Eating Disorders

Most commonly anorexia & bulimia nervosas (prevalence ~1-2% each, >90% are F) which peak in 2nd-3rd decades and are characterised by disturbances in thinking & behaviour re food, eating & body weight or shape. Other eating disorders include morbid obesity and pica.

Feature of AN & BN include:

- Distorted body image
- Self-induced vomiting, misuse of laxatives, diuretics or appetite suppressants
- Excessive exercise
- In anorexia nervosa:
    - Morbid fear of weight gain/fatness
    - Restricted dietary intake
    - Amenorrhoea or failure to reach menarche in women, loss of sexual interest in men
    - BMI≤17.5 for adults with wt≤85% normal.
    - Mortality ~6%
- In bulimia nervosa:
    - Preoccupation with food, weight and shape
    - Cycles of binge eating episodes, followed by purging, excessive dieting or exercise
    - Weight/BMI tends to be normal-sl overweight.

Comorbid psychiatric illnesses are common (up to 80%) including: depression, anxiety disorders, OCD, substance abuse, DSH & suicidal ideation

Complications: Malnutrition, electrolyte imbalance esp hypokalaemia, sepsis, RF, bone marrow suppression, acute oesophageal tears, amenorrhoea, constipation, suicide attempts.

Management

Safety
Assessment
Confirmation of provisional diagnosis
Consultation
Immediate treatment
Transfer of care

Safety

Observation is important as patients may try to purge themselves in ED. Also a suicide risk.

Assessment

Often poor insight, denial, reluctance to give history & non-compliance with management.

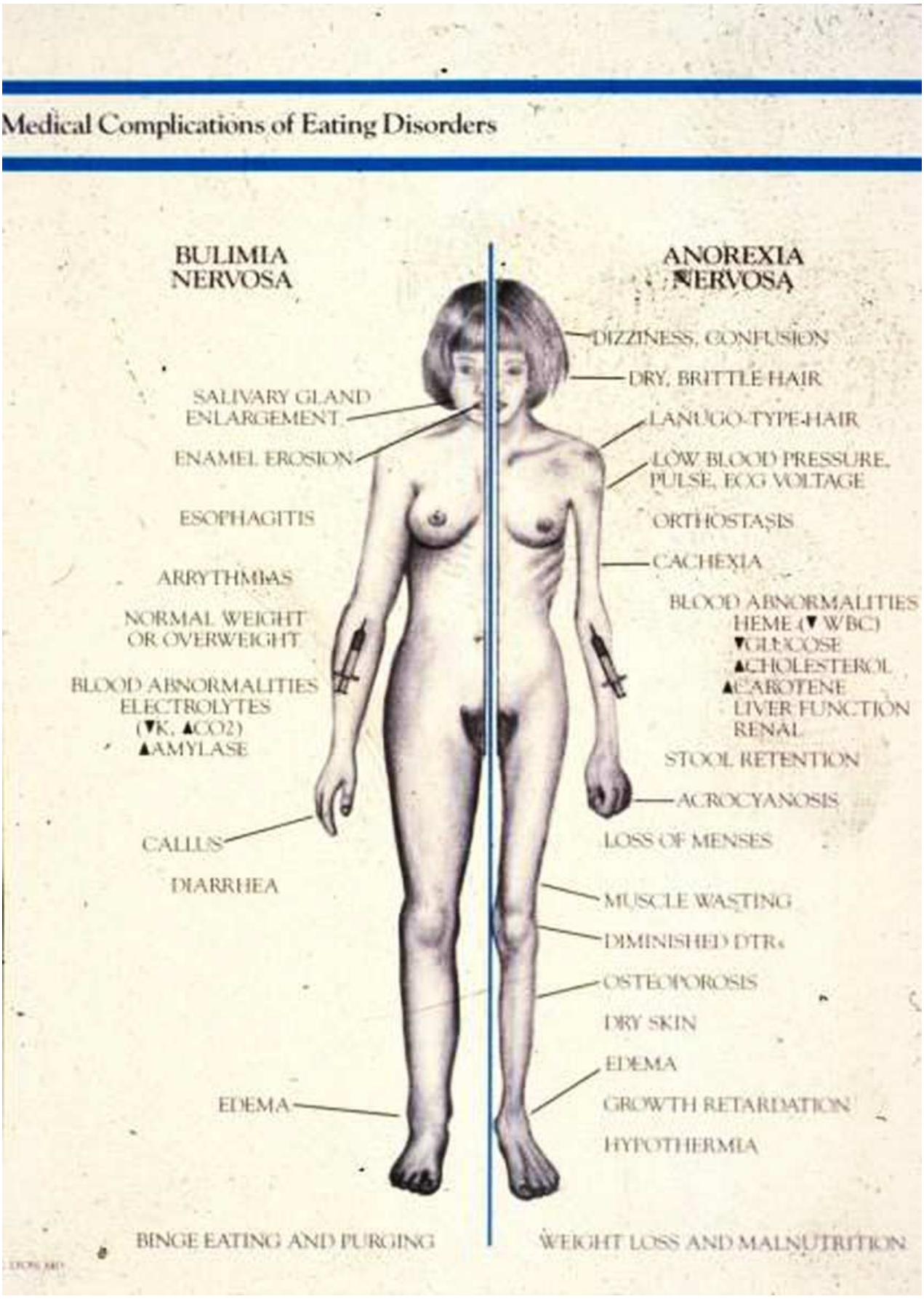
History:

Attitudes to food. Eating, weight gain pattern. Socio-cultural background. Family dynamics.

- *The SCOFF Questionnaire (>1 positive response → possible disorder)*
    - Do you ever make yourself sick because you feel uncomfortably full?
    - Do you worry you have lost control over how much you eat?
    - Have you recently lost more than 6kg in a three month period?
    - Do you believe yourself to be fat when others say you are too thin?
    - Would you say that food dominates your life?

Exam – Physical & Mental State

Physical exam may reveal emaciation, lanugo hair. Also pitted teeth, parotid swelling & Russell's sign (calluses on knuckles) from repeated induced vomiting. Evidence of Cx: dehydration, sepsis, arrhythmias (bradycardia), hypothermia, anaemia, osteoporosis, acute gastric dilation (binging). In MSE screen for evidence of depression, anxiety, obsessionality, substance abuse, or other psychiatric condition, DSH; ask about suicide ideation and assess insight/motivation.



Confirmation of provisional diagnosis

Corroboration: Important as patients often deny there is a problem. Family, friends, GP, notes.
Investigations: Weight/BMI, U/A, ECG, UEC, CMP, BSL, FBC, TFT, LFT, ABG, hormone levels.

Consultation

Mental health± Adolescent Health teams.

Immediate treatment

Rehydration, electrolyte replacement, nutritional support. Rx for complications.
D/W MH team re combination RX of antidepressants & CBT.

Transfer of care

Consider admission if on medical grounds if:

- T<35.5°C
- BP<90/60mmHg in adults or <80/40mmHg in adolescents or postural drop ≥20mmHg
- Tachycardia / bradycardia or other ECG abnormality
- BMI<15kg/m^2 or rapid weight loss (≥1kg/week over >4w)
- Significant electrolyte disturbance (e.g. K^+<3.0mmol/L)
- Dehydration or urinary ketones
- Unable to eat
- Refeeding syndrome

Consider admission if on mental health grounds if:

- Suicidal ideation or significant eating disordered symptoms
- Treatment resistance or sabotage
- Treatment of comorbid mental illness

Discharge may be possible after consultation with MH team and referral to appropriate community-based eating disorders services, a mental health professional, GP and dietician.