

Eating disorders

Eating disorders - F50 (Clinical term: Eating disorders Eu50)

Presenting complaints

The family may ask for help because of the patient's loss of weight, refusal to eat, vomiting or amenorrhoea. Earlier stages may include levels of dietary restriction that cause alarm within the family.

The patient may engage in extreme dietary restriction, binge eating, and various forms of extreme weight-control behaviour, such as self-induced vomiting, driven exercising or laxative misuse.

Both anorexia nervosa and bulimia nervosa may present as physical disorders:

- Non-specific symptoms: abdominal pain, bloating, constipation, cold intolerance, light-headedness, hair, nail or skin changes.
- Food allergy/intolerance and chronic fatigue syndromes sometimes precede the development of an eating disorder and may cause diagnostic confusion.
- Amenorrhoea, fertility problems, gastrointestinal and oropharyngeal problems.
- Low mood, anxiety/irritability.

Although the range of physical presenting complaints is large, in practice the most important task for the practitioner in primary care is to be alert to the possibility of an eating disorder and to enquire further in a sensitive manner.

Diagnostic features

Common features are:

- unreasonable fear of being fat or gaining weight
- self-evaluation almost exclusively based on shape and weight
- extensive efforts to control/reduce weight (eg strict dieting, vomiting, use of purgatives, excessive exercise)
- denial that weight or eating habits are a problem (anorexia nervosa)
- obsessional symptoms
- relationship difficulties
- increasing withdrawal
- school and work problems.

Patients with **anorexia nervosa** typically show:

- severe dietary restriction despite very low weight (body mass index <17.5 kg/m²)
- morbid fear of fatness
- distorted body image (ie an unreasonable belief that one is overweight)
- amenorrhoea.
- A proportion of patients binge and purge.

Patients with **bulimia nervosa** typically show:

- binge-eating (ie discrete episodes of uncontrolled overeating)
- purging (attempts to eliminate food by self-induced vomiting or via diuretic or laxative use)
- strict dieting and other compensatory measures such as excessive exercise
- self-evaluation based on shape and weight.

A patient may show both anorexic and bulimic patterns at different times. In addition, full criteria for anorexia or bulimia nervosa are not fulfilled by 30-50% of patients with clinically significant eating disorders (these patients are said to have atypical eating disorders or eating disorders not otherwise specified [EDNOS]).

Differential diagnosis and co-existing conditions

- Physical illness (eg malabsorption syndrome, chronic inflammatory intestinal diseases, tumours, tuberculosis, vasculitis and diabetes mellitus) may cause weight loss or vomiting, although it is not self-induced.
- There may be co-existing problems such as Depression - F32#, Generalized anxiety - F41.1, Obsessive-compulsive disorder - F42, Drug use disorders - F11# or Self-harm.

The differential diagnosis of weight loss is large, but when an appropriate history is taken with corroboration, it is unusual for diagnostic difficulty to occur. It is important not to delay diagnosis by over-investigation and referral, which may render the doctor complicit with the anorexic denial of the patient.

Medical consequences of severe weight loss include impaired attention and concentration, impaired visuo-spatial abilities and poor memory, hypotension, bradycardia, ECG alterations, arrhythmias, mitral valve prolapse, bone marrow suppression, osteoporosis, low glucose, amenorrhoea, muscle weakness, impaired gastric emptying, constipation.

Medical complications of purging include dental problems, salivary-gland swelling, upper and lower gastrointestinal bleeding, dehydration and electrolyte imbalance, cardiac arrhythmias and epileptic seizures.

Essential information for patient and family

- Purging and severe starvation may cause serious physical harm. Anorexia nervosa can be life-threatening.
- Purging and severe dieting are ineffective ways of achieving lasting weight-control.
- Information leaflets, self-help books and self-help organizations such as the Eating Disorders Association may be helpful in explaining the diagnosis and available treatment options, providing information about what practical steps the person can take to overcome their difficulties and putting patients and their families in touch with other patients.

General management and advice to patient and family

(ref 115,116)

The GP can undertake straightforward steps to treat eating disorders with the help of the practice counsellor, practice nurse and/or a dietician, although most cases will be referred on for specialist

treatment.

It is important to support the family and to engage them constructively in management.

In anorexia nervosa :

- It is helpful to see the patient without, as well as with, the family.
- Expect denial and ambivalence. Elicit the patient's concerns about the negative effects of the eating problem on aspects of their life. Ask the patient about the benefits that their eating has for them (eg the feeling of being in control, feeling safe, being able to get care and attention from family). Don't try to force the patient to change if he/she is not ready.
- Educate the patient about food and weight.
- Weigh the patient regularly and chart his/her weight. Set manageable goals in agreement with the patient (eg aim for a 0.5 kg weight increase per week [this requires a calorie intake of about 2500 kcal per day]). A supportive family member may be able to help the patient achieve this. Consultation with a dietician may be helpful to establish normal calorie and nutrient intake and regular patterns of eating. If after four to eight weeks this approach is not succeeding, refer the patient to a specialist.
- A return to normal eating habits may be a distant goal.
- Encourage the family to be patient and consistent.

In bulimia nervosa :

- Use a collaborative approach.
- Ask the patient to obtain one of the readily available cognitive behavioural self-help books (see below) (ref 117). These provide reliable sources of information and specific guidance for overcoming the eating disorder. Encourage the patient to follow the advice contained in the book and see them at one to two week intervals to oversee their use of the book. If after eight weeks this approach is not succeeding, refer the patient to a specialist.
- Discuss the patient's biased beliefs about weight, shape and eating (eg carbohydrates are fattening) and encourage review of rigid views about body image (eg patients believe no one will like them unless they are very thin). Do not simply state that the patient's view is wrong.

References

115 NICE will publish a guideline on the management of eating disorders in January 2004.

116 Fairburn CG, Harrison PJ. Eating disorders. *Lancet* 2003, 361: 407-416. (AI) This is an up-to-date evidence-based review of all aspects of eating disorders including their management. A specific form of cognitive behaviour therapy is the most effective treatment for patients with eating disorders, although few patients seem to receive it in practice. Treatment of anorexia nervosa and atypical eating disorders has received remarkably little research attention.

117 A Cochrane review will soon be available. Schmidt U, Perkins S, Winn S et al. Self-help and guided self-help for eating disorders (Protocol for a Cochrane Review). In: *The Cochrane Library*, Issue 4, 2003. Oxford: Update Software.

Medication

(ref 115,116)

- In bulimia nervosa, antidepressants (eg fluoxetine at 60 mg mane) are effective in reducing bingeing and vomiting in a proportion of cases (ref 118); however, compliance with medication may be poor, and long-term benefit uncertain (BNF section 4.3). Any beneficial effects will be evident within two to four weeks. If after eight weeks this approach is not succeeding, refer the patient to a specialist.
- No pharmacological treatment for anorexia nervosa has been established to date (ref 119). Psychiatric conditions (eg depression) may co-occur and may respond to pharmacological treatment, although effectiveness may be reduced while at low weight.
- Order blood tests for urea and electrolytes with patients who are vomiting frequently or regularly misusing laxatives.

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117 A Cochrane review will soon be available. Schmidt U, Perkins S, Winn S et al. Self-help and guided self-help for eating disorders (Protocol for a Cochrane Review). In: *The Cochrane Library*, Issue 4, 2003. Oxford: Update Software.

118 Bacaltchuk J, Hay P. Antidepressants versus placebo for people with bulimia nervosa (Cochrane Review). In: *The Cochrane Library*, Issue 2, 2003. Oxford: Update Software. (AI). Sixteen studies were analysed. The use of a single antidepressant agent was clinically effective for the treatment of bulimia nervosa compared with placebo, with an overall greater remission rate but a higher dropout rate. No differential effect regarding efficacy and tolerability among the various classes of antidepressants could be demonstrated.

119 Treasure J, Schmidt U. Anorexia nervosa. *Clinical Evidence* 2002, 8: 903-913. (AI) No evidence was found of beneficial effects for tricyclic antidepressants or SSRIs.

Referral

Refer to secondary mental health services for non-urgent assessment if there is a lack of progress in primary care (see above), despite the above measures described. If available, consider family therapy for anorexic patients (under 18 years), (ref 120) individual psychotherapy for anorexic patients over 18,(ref 121) and cognitive behavioural therapy (ref 122) for those with bulimia nervosa.

Consider non-statutory/voluntary services/self-help organizations, such as the Eating Disorders Association.

Refer for urgent assessment (if possible, to secondary mental health services with expertise in eating disorders) if physically unwell (ref 123).

References

120 Russell GFM, Sz mukler GI, Dare C, Eisler I. An evaluation of family therapy in anorexia nervosa and bulimia nervosa. *Arch Gen Psychiatr* 1987, 44: 1047-1056. (CIII) Patients with anorexia nervosa with onset at or before age 18 and of less than three year's duration did better with family therapy than individual therapy. Moreover, older patients did better with individual therapy. However, a major UK review, while supporting these recommendations, states that there are currently no high quality reviews of psychological treatments for anorexia nervosa (Gloaguen V, Cottraux J, Cucherat M et al. A meta-analysis of the effects on cognitive therapy in depressed patients. *J Affect Disord* 1998, 49: 59-72).

121 A Cochrane review will soon be available. Hay P, Bacaltchuk J, Claudino A, Ben-Tovim D. Individual psychotherapy in the outpatient treatment of adults with anorexia nervosa (Cochrane Review). In: *The Cochrane Library*, Issue 4, 2003. Oxford: Update Software.

122a Bacaltchuk J, Hay P, Trefiglio R. Antidepressants versus psychological treatments and their combination for bulimia nervosa (Cochrane Review). In: *The Cochrane Library*, Issue 2, 2003. Oxford: Update Software (AI) Seventeen studies were looked at. Using a more conservative statistical approach, combination treatments were superior to single psychotherapy. Psychotherapy appeared to be more acceptable to subjects. When antidepressants were combined with psychological treatments, acceptability of the latter was significantly reduced.

122b Hay PJ, Bacaltchuk J. Psychotherapy for bulimia nervosa and bingeing (Cochrane Review). In: *The Cochrane Library*, Issue 2, 2003. Oxford: Update Software. (AI) Thirty-four studies were analysed. There is small body of evidence supporting the efficacy of cognitive behaviour therapy in bulimia nervosa and similar syndromes.

123 Eating Disorders Special Interest Group, Royal College of Psychiatry. Primary Care Protocol for the Management of Adults with Eating Disorders. URL <http://www.rcpsych.ac.uk/college/sig/eatdis.htm>.

Resources for patients and families

Eating Disorders Association (EDA) 01603 621 414 (helpline: 9am–6.30pm)

Email: info@edauk.com; website: <http://www.edauk.com>.

Self-help support groups for sufferers, their relatives and friends. It assists in putting people in touch with sources of help in their own area.

Centre for Eating Disorders (Scotland) 0131 668 3051 (helpline)

Psychotherapy for individuals, self-help manuals and information packs.

Anorexia Bulimia Careline (Northern Ireland) 02890 614 440 (helpline)

Leaflets are available from the Royal College of Psychiatrists (<http://www.rcpsych.ac.uk>):

Anorexia and Bulimia, Changing Minds: Anorexia and Bulimia, and Worries about Weight.

Bulimia nervosa and binge eating disorders:

Bulimia Nervosa – A Cognitive Therapy Programme for Clients by Myra Cooper et al. Jessica Kingsley, 2000.
Self-help manual.

Bulimia and Binge Eating by P Cooper. Constable & Robinson, London, 1995.
Self-help manual.

Overcoming Binge Eating by Christopher Fairburn. New York: Guilford Press, 1995.
Self-help manual.

Overcoming Bulimia. University of Leeds Media Innovations Ltd, 3 Gemini Business Park, Sheepscar Way, Leeds LS7 3JB. Tel: 0113 262 1600; website <http://www.calipso.co.uk>.
A CD-ROM self-help package.

The Mental Health Foundation produces the information booklet All About Bulimia Nervosa. Publications, The Mental Health Foundation, 7th Floor, 83 Victoria Street, London SW1H 0HW. Tel: 020 7802 0304; website: <http://www.mentalhealth.org.uk>.

Anorexia nervosa:

Overcoming Anorexia Nervosa. A Self-Help Guide Using Cognitive Behavioural Techniques by Christopher Freeman. London: Constable & Robinson, 2002.
Self-help manual.

Getting Better Bit(e) by Bit(e) by Ulrike Schmidt and Janet Treasure. Psychology Press, 1997.
Self-help manual.

Anorexia Nervosa – The Wish to Change, 2nd edition, by AH Crisp et al. Psychology Press, 1996.
Self-help manual.

Overcoming Anorexia. University of Leeds Media Innovations Ltd, 3 Gemini Business Park, Sheepscar Way, Leeds LS7 3JB. Tel: 0113 262 1600; website: <http://www.calipso.co.uk>.
A CD-ROM self-help package. Available early 2004.

Anorexia Nervosa: A Survival Guide for Families, Friends and Sufferers by Janet Treasure. Psychology Press, 1997.
The Mental Health Foundation produces the information booklet All About Anorexia Nervosa. Publications, The Mental Health Foundation, 7th Floor, 83 Victoria Street, London SW1H 0HW. Tel: 020 7802 0304; website: <http://www.mentalhealth.org.uk>