

# Eating disorders

**Eating disorders in children and adolescents - F50\*** (F98.2 refers only to infants and early childhood). (Clinical term: Eating disorders Eu50) \* The current ICD-10 classification does not distinguish between adults and children and adolescents.

## Presenting complaints

- The family may ask for help because of the patient's loss of weight, refusal to eat, vomiting or amenorrhea. The family unit is often under considerable stress by the time help is sought.
- Patients may present with symptoms of binge-eating and purging or laxative abuse.

## Differential diagnosis

- Depressive disorder - F32 (often occurs along with bulimia or anorexia).
- Physical illness (eg tuberculosis, acquired immune deficiency disease, endocrine disorders, inflammatory bowel disease and hyperthyroidism) may cause weight loss, but it can usually be distinguished by the lack of a distorted body image and a desire to put on weight.
- Food refusal - refusal of food which does not involve preoccupation with body shape or weight and which is best viewed as oppositional behavioural difficulties that often resolve with time.
- Selective eating - children consume an extremely narrow range of food, but are generally of appropriate height and weight, indicating that their energy intake is probably sufficient. Sometimes this occurs as part of Asperger syndrome.
- Food avoidance emotional disorder - this term is applied to emotional disorders in which food avoidance is prominent, eg certain cases of depression, obsessive-compulsive disorder or school refusal, but which do not fulfil the diagnostic criteria for anorexia nervosa.
- Functional dysphagia - a rare condition in which the history is of a traumatic episode of choking or difficulty swallowing, followed by food avoidance which is usually selective and which may lead to weight loss.
- Pervasive refusal syndrome - profound and pervasive refusal to eat, drink, walk, talk, or engage in any form of self-care.

Routine laboratory investigations should include serum electrolytes, liver enzymes, full blood count, renal function, glucose, full protein and albumin.

## Essential information for patient and family

- In children and adolescents, some eating disorders (anorexia nervosa and pervasive refusal syndrome) represent potentially life-threatening conditions that impede physical, emotional and behavioural growth and development.
- If treated soon after onset, child and adolescent eating disorders have a relatively good prognosis; however, if not treated they may become chronic conditions by adulthood.
- In severe cases of pre-pubertal anorexia nervosa, the medical consequences may be irreversible. For example growth retardation; delayed puberty may result in sterility and incomplete development of secondary sex characteristics; and impaired acquisition of

peak bone mass during the second decade of life may result in osteoporosis in adulthood.

## General management and advice to patient and family

(ref 262)

Eating disorders are serious conditions with a high lifetime mortality, mainly from suicide.

The GP can undertake early simple steps to treat eating disorder with the help of the practice nurse, counsellor and/or dietician.

### Anorexia nervosa

- Family involvement is essential for any intervention with children and adolescents (ref 263)
- The patient, parents and other family members need information and education about the disorder.
- Expect denial from the patient. Encourage and empower parents to be in charge concerning the child's health, eating and safety. Emphasis should be placed on empowering parents as controllers of the patient's food intake.
- Weigh the patient weekly and chart their weight. Set manageable goals in agreement with the patient and their family; for example, aim for a 0.5 kg weight increase per week. For patients who are denying the illness, setting the task of gaining weight can often be usefully presented as 'diagnostic'- someone who is not suffering from an eating disorder should be able to gain weight relatively easily.
- Older adolescents might benefit from individual support.

### Bulimia nervosa

- Family involvement and providing information and education are equally important as they are in anorexia nervosa (ref 263).
- Older adolescents might benefit from individual support and the use of appropriate self-help literature.

### References

**262** Robin A, Gilroy M, Dennis AB. Treatment of eating disorders in children and adolescents. *Clin Psychol* 1998, 18(4): 421-446. (CIV)

**263** Eisler I, Le Grange D, Asen E. Family interventions. In: Treasure J, Schmidt U, van Furth E (eds.) *Handbook of Eating Disorders*. Chichester: John Wiley and Sons, 2003.

### Medication

- Antidepressant medication (eg fluoxetine up to 60 mg daily) usually helps to reduce the frequency of bingeing and vomiting in some patients with bulimia nervosa, but it is not a cure (BNF 4.3.3).

- No psychoactive medication has proven effective with anorexia nervosa. Antidepressant medication may be beneficial for children and adolescents with concurrent depressive disorder.

## **Liaison and referral**

Young people with eating disorders are at risk of other mental health problems, including suicide; therefore liaison with the Child and Adolescent Mental Health Service (CAMHS) is always recommended.

### **Anorexia nervosa**

- If there is lack of a rapid improvement in eating patterns and weight, refer to the CAMHS, or to the more specialist Children and Adolescent Eating Disorder Service, if locally available. Intensive treatments of early-onset anorexia nervosa can prevent many of the more severe consequences from occurring. In addition, evidence indicates that treatment outcomes are more favourable when eating disorders are treated soon after their onset.
- Refer for urgent assessment if there has been rapid weight loss or the body mass index (BMI) of the patient is low. The BMI cut-offs need to be adjusted for growth. Specialist intervention might prevent the need for inpatient treatment even in individuals who are seriously underweight.

### **Bulimia nervosa**

- Consider referral to CAMHS or a specialist Eating Disorder Service if there is a lack of progress in primary care or if more specific treatments (eg cognitive behavioural therapy or family therapy) are not available.

## **Resources for patients and families**

**Eating Disorders Association (EDA)** 0845 634 7650 (Youthline [for under 19s] 4.00pm–6.30pm, weekdays)

Email: [info@edauk.com](mailto:info@edauk.com); website: <http://www.edauk.com>

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

Leaflets are available from the Royal College of Psychiatrists (<http://www.rcpsych.ac.uk>): Anorexia and Bulimia, Changing Minds: Anorexia and Bulimia, Understanding Eating Disorders in Young People, and Worries about Weight.