How to spot a Tiger in the Jungle

RECOGNISING EATING DISORDERS IN PRIMARY CARE

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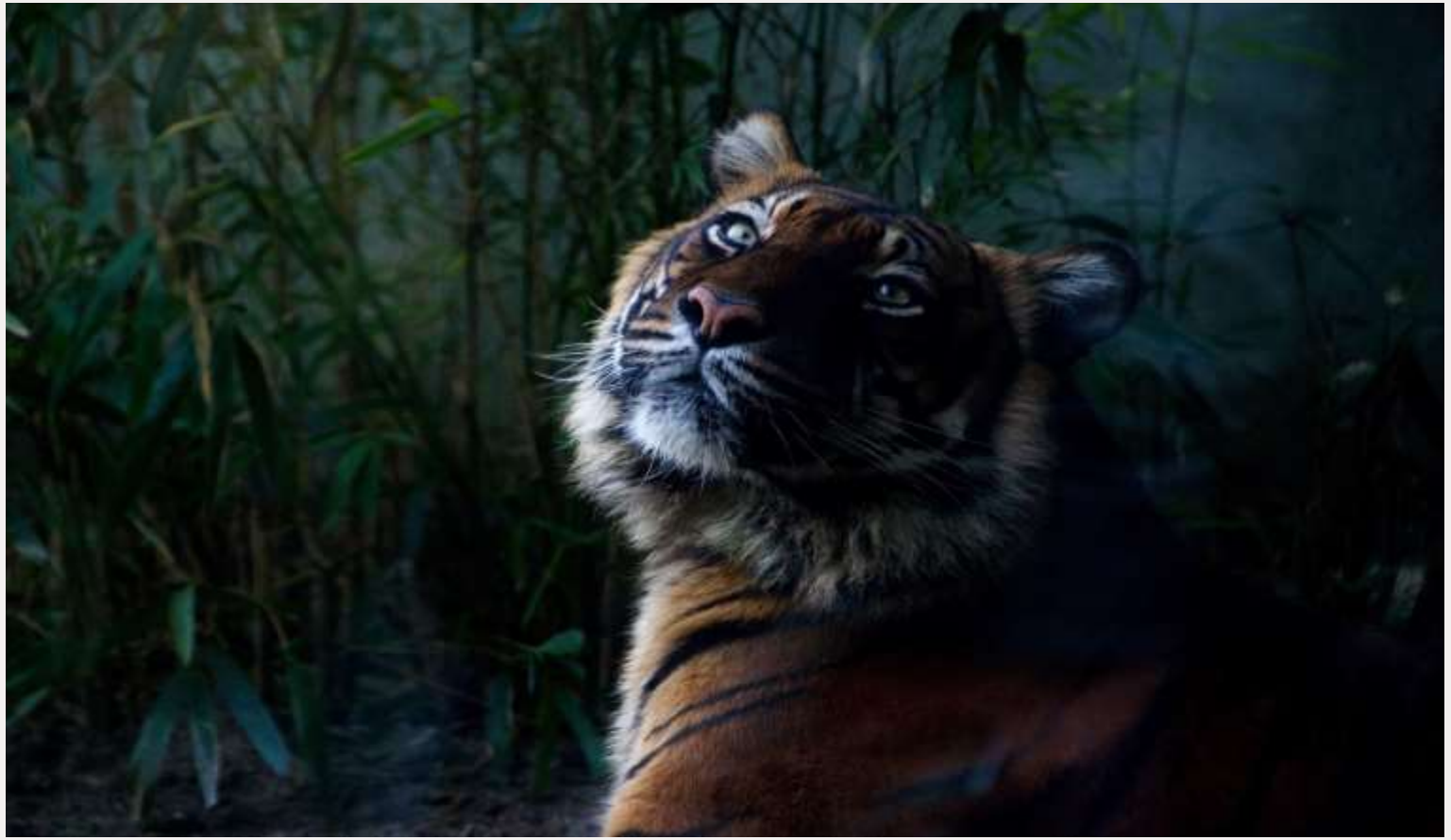

What are eating disorders?

- **Categories:**
- **Anorexia Nervosa:** extreme food restriction with loss of weight; fear of maintaining a 'normal' body weight; disturbed body image; may compensate for eating (exercise/purging)
- **Bulimia Nervosa:** periods of restriction interspersed with discreet episodes of binge eating (large volume of food, short space of time, sense of loss of control); occurring at least once a week for 3 months; with compensatory behaviours (purging/laxatives/excessive exercise); body image disturbance and fear of weight gain; strict adherence to an arbitrary weight range
- **Binge Eating Disorder:** also characterized by binge eating episodes, but usually lacks the purging/compensatory behaviours
- **EDNOS:** eating disorder not otherwise specified – has some of the elements of the above disorders but not sufficient to meet diagnostic criteria
- **ARFID (OSFED):** avoidant and restrictive food intake disorder OR other specific feeding and eating disorders; not driven by weight and shape concerns per se (fear of vomiting or choking/physical discomfort on eating/dislike of certain food tastes or textures/'extreme' fussy-eating; overlap with neurodevelopmental disorers
- Most Common in adolescents – Anorexia Nervosa, restrictive or binge-purge subtype

Incidence and Prevalence

- Peak age of onset in adolescence (14 – 19 years) – better prognosis than adult onset if treated early
- Recent UK study: 14 new cases/100,000 population in adolescent age group; 3/100,000 for boys; 37/100,000 for girls
- Males represent 25% of people with AN and they are at higher risk of dying, in part because they are often diagnosed later
- Life-time prevalence is around 1-4% of adults (have met the diagnostic criteria for ED at some stage in their life)
- More common in young women and athletes (especially weight based or aesthetic sports – 10% of males in these sports and 35% of females)
- 2009 study of female Division II college athletes in US: 25% disordered eating; 26% menstrual dysfunction; 10% low bone mineral density; 3% all 3 symptoms
- Incidence is on the rise over the last couple of years – marked increase in referrals to CAMHS ED services over the pandemic
- UK and US statistics suggest 1.5 to double referral rates over latter stages of 2020

Who does It Affect?

- Risk in young men and women is highest between 13 and 17 years of age (slightly older for BN)
- Some occupational or recreational activities are associated with a greater risk of eating disorder such as aesthetic/weight-based sport (gymnastics/ice skating/skiing/long distance running/boxing, etc.), fashion, dance, and modelling.
  - REDS – relative energy deficiency syndrome
- Typical patient: young woman (peak age of onset around 14 years); high achieving yet emotionally sensitive; driven/competitive nature; anxious and perfectionistic disposition; controlling/enmeshed family dynamics
- However: Can affect any social demographic; increasing incidence in young men; significant overlap with developmental trauma; ASD
- Comorbidity: OCD; anxiety and mood disorders; emerging personality disorders; PTSD; substance use disorder

Why are teenagers more vulnerable?

- Developmental stage
    - physically: changing bodies and physical nutritional requirements, hormonal changes
    - emotionally: cognitive maturity outstrips emotional
    - socially: separation and individuation stage; degrees of agency
    - neurologically & academically: GCSE and A-level pressures; brain development
- Social media and other sources of uncontrolled information
- Diet culture – idealized body shapes and expectations
- 'Health' and 'Environmental' misinformation – vegan diets, clean diets, maligned food groups

Clinical Presentation

- **Mental disorder** – extreme fear of fatness and body image distortion; eating distress; ego-syntonic (the illness is the solution, not the problem!); shame, guilt and secrecy; often comorbid mental disorders
- **<u>Suspect an eating disorder in anyone presenting with:</u>**
- Unusually low or high BMI for their age (including children with failing growth/delayed puberty)
- Rapid weight loss
- Change in eating behaviour - dieting or restrictive eating causing concern to family/carers, or other professionals.
- Mental health problems (such as stress, anxiety and depression) or social withdrawal.
- Disproportionate concern about body weight or shape.
- Poor control of chronic diseases affected by diet (such as diabetes or coeliac disease).
- Menstrual or other endocrine disturbances.
- Unexplained gastrointestinal symptoms, electrolyte imbalance or hypoglycaemia.
- Physical signs of malnutrition (such as poor circulation, dizziness, palpitations, fainting or pallor) or compensatory behaviours such as laxative misuse, vomiting or excessive exercise.

Prognosis

- Tend to be chronic disorders:
- Around 1 in 4 Adolescents with AN, followed up for 10 years still had an eating disorder (J Child Psychol Psychiatry, 2001)
- Another 2001 study that had done 21-year follow-up on 84 patients following hospitalization for AN: 50% full recovery; 10% chronic AN: 15% death rate from causes related to AN
- Highest mortality rate of any psychiatric disorder – 4% death rate due to complication of AN (400 times> death rate than CV-19)
- Young people aged 15 – 24 years with AN have 10 x risk of dying compared to same aged peers (cardiac complications, severe infection, suicide)
- High rate of psychiatric co-morbidity and physical complications
- High rates ongoing impairment in social and occupational functioning
- Prognosis improves significantly if appropriate treatment is received within 1 year of onset – 60% adolescents make full recovery if specialist treatment is received early on

Assessment for an eating disorder – how to approach the person

- "Connect before you correct":-

  - ego-syntonic disorder which serves a function for the sufferer

  - high degree of shame, guilt, secrecy associated with ED

  - fear of letting go of a coping mechanism

  -may not recognise there is a problem

- Name what you have noticed in a non-judgemental empathic way – show concern not judgement
- Explore the person's awareness and insight into the issues relevant to your own level of expertise
- Reassure that help is available

Case Study – Miss MT

- 16 y/o girl – brought to GP by her mother with loss of menstruation
- Recent decision to embark on more healthy eating and taken up daily running
- Gradual yet persistent weight loss over the last year; however, BMI = 19
- BP 110/70mmHg; pulse 43bpm; poor peripheral circulation
- Blood tests revealed iron deficiency anaemia – no organic cause could be found
- Gynaecological examination was unremarkable
- M showed lack of concern about loss of menses and reluctance to increase her weight
- Academically high achieving, perfectionist, driven
- Teased by peers for being higher weight
- Strict parental structure with quite traditional approach and high expectations
- What would you like to know and what happened next?

Assessment: Psychological parameters

- The SCOFF questionnaire – two or more positive answers to the following questions are suggestive of anorexia nervosa or bulimia nervosa.
  - 'Do you ever make yourself sick because you feel uncomfortably full?'
  - 'Do you worry that you have lost control over how much you eat?'
  - 'Have you recently lost more than one stone in a 3-month period?'
  - 'Do you believe yourself to be fat when others say you are too thin?'
  - 'Would you say that food dominates your life?'

  - There are also useful assessment tools on the NICE website and RC Psych website
  - Psychiatric co-morbidities: depression, anxiety (including social), OCD, ASD

Assessment: physical assessment

- Affects every organ system
- Short term concerns: cardiovascular; gastrointestinal; neuropsychiatric; haematological; immunological; hormonal; musculoskeletal
- Long-term concerns: musculoskeletal (osteoporosis); reproductive dysfunction; gastrointestinal; cardiovascular; immunological
- Physical Examination:-

  - height, weight + rate of weight loss; BP (sitting/standing), pulse, ECG (bradycardia, QTc, arrythmias); circulation

  - Bloods: FBC, U&Es, LFTs, TFTs, CMP, reproductive hormone profile

  - General physical exam (skin colour, dehydration, lanugo) SUSS test

- MEED (medical emergencies in eating disorders) Guidance – useful index regarding degree of risk and urgency of referral; Gives a useful RAG rating

Differential diagnosis

- **The differential diagnosis of weight loss includes:**
- Malabsorption for example coeliac disease, inflammatory bowel disease or peptic ulcer.
- Malignancy.
- Drug or alcohol misuse.
- Infection for example tuberculosis, HIV, infectious mononucleosis.
- Autoimmune disease including rheumatological disorders.
- Endocrine disorder for example hyperthyroidism, diabetes mellitus, hypercortisolism, adrenal insufficiency.

- **The differential diagnosis of amenorrhoea includes:**
- Pregnancy.
- Primary ovarian failure.
- Polycystic ovary syndrome.
- Pituitary prolactinoma.
- Hypothalamic causes.
- **The psychiatric differential diagnosis includes:**
- Depression.
- Anxiety.
- Obsessive-compulsive disorder.
- Body dysmorphic disorder.
- Substance misuse.
- Psychosis or schizophrenia.

Management

- **Refer immediately to an age-appropriate eating disorder service for specialist assessment and management:**
- **DO NOT** use a watchful waiting strategy for managing eating disorders.
- Locally agreed care pathways/service provision: referral may be to a community mental health team (CMHT), child and adolescent services (CAMHS), or a specialist eating disorder unit.
- Consider simultaneous paediatric referral for children and young people with eating disorders.

- Urgency depends on the specific clinical situation and on clinical judgement — if unsure seek advice from the nearest specialist eating disorders service.
- May require emergency medical or psychiatric referral – next slide

- **While awaiting specialist assessment:**
- Regular review (with frequency dependant on the clinical situation [for example weekly in children]) to monitor level of physical and mental health risk and consider the need for urgent admission, further investigations, or increasing the urgency of referral.

- Consider the possibility of complications and monitor/manage appropriately, seeking specialist advice when indicated.
- Physical co-morbidities (such as diabetes or pregnant women: ensure specialist input - increased monitoring and alterations to treatment may be required.

- When prescribing medication: take into account the impact of malnutrition and compensatory behaviour on medication effectiveness (for example the oral contraceptive pill) and the risk of side effects (in particular, cardiac side effects).

How to refer non-urgent cases

- Surrey PCT GPs / Clinicians are advised to access the Surrey Children Eating Disorders Service ***Mindworks Surrey Portal.***

- Once on that page, simply follow the referral pathway by selecting: " Ask for Help or Support"; this will prompt them to select the desired pathway:

    - GPs - requests for support

    - All requests for support (except neurodevelopmental requests for support)

- Please make your request via:

- The national electronic referral system (e-RS) which is now accepting children's referrals. Please note: you will not be able to use the link outside of an NHS service site.
- Or visit the secure Riviam web portal: Please make your request for support on Google Chrome.
- Or you can call Access and Advice (which replaced the CAMHS Single Point of Access) on 0300 222 5755 who are open 9am to 6pm, Monday to Friday. The service is not open on bank holidays.

- Referral will be triaged by AAT in the first instance to ensure that it is ED indicated and the request for assistance will then be emailed to our team via our CEDS Admin inbox.

Emergency referral for admission

Some medically unstable people with ED can appear deceptively well – low threshold for concern is essential, seek specialist advice if unsure!

Severely compromised physical health including:

- BMI – dangerously low or rapid weight loss (>1kg/week)
- Cardiovascular instability
- Hypothermia.
- Reduced muscle power
- Concurrent infection.
- Overall ill health or rapid deterioration.
- Abnormal blood tests such as electrolyte imbalance or hypoglycaemia.
- Risk of refeeding syndrome

Acute mental health risk (such as risk of suicide attempt or serious self-harm)

Lack of support at home

MEED and Junior MARSIPAN guidance are useful assessment tools

If unsure where to admit (for example acute psychiatric ward, specialist eating disorders unit or acute medical/paediatric ward) discuss with a specialist.

Most appropriate place to admit a person with a life-threatening eating disorder is not always obvious - depends on local services and practice.

Children and adolescents should be admitted to age-appropriate facilities.

If physical health is at serious risk - can only be treated safely as an inpatient

If not consenting – Consider MHA

MEED – Medical Risk Algorithm

Questions?