Eating Disorders

Anorexia Nervosa
Anorexia nervosa usually affects women. The onset is typically during school age, most commonly between 16 and 17 years. It is more common in western cultures. People at high risk are from higher social classes, high achievers, people with obsessional traits and those whose family seems over controlling.

Bodily image is usually disturbed: patients may have a misperception of body size (rare) and disparagement (or hatred) of one’s body, which is more common.

Denial is also very common and anorexics often try to hide signs and symptoms. Obsessional symptoms are common e.g. a key feature is calorie counting and these can extend to other areas such as cleanliness and housework.

Main clinical features

1) Pursuit of thinness:
   - Dieting/weight phobia-overvalued idea about shape and weight
   - Weight loss- At least 15% below normal body weight for age and sex. (BMI = 17.5 or less)
   - Avoidance of carbohydrates
   - Self-Induced vomiting
   - Excessive exercise
   - Purging

2) Preoccupation with food (some binge-eat)
   - Amenorrhoea
   - Low mood/ Depression / social withdrawal
   - Lack of sexual interest

3) Consequences of starvation
   - Emaciation
   - Constipation
   - Low blood-pressure
   - Bradycardia
   - Sensitive to the cold/blue extremities
   - Hypothermia

4) Consequence of vomiting and laxative abuse
   - Alkalosis
   - Hypokalaemia

The condition usually begins with ordinary efforts at dieting by a person who may be overweight at the time, and progresses to relentless weight loss.
Aetiology
Appears to be a result from a combination of individual genetic predisposition and social factors that encourage dieting. Many students diet at some point and stop without difficulty. Those progressing to anorexia are more likely to have low self-esteem and a preoccupation with appearance. When the disorder has started, concern and overprotection by the family and arguments about food and meals may help to perpetuate it.

Course and Prognosis
Fluctuating course with periods of partial remission

Prognosis
- 1/5 = Full recovery
- 1/5 = Remain severely ill
- 3/5 = Chronic, fluctuating course

There is increased mortality both from effects of starvation and from suicide.

Assessment
1) A thorough history of development of the disorder and patient's idea's
2) SCOFF questionnaire: Screens for eating disorders
   - Do you 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 **Food** dominates your life?

Two or more positive answers indicate a likely case of anorexia or bulimia.

3) Mental State Examination – especially look at depressive symptoms
4) Interview parents/other informants
5) Assess family interactions – especially attitudes in relation to food
6) Physical examination – especially looking at distribution of body hair (abnormal in pituitary failure), emaciation, vitamin deficiency, reduced peripheral circulation. Also look for organic course such as malabsorption, endocrine disorder or cancer.

Treatment
If evidence of severe weight loss or severe emotional problems, refer to a psychiatrist, otherwise proceed to:

- Establish working relationship with the patient and family members.
- Give advice about healthy eating – a diet plan, and the hazard of extreme dieting.
- Agree a target for weight gain, and plan for achieving this.
- Treat depressive disorder if present.
- Help with personal and family problems.
- Arrange regular follow-up.
Treatment in hospital may be needed if: weight is dangerously low, less than 65% of standard weight, rapid weight loss, or severe depression is evident. Rarely with severe weight loss, admission for nasogastric feeding may need to be offered.

**Bulimia Nervosa**

The term "bulimia" refers to episodes of uncontrolled excessive eating, sometimes called binges. The symptom of bulimia can occur in some cases of Anorexia nervosa, but it also occurs without preceding anorexia nervosa in the syndrome bulimia nervosa.

Bulimia nervosa has two principal components:

1) Bulimia (excessive eating).
2) Behaviour intended to prevent weight gain (vomiting, purgatives or excessive exercise).

The balance between the two usually results in the patients being of normal weight.

It is more frequent in developed countries. The patients are usually females aged 15-40 years, with a prevalence of 1-2%. Patients have normal menses. They are excessively concerned with their shape and weight. Unlike anorexic patients most bulimics accept the need for treatment.

Episodes of bulimia may be precipitated by stressful events or by the breaking of self-imposed dietary rules, or they may be planned. It is this extreme lack of control over eating that distinguishes bulimia from anorexia. During these episodes enormous amounts of food are consumed. This may be any food, but usually "forbidden food" which does not have to be cooked. There is a feeling of lack of control over eating behaviour during binges. At first it brings pleasurable relief from the urge to eat and other kinds of tension, but this is followed by guilt and disgust. The patient induces vomiting at first with their finger then by an effort of will.

Depressive symptoms are common. Usually secondary to the eating disorder. Feelings of depression, guilt and self-disgust are common. Patients sometimes abuse alcohol because of their low mood.

**Main clinical features**

1) Excessive concern with shape and weight – Binges/Preventing weight gain
   - Dietary restraint
   - Self–induced vomiting
   - Excessive exercise
   - Purging

2) Consequent normal body weight

3) Consequences of potassium depletion
   - Weakness
   - Cardiac arrhythmias
   - Renal Impairment
4) Other consequences of repeated vomiting

- Swollen parotid glands
- Pitted teeth – vomiting of acid gastric contents

Aetiology
Unlike anorexia nervosa, genetic factors do not seem to be important, although low self-esteem and perfectionism are predisposing factors. Two important types of risk factor are those that increase the likelihood of dieting and those for psychiatric disorder in general.

Assessment
Assessment is similar to anorexia nervosa however it is usually easier because the patient recognises the need for treatment. Physical state of the patient is assessed. Mental state assessment should also be conducted, looking for signs of depression.

Treatment
The treatment of choice is cognitive-behavioural therapy designed to reduce dietary restraint and increase control over eating and vomiting and which results in a full and lasting recovery between a half and two-thirds of patients. Only patients who fail to benefit from this type of intervention need to be referred for full specialist treatment. Options for those who fail to respond to this treatment include SSRI’s, or changing to a different form of psychotherapy.

References
Eating Disorders: Notes for OSCE Station

Example:

You are asked to take a history from the mother of a teenager (aged 15 years) who is concerned that her daughter has lost weight.

Key Points:

- How much weight has been lost over what period of time?
- What does the teenager think about the weight loss?
- What is the normal pattern of eating? What was eaten previous day?
- Any stated reason for not eating?
- Rule out any organic cause – any physical symptoms?
- Has the child got diarrhoea or vomiting?
- Been abroad recently?

- Body image- what does she think about her weight and appearance?
- Periods- ? secondary amenorrhoea
- Psychological factors – ascertain relationships at home with the family, relationships at school – ? bullying
- Are there family arguments at dinner time?
- Does the child take a packed lunch to school?
- Any evidence of pre-occupation with food, hording, cooking excessively for others, binging, self-induced vomiting, laxative use etc?

- Is there a family history of anything like this?
- Family history of any metabolic conditions

Tasks:

1. Discover exactly what the mother means by weight loss
2. Rule out any organic cause, including; infective, metabolic, endocrine.
3. Explore psychological factors; you may need to go right back to the child’s birth and their childhood.
4. Consider all relationships in the child’s life e.g. friends, family etc One person may have affected the child greatly
5. Go through all the symptoms of eating disorders systematically to see if the child has any related symptoms.
6. Finish by asking the mother how she is and how the rest of the family are coping. A condition like this is likely to put a lot of strain on a family.