

## Guidelines for GPs and other Professionals: Eating Disorders

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# Purpose of Guidelines

Eating disorders, together with their many physical and psychological complications, are a significant cause of ill health, mortality and poor quality of life for sufferers. Even following recovery individuals may suffer long term health problems as a result of their illness.

Early diagnosis and intervention are correlated with improved outcomes in patients who have eating disorders which can prevent years of suffering for an individual. Primary care providers, such as GPs, come into contact with young people and adults on a daily basis and therefore have an important role in the early identification and treatment of an eating disorder.

The purpose of these guidelines, in conjunction with the care pathway, is aimed at ensuring the most appropriate service is delivered in a timely manner to ensure the most positive outcome.

# Research Evidence and National Guidance Used in Developing the Guidelines

Eating Disorders Council Report 1992 RDCP.

Eating Disorders in the U.K., policies for service development and training. 2000, RCP.

A General Practitioners Guide to Eating Disorders. Myers S. Davies MP, Treasure J. 1993.

Eating Disorders - a guide for primary care. Eating Disorders Association.

Eating disorders, Body Image and the Media. BMA, Board of Science and Education 2001

Obesity NICE Guidance (2006)

A GENERAL PRACTITIONER'S GUIDE TO EATING DISORDERS, kings college London

Re Anstine D, Grinenko D. Rapid screening for disordered eating in college-aged females in the primary care setting. J Adolesc Health 2000;26:338–42.

Morgan J. F. (1999). British Medical Journal, 319: 1467

A GUIDE TO THE MEDICAL RISK ASSESSMENT FOR EATING DISORDERS by Professor Janet Treasure (2004)

# Epidemiology and Diagnostic Criteria of Eating Disorders

## Epidemiology of Eating Disorders

Assessing the prevalence of eating disorders is complicated, as some sufferers may actively avoid detection and also can present to a variety of medical specialities under several diagnostic guises. Current prevalence rates indicate the following:

- **Approximately 1.6 million people may have an eating disorder at any one time in the UK (1)**
- **14-25 year olds are most at risk for developing an eating disorder**
- **Of the 1.6 million sufferers between 8000 and 16,000 are male.**
- **Obesity has more than trebled in recent years, with 17% of men and 21% of women being clinically obese (BMI above 30)**
- **An average GP list includes approximately 2,000 patients at any one time and is likely to include 1-2 patients with Anorexia Nervosa, 18 patients with Bulimia Nervosa and up to 10% of female adolescents will be using harmful weight reduction techniques.**

## Diagnostic Criteria of Eating Disorders

### **Anorexia nervosa**

- A maintained body weight of at least 15% below that expected for the height of individual  
i.e.  $BMI \leq 17.5$  (weight in kilograms divided by height in metres squared)
- Morbid "fear of fatness"
- Distorted body image/self esteem unduly influenced by weight and shape.
- Weight loss is self-induced by voluntary avoidance of food and also sometimes other weight losing methods such as self-induced vomiting, purging, excessive exercise or use of appetite suppressant drugs or diuretics.
- Amenorrhoea > 3 months

### **Bulimia Nervosa**

- Episodes of overeating on a large amount of food in a discrete period of time (binges) where an individual feels that they cannot stop eating or control how much they are eating.

- Recurrent compensatory behaviour in order to prevent weight gain, such as induced vomiting, misuse of laxatives, diuretics, appetite suppressants, enemas, fasting or excessive exercise
- Disturbance in the perception of body image with a morbid “fear of fatness”
- Body image/self esteem unduly influenced by weight and shape.

*NOTE: A proportion of cases fluctuate between these two syndromes.*

### **Binge Eating Disorder**

- Episodes of overeating on a large amount of food in a discrete period of time (binges) where an individual feels out of control with regards to the amount of food or type of food they are eating
- Binge eating episodes are related to at least three of the following:
  - (1) eating until feeling uncomfortably full
  - (2) eating large quantities of food when not even hungry
  - (3) eating noticeably faster than is considered normal
  - (4) eating alone due to embarrassment of overeating
  - (5) feelings of disgust, depression, or guilt after a binge

- Marked distress concerning binge eating

There are no recurring efforts to compensate for **binge eating**, such as purging or excessive exercise

# Identification and Detection

Early detection of eating disorders and intervention is critical to successful outcomes.

A disorder of less than 18 months duration often responds quickly to relatively short-term treatment. Unfortunately, due to the secretive nature of these disorders 20% of patients do not articulate a morbid fear of fatness. As a result individuals are frequently not diagnosed until their eating disorder is well established.

## Early Warning Signs of ED

It is important to be mindful of the symptoms and behaviours that can be indicative of an eating disorder:

### **Behavioural and psychological symptoms may include the following:**

- Dieting, missing meals or avoidance of food, but there may be a denial of this
- Denial of feeling hungry
- Stating a need to eat less than others or eating very small portions
- Eating more slowly
- Playing with and pushing food around the plate
- Avoiding eating with others and opting out of meal times
- Secrecy around food and eating
- Increased interest in preparing food, reading recipes, watching food based TV programmes
- Wearing baggy clothes, or more clothes to conceal weight loss
- Reluctance to participate in activities where the body will be viewed by others i.e. physical education, swimming
- Feeling fat and denying they are thin even when people pass comment – distorted body image
- Increased sensitivity about body shape
- Increased interest in weighing and checking in mirrors
- Increased obsessiveness in certain behaviours and perfectionism
- Mood changes – particularly depressive symptoms
- Low self-esteem
- Increase in exercise, both overt and exercising in secret
- Spending increased time in the bathroom after meals
- Use of diuretics, laxatives and self-induced / spontaneous vomiting

### **Physical Symptoms Include the Following:**

Patients with eating disorders can have a wide range of symptoms. Patients may not perceive that they have a problem and therefore might deny that they have symptoms, but their family members might express concern. Talking to the family and patient together, as well as talking to the patient individually is therefore appropriate.

- Amenorrhea
- Constipation
- Headaches
- Fainting
- Dizziness
- Fatigue / Lethargy
- Palpitations
- Cold intolerance
- Dry Skin
- Hair Loss
- Bloating
- Fullness
- Gastroesophageal Reflux Disease
- Abdominal Pain
- Polyuria (diuresis)
- Polydipsia (increased thirst)
- Sore throat (from vomiting)
- Dental Enamel Erosion
- Lanugo (fine body Hair)

### **The SCOFF Questionnaire - A Screening Tool For Eating Disorders**

When screening for a possible eating disorder the following five simple questions could be considered.

#### **The SCOFF questions\***

(1) Do you make yourself **S**ick because you feel uncomfortably full?  
 (2) Do you worry you have lost **C**ontrol over how much you eat?  
 (3) Have you recently lost more than **O**ne stone in a 3 month period?  
 (4) Do you believe yourself to be **F**at when others say you are too thin?  
 (5) Would you say **F**ood dominates your life? \* One point for every "yes"; a score of 2 or more indicates a likely case of eating disorder.

**Ref: Morgan J. F. (1999). British Medical Journal, 319: 1467.**

Other screening questions that might be helpful for suspected Anorexia or Bulimia are:

- How many diets have you been on in the past year?
- Do you think you should be dieting?
- Are you dissatisfied with your body size?
- Does your weight affect the way you think about yourself?

*Information from Anstine D, Grinenko D. Rapid screening for disordered eating in college-aged females in the primary care setting. J Adolesc Health 2000;26:338–42.*

# Medical Investigations and Management

Eating disorders are associated with high levels of physical complications which are often irreversible, lead to multiple medical investigations and have significant resource implications in their management. Eating disorders have one of the highest levels of mortality of any psychiatric illness.

Complications associated with eating disorders can affect nearly every organ system. However, many patients might have a completely normal physical examination, especially early in the disorder. Therefore a normal physical examination does not rule out an eating disorder.

Recommended Medical Checks by GP or Paediatrician to be undertaken on a monthly basis include:

## **Anorexia Nervosa**

### Physical Examination

- Monitor Weight (initially monthly - increase if weight falling)  
*Please note that some patients with eating disorders, to avoid revealing their true weight, might drink extra fluids, put weights in their pockets, or wear layers of heavy clothing before being weighed*
- Body mass index: (weight in kilograms divided by height in metres squared)
- anorexia <17.5
- medium risk 13–15
- high risk <13
  
- Blood Pressure
- Temperature
- Respiration
- Sit up–Squat–Stand (SUSS) test
- Lanugo (fine body hair)

### Physical Investigations

Full Blood count  
Us&Es  
Calcium  
Magnesium  
Phosphate  
Serum proteins  
Liver function tests  
Potassium  
Urinalysis  
ECG

## **Bulimia Nervosa**

### Physical Examination

- Monitor Weight (initially monthly - increase if weight falling)
  - Body mass index: (weight in kilograms divided by height in metres squared)
  - Severely Underweight <17.5
  - Underweight 17.5-19
  - Normal 20-25
  - Overweight 25-29.9
  - Obesity > 30
- 
- Blood Pressure
  - Calluses on the dorsum of the dominant hand
  - Dental Enamel Erosion
  - Salivary Gland Enlargement
  - cardiomegaly (ipecac toxicity)

### Physical Investigations

Full Blood count  
Us&Es  
Calcium  
Magnesium  
Phosphate  
Potassium  
Urinalysis  
ECG

## **Important Physical Features of Anorexia Nervosa and Bulimia Nervosa**

### **Features**

#### ***Anorexia nervosa***

#### ***Bulimia nervosa***

History and symptoms

Amenorrhea, constipation, headaches, fainting, dizziness, fatigue, cold intolerance

Bloating, fullness, lethargy, GERD, abdominal pain, sore throat (from vomiting)

Physical findings

Cachexia, acrocyanosis, dry skin, hair loss, bradycardia, orthostatic hypotension, hypothermia, loss of muscle mass and subcutaneous fat, lanugo

Knuckle calluses, dental enamel erosion, salivary gland enlargement, cardiomegaly (ipecac toxicity)

Laboratory abnormalities

Hypoglycemia, leukopenia, elevated liver enzymes, euthyroid sick syndrome (low TSH level, normal T3, T4 levels)

Hypochloremic, hypokalemic, or metabolic alkalosis (from vomiting), hypokalemia (from laxatives or diuretics), elevated salivary amylase (might also be present in bingeing/purging subtype of anorexia)

ECG findings

Low voltage; prolonged QT interval, bradycardia

Low voltage; prolonged QT interval, bradycardia

*GERD = gastroesophageal reflux disease; TSH = thyroid-stimulating hormone; T3 = triiodothyronine; T4 = thyroxine; ECG = electrocardiogram.*

### **Binge Eating Disorder**

#### Physical Examination

- Monitor Weight (initially monthly)

- Body mass index: (weight in kilograms divided by height in metres squared)

**Classification**

Healthy weight  
Overweight  
Obesity I  
Obesity II  
Obesity III

**BMI (kg/m<sup>2</sup>)**

20 –24.9  
25–29.9  
30–34.9  
35–39.9  
40 or more

- Blood Pressure

Physical Investigations

**Assess for co-morbidities such as:**

- Type 2 diabetes
- Hypertension
- Cardiovascular disease
- Osteoarthritis
- Dyslipidaemia
- Sleep apnoea

Using the following tests:

- Blood Pressure
  - Full blood count
  - U's and E's
  - ECG
  - LFT
  - Plasma lipid profile
  - Total Cholesterol
  - HDL and LDL cholesterol levels
  - Serum TSH levels
- Fasting blood glucose levels

# Patient Motivation for Accessing Support

Unlike many other psychiatric conditions where symptoms are experienced as distressing and disruptive, eating disorders are unusual in that the associated thoughts and behaviours often perform a valued function in clients' lives. Therefore, many individuals with eating disorders typically express, either directly or indirectly, intense ambivalence about change.

As a result, simply telling people to stop their risky health behaviour is often not enough, in fact it can increase their *resistance* to change. Even when we know that we should improve our health behaviour we are often *ambivalent*, that is we can see the *advantages* of making changes, but also the *disadvantages*. Patients with eating disorders are often stuck in *ambivalence* because the good things they gain from having an eating disorder far outweigh the gains from making changes.

Motivational interviewing is a method for helping people overcome their ambivalence and increase their motivation to make changes in their life.

*"What do you see the problem as?"*

*"What about other people?"*

- **Identify pros and cons** - a balance sheet

Must be non-judgemental

- **Then discuss motivation**

*"What do you enjoy about dieting/eating/exercising?"*

Acknowledge negative, while reinforcing positive -

*"I hear what you are saying, but..."*

Explore in detail reasons for changing behaviour -

*"Why do you want to stop?"*

# Referral Information

## **How to make a referral:**

A copy of our referral form is available [here](#). It can then be faxed, posted or e-mailed directly to the Eating Disorders Service.

The referral form should include as many details as possible. Essential information required to accept the referral is as follows:

- Current weight
- History of weight and any current changes to weight
- Height
- Eating behaviours: dieting, vomiting, laxative, bingeing
- Outcome of physical investigations

## **Criteria for urgent assessment:**

An urgent referral to the Eating Disorders Service reflects the level of risk and severity of problems associated with the eating disorder. Our criteria for urgent assessment include the following:

- Body Mass Index below 17.5 or above 40
- Rapid weight loss i.e. 1kg per week
- Physical Investigations reveal abnormalities indicating significant risk to health
- Severe vomiting or laxative misuse
- Diabetes
- Pregnant
- Recent or imminent discharge from eating disorder inpatient services
- Recent or imminent discharge from Child and Adolescent Services

**If immediate medical intervention is required for a person suffering from significant and imminent health risks to life then please refer directly to local General Hospital.**

**If immediate intervention is required for a person presenting as a significant risk of harming themselves not related to their eating disorder, i.e. suicide or self-harming behaviour then please refer directly to their local Community Mental Health Team or Accident and Emergency**