating with others?
• Which foods feel 'safe' and what do you avoid?
• Do you ever vomit, exercise, abuse laxatives and /or diuretics? If so how much and when?
• Do you ever lose control or binge? How often and what do you eat?

2. Eliciting psychopathology
• What do you think of your current weight?
• What do you see as your ideal weight?
• How would you feel if you were the normal weight for your height?
• How much of the day do you spend thinking of food and your weight?
• Do you ever get depressed or guilty? Do you ever feel suicidal?
• Has your life become more ritualised?
• Do you have compulsions to do things e.g. binge, over exercise?

3. Screening of Important physical symptoms
• When was your last period?
• Have you noticed any weakness in your muscles? What about climbing stairs or brushing your hair?
• Are you more sensitive to the cold than others?
• What is your sleep like?
• Have you fainted or had dizzy spells?
• Have you problems with your teeth (hot/cold sensitivity etc) ?
• Have you had any problems with your digestive system?

What signs and symptoms should I look out for in someone with severe weight loss?

1. Reproductive function: loss of menstruation, fertility and pregnancy difficulties.
2. Musculoskeletal: myopathy particularly of the limb girdle muscles, pathological fractures, teeth problems.
3. Cardiovascular: palpitations, syncope, postural & resting hypotension, bradycardia.
4. Renal: nocturia, renal stones, acute failure.
5. Skin and hair: loss of head hair, increase in body hair, dry skin, acrocyanosis, chilblains.
6. Metabolic: hypoglycaemia, liver dysfunction, hypercholesterolaemia, hypothermia.
7. Gastrointestinal: delayed gastric emptying, constipation.
8. Central nervous system: poor concentration, difficulty in undertaking complex thought

What signs and symptoms should I look out for in someone who is bingeing, vomiting or abusing laxatives?

1. Gastrointestinal tracts: teeth, salivary gland hypertrophy, upper and lower intestinal tract bleeding, abdominal distension, constipation.
2. Renal: oedema, dehydration, stones, failure.
3. Cardiovascular: dysrythmias, postural hypotension.
4. Central nervous system: tetany, fits.
5. Metabolic: dehydration, hypokalaemia, hyponataemia.
6. Drug effects: caffeine, slimming tablets such as diethylpropion, amphetamines and ecstasy can be abused.

What should I look out for in the physical examination?

• Skin for lanugo hair, Raynaud's, chilblains, callus on hand, self mutilation.
• Mouth for teeth protheses, loss of enamel, abrasions.
• Lying and standing blood pressure for dehydration and reduced autonomic nervous system function.
• Ability to rise from a squat for proximal myopathy.

What investigations should I consider?
What abnormal results might I expect?

Blood chemistry: urea and electrolytes are usually sufficient unless there are other indications.
Potassium <3.5mmol/l – vomiting or laxative abuse
Bicarbonate >30mmol/l – vomiting
Bicarbonate <18mmol/l – laxative abuse

Blood count: may be helpful if low weight.
Anaemia (Hb 9-12g/100ml – usually normochromic normocyctic)
White cell count 2-4 x 10/l
Platelet deficiency (rare)
ESR normal

Urinary drug screen:
Laxative abuse

How can I manage someone with anorexia nervosa in the practice?

• Step 1: Establishing the therapeutic relationship

1. Help to move the patient into the position where they are interested in considering change (usually people with anorexia nervosa do not want to change but may have been advised to come from family, friends or work colleagues.

2. A motivational interviewing approach can help with patient's ambivalence about change. See downloadable information on *www.eatingresearch.com*.

3. Offer an expert resource about starvation effects, nutrition and eating disorders. Books for patients and carers are available – see the *resources* listing on *www.eatingresearch.com*. Information is also available on websites listed on the site.

4. Counseling of other issues – eg relationship problems, perfectionist, rigid and anxious traits.

5. Information sharing with carers can be invaluable and should be encouraged even if the index case herself will not come. See *www.eatingresearch.com* for resources for carers.

• Step 2: Focus on establishing nutritional health and managing the risk of malnutrition

Weigh the patient regularly and chart the progress.
Give dietary advice – healthy diet, trial of 'safe' and 'unsafe' foods.
See *www.eatingresearch.com* for downloadable resource about risk management.

• Step 3: Family work

1. It is helpful to include the family in any plan about treatment especially in younger patients. Parents need information and knowledge about eating disorders. See *www.eatingresearch.com* for resources for carers.

2. Relatives need to be clear about treatment goals.

3. Educating the parents - anorexia is an illness and is not caused by stubbornness on the part of the patient.

4. Parents need to be firm, consistent and empathic.

5. Teaching parents reflective listening and motivational interviewing skills can be helpful. See *www.eatingresearch.com*.

How can I manage someone with bulimia nervosa in the practice?

There are self-treatment books and CDs on CBT treatment available. See *for health professionals* and *resources* pages on *www.eatingresearch.com*.

• **Step 1: Focus on regular eating**

1. Aim to eat three regular meals per day, which reduces the urge to binge.

2. Aim for a diet with low glycaemic index food to keep blood sugar levels constant.

3. Gradual goals to minimise weight-reducing behaviors (vomiting, laxatives, etc).

4. Education as to medical consequences of weight reducing behaviors and the fact that the brain becomes addicted to food (and other substances) if there is (a) starvation (b) intermittent consumption of high sugar/fat food (c) stress (d) vomiting.

5. Advice as to healthy balanced diet.

Step 2: Establishing the therapeutic relationship

1. Aim for a collaborative approach to the disturbed behavior.

2. Acknowledge that there will be many relapses and difficulties on the path to regular eating.

3. Counselling of other issues – eg sexual abuse, relationship problems, alcohol and/or drug abuse.

Step 3: Specific strategies

1. Keeping food diaries.

These are the mainstay of help in bulimia nervosa (see example on the next page). It may take weeks for the patient to be able to do this because it is often difficult to confront painful reality.

Time	Food and liquid consumed	Place and circumstances/how I felt before	Bingeing/vomiting/laxative use	How I felt after
7:45	3 bowls of cereal and milk	Kitchen, felt worried about the day and felt fat	Binged/vomited in the toilet/took 10 laxative tablets	Depressed. Bound to be a terrible day. I'm not going to eat anything else all day
9:45	Apple	office at work, felt hungry but not panicky	None	Guilty & depressed because I wasn't going to eat anything today

2. Behavioral Strategies
Using the diary, the patient should be encouraged to see her behavior and how she may change this, eg:

• Decide that she will try not to vomit before 9am, and then 10am, etc.
• Decide on certain foods that feel 'safe' and eat those at times that feel more difficult.
• Plan to do something immediately after eating to take her mind off vomiting.
• Decide before she starts eating how much she is going to eat and try to stick to that.
• Only keep so much food in the house.
• Only go shopping with preplanned lists and limited money and avoid the sight and smell of highly palatable foods when hungry.

3. Cognitive approaches
• Identify beliefs (using the diary), eg 'if I eat a chocolate bar I will put on a stone', and underlying assumptions, eg 'all people who are fat are worthless'.
• Challenge beliefs by discussion and support from literature.
• Change beliefs by consistent approach.

Are there any special circumstances that I should know about?

1. Medication
In anorexia nervosa, medication does not usually help associated symptoms of anxiety and/or depression. These will lift as the patient's weight improves. In bulimia nervosa, antidepressants, especially 5HT reuptake inhibitors, can be helpful in the short term. Suppression of symptoms rather than abstinence is out come but compliance is likely to be erratic and there is a possible risk of overdose in this patient group.

2. Compulsory admission
If a patient is severely ill, particularly with medical complications or suicidal ideation, as described above, inpatient treatment may be needed to save a patients' life. Rarely the patient will have lost insight into the severity of her illness and will resist in-patient treatment. In these circumstances the Mental Health Act will need to be used, and a Section 3 (Treatment Order) will probably be the most appropriate.

3. Pre-adolescent anorexia nervosa
Anorexia nervosa can occur in children even as young as 7 or 8 although this not very common. In such cases, failure of growth or weight gain rather than loss of weight is seen and specialist advice should be sought early.

4. Anorexia nervosa in males
When this does occur, it often presents with excessive exercising and a desire for 'healthiness'. The prognosis is worse than for females but that may be because they are diagnosed later.

When should I refer to the psychiatric services?

Indications for urgent referral to psychiatric services include:

1. Medical complications
(see *www.eatingresearch.com* downloadable resources on the *for health professionals* pages).

2. Psychological complications:
• Moderate to severe depression, especially with suicidal ideation.
• Uncertainty about the diagnosis.
• Complicating factors, eg associated substances or alcohol abuse.

3. Failure of current management.

4. Diagnostic uncertainty.

Where can I get further help?

1. Local Psychiatric Service
In you local district here may be one consultant who has a special interest in eating disorders.

2. Specialist Eating Disorders Unit
This may be a national or a regional centre.

3. ***beat*** *(formerly the Eating Disorders Association)*
This is a nationwide organisation that offers a number of services including telephone advice, self-help groups, family groups and individual counseling, training courses and information on service provision. www.b-eat.co.uk.

Reference List

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