Managing adults with Eating Disorders in primary care

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Agenda

- Diagnosis, Epidemiology and Outcome
- What to do in a 10 minute consultation
- Assessment
- Medical risks
- NICE guidance
- Referral
- Resources
- Approaches that work
- Driving
- Students

Clinical Eating Disorders

- Anorexia nervosa
  - "pure" restrictors
  - binge/purgers
- Bulimia nervosa
- Atypical eating disorders "ED-NOS"

not morbid obesity

ANOREXIA NERVOSA

Characteristic over-evaluation of shape and weight, morbid fear of weight gain, distorted body image

Active maintenance of unduly **low body weight** - BMI $\leq$ 17.5

Amenorrhoea (unless on OCP)

BULIMIA NERVOSA

Characteristic over-evaluation of shape and weight, morbid fear of weight gain, distorted body image

Extreme methods of weight control but BMI $\geq$ 17.5

Recurrent **binge eating** - $\geq$ 2x/week for $\geq$ 3/12

ATYPICAL EATING DISORDERS (ED-NOS)

Partial/mixed syndromes of AN or BN, such as...

- "AN" but still menstruating
- "AN" but BMI > 17.5
- "BN" but binges < 2x/week or < 3/12
- Extreme methods of weight control but ~normal weight and not bingeing
- Induces vomiting after meals but no binges
- Lacks characteristic psychopathology… or so she says
- Insulin omission only weight controlling behaviour

or…

- **Binge Eating Disorder** – binges without extreme weight control behaviours, lack ED psychopathology, different population cf AN, BN, ED-NOS. *Currently not treated in local NHS*

Epidemiology of EDs

- 4% women will have an ED in their lifetime
- ~10% are male

Epidemiology

On your list of 10 000 you are likely to have

- 1-3 pts with AN
- 10-18 pts with BN
- 5-10% of adolescent girls in your practice will have used wgt control methods other than dieting, such as V, L, XS exercise

Epidemiology reveals that:-

- Many people with ED not known to services, for BN mean of 5yrs before seeking help
- ED pts consult GPs more than general pop, for psych/gynae/gastro symptoms
- <50% cases identified in primary care
- ?because… shame/concealment, ethnicity, social class, male pts, “GPs unhelpful”

Outcome at 10 years after contact with specialist ED service:

	AN	BN
• No eating disorder	50%	60%
• ED-NOS	15%	20%
• Crossover AN↔BN	30%	1%
• Persisting index disorder	10%	20%
• Death	10%	<1%

Outcome cont.

- Recovery takes time… 5yrs after weight restoration for AN
- some fluctuation and residual symptoms even at recovery
- data only on pts treated in specialist services

Your experiences of working with people with EDs

Their experience of working with you

Assessment in Primary Care

"what can I best do in 10 minutes?"

NB: Adults VS >18yos

- Parents' VS child's concerns
- Parents' capacity to contain anxiety and support change ("Maudsley Model" Family Therapy, Locke and le Grange 2015)
- Evidence against specialist admissions (TOuCAN study Gowers 2007)
- Lower threshold of medical concern
- Transitions to adults services, differing goals

Screening

- NICE suggests screening questions:
  - "Do you worry excessively about your weight?"
  - "Do you think you have an eating problem?"
- SCOFF questionnaire (Morgan et al 1999): Screening instrument validated in DGH settings… **s**ick, **c**ontrol, **o**ne stone, **f**at, **f**ood (score 1 or 0, total ≥2 suggests ED)
- NICE recommends screening target groups:
  - young women with low BMI
  - those of normal weight consulting about weight concerns
  - menstrual disturbance/amenorrhoea
  - children with poor growth
  - signs of vomiting/starvation
  - gastrointestinal symptoms
  - young non-compliant diabetics

Assumptions at assessment

The doctors' s:-

- All pts want something…Dx/Rx
- I'll provide this something…
- I'll do this now

The patient's:-

- I don't need to be seen
- They'll think I'm silly, wasting their time
- They will tell me what to do
- They will take control, make me change, I must be ready to resist
- They don' t understand how important this is to me *[egosyntonic, no other illness so positively valued]*
- I'm fine, in control, can stop this any time

The first minutes...

- “How do you feel about being here talking about this?”
- What do they hope for from this meeting?
- What are their fears about discussing ED?

- being judged
- being controlled, told to change
- “over-reaction” - you will section me or make me go to hospital
- “under-reaction” -you will dismiss me as being silly

Managing the mixed feelings…

- **Assume ambivalence**
- Explore and acknowledge their concerns – be curious
- Slow down, take the heat out, plan for the long game
- Discuss and look round the options - what would treatment/change look like?
- No change is an option
- Resist taking over, but may be necessary to say…
- "I do need to weigh you and take some blood"
- See them again next week

The next appointments

- What did they make of the first meeting?
- Results of tests – NB don't say "looks like your blood tests are all fine"
- Weigh again… any change? Their feelings about this?
- Review options -"No Change" is still an option…

"but I don't want to stay as I am…" can lead to opting in

- Acknowledge "there is no nice way out of this"

- See her again soon
- See her alone
- What could she do between now and next week? (food diary, self help book, make a change however small?)
- Help *her* make plans (not your plan)... but realistic and with time and safety boundaries
- Offer to see the family (remind her you will keep confidentiality if safe to do so)
- Over several appointments build up your assessment (ED symptoms, psychosocial factors)

- Show that you think this is serious (the voice of anorexia will be telling her there is nothing wrong)
- Monitor her medical condition, weigh her
- This is her dilemma her responsibility, but...
- Act decisively if necessary
- Trust your clinical judgement, not her reassurance
- OK to be frank about potential for deceipt (eg falsifying weight)
- Discuss with specialist team/refer
- Balance your duty of care with efforts to engage and respect for confidentiality

ED symptoms assessment

- feelings towards weight and shape and eating
- weight history: highest & lowest, her "ideal"
- which weight controlling behaviours?
  - "dieting", complete fasting, XS exercise, vomiting, lax abuse, other drugs, binges, body checking, chew spitting
- eating pattern… may be rigid or chaotic
- Menstrual Hx

Psychosocial assessment

- Look for and treat other mental illness (anxiety and depressive disorders common, OCD)
- Predisposing factors?
  - childhood trauma
  - family history
  - childhood environment
  - personality traits
    - perfectionistic/obsessional
    - Impulsive
    - low self esteem
    - difficulty expressing emotions

NO ONE TYPE OF PERSON/FAMILY GETS EDs

- Any clear precipitant? (rarely a specific trigger)

Medical Assessment

- May be at medical risk even if normal bloods or reports few symptoms (don't be too easily reassured, trust your clinical impression)
- AN pts can appear deceptively well, eg powerful drive to exercise overrides lack of nutritional reserve, appear energetic to point of collapse
- Assess risk from combination of factors eg
  - sequential BMIs (potential for deceit, OK to be open about this)
  - muscle strength (stand straight from squat, sit up from lying flat, stairs)
  - BP lying/standing
  - pulse
  - temperature (NB may not rise in response to infection)

NB – lack of information (pt refuses bloods/weighing) will hasten GP to take immediate action… discuss this with pt

Indications of medical risk

- very low BMI… <14
- on-going rapid weight loss eg 0.5-1kg/wk (irrespective of BMI)
- weakness or collapse (?dehydrated, arrhythmia, myopathy)
- poor fluid intake/dehydration (postural dizziness)
- metabolic disturbance: Na, **K**, Glc, LFTs, Ca, Phos, WCC/plts
- vigorous prolonged exercise at low weight
- extent of purging
- disruption of routine and rigid eating habit (journey, holiday, moving away from home, exams)
- history of previous medical problems
- Poor engagement: DNAs, resists weighing/bloods/ECG, non-compliant eg K+ supplements
- other risks eg alcohol/street drugs

Investigations

- Frequent (1-2 weekly) if at high risk: FBC, U&E, LFTs, Glc, Phos, Mg... "EDs **are** inconvenient"
  - symptomatic (palpitations, collapse, ↑weakness)
  - previous abnormalities at assessment
  - unstable or very low BMI eg <14
  - severe purging, such as vomiting ≥2x/day
  - early weeks of increasing feeding/weight
- ECG if BMI<14 or frequent purging

  corrected QT (QTc) >450 msec → risk esp with ↓K+
- Other investigations may be appropriate
  - DEXA scan if amenorrhoea >2yrs
  - TFTs at assessment
  - Sex hormones and pelvic USS if amenorrhoea persists after wt restoration

Guidelines on medical risk management in eating disorders

- Network-ed GP facing website
- Institute of Psychiatry at Kings College website, with scoring systems for degree of medical risk, and guidance for GPs on management
- Medical information leaflets

  beat (formerly ED Assoc) and IoP Kings and RCPsych websites
- Nutritional guidance

  IoP Kings website
- MARSIPAN Guideline 2014 (RCP and RCPsych)

CR162

MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa

October 2010

COLLEGE REPORT

MARSIPAN GUIDELINE - risk assessment in anorexia nervosa

1. Body mass index: weight (kg)/height2 (m2)
☐ anorexia <17.5
☐ medium risk 13–15
☐ high risk <13
2. Physical examination
☐ low pulse, blood pressure and core temperature
☐ muscle power reduced
☐ Sit up–Squat–Stand (SUSS) test
3. Blood tests
☐ sodium low: suspect water loading (<125mmol/l high risk)
☐ potassium low: vomiting or laxative abuse (<3mmol/l high risk)
Note: low sodium and potassium can occur in malnutrition with or without water loading or purging
☐ raised transaminases
☐ hypoglycaemia: blood glucose <3mmol/l (if present, suspect occult infection, especially with low albumin or raised c-reactive protein)
4. ECG
☐ bradycardia
☐ raised QTc (>450 ms)
☐ non-specific T-wave changes
☐ hypokalaemic changes

MARSIPAN GUIDELINE

Criteria for different risk levels are hard to apply because of the influence of variables such as rate of onset, chronicity, reserves, other conditions and medication. **When deciding on hospital admission, any life-threatening change may trigger the need for an admission** and we would not advocate rigid rules, preferring a thorough clinical assessment

Managing the risk

- Collaborative with pt/carers… "what can be done so that *you* can avoid having to come in to hospital?"
- Level of medical (and psych/soc) risk? Stable or increasing?
- Level of your response
  - call and discuss with MH/ED team (STEPs – 0117 414 6645)
  - refer First Step in Bristol, MH team generic referral BANES SGlos NSom
  - ALL REFERRALS TO STEPS BY FAX: 0117 414 6654
  - increase apptmts/monitoring frequency
  - liaison with MH/ED team, physician – you are not alone in this
  - share more information with carers as risk increases (confidentiality is NOT absolute)
  - admission – planned if possible
- Sando K, nutritional suppl drinks may be easier than food
- No surprises, discuss possibilities early, set "bottom line" and keep to it (discuss with EDS/medics)

NICE Clinical Guideline 9

January 2004, new Guideline due May 2017

Eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders

NB – mostly "C" grade evidence

NICE: Bulimia Nervosa

- Consider initial primary care Rx
  - (guided) self help programme
  - and/or high dose SSRI
- CBT-BN should be offered - “A” evidence Manualised, 16-20 sessions, 4-5 months
- IPT an alternative, but delayed effect
- U&Es if vomiting frequently
- may require mineral supplements if unable to reduce purging
- nearly all Rx as out pt
- Pts with poor impulse control less likely to respond

NICE: Anorexia Nervosa

- *Must include monitoring physical state*
- Most pts should be managed with weekly psychological Rx and physical monitoring, >6/12, "by a professional competent in EDs"
- Stepped care - more intense Rx added prn - day pt, in pt
- Dietary counseling alone not sufficient Rx
- Individual *and* family work for adolescents
- Following an admission for weight gain, continue out pt work for "at least 12 months"
- **Enduring AN not in contact with MHS – annual GP review**

When to refer?

- Refer AN as soon as pt permits – or sooner!
- Longer duration worsens prognosis
- BN pts often ill for years by time of presentation
- Consider primary care management for BN and ED-NOS before referral
  - SSRIs (though evidence limited)
  - Guided Self-Help (?delivered by IAPT)
- Refer urgently for very low weight, rapid wt loss, severe compensatory behaviours, physical complications, abnormal chemistry/ECG
- Medical emergency $\rightarrow$ A&E (*and* refer to MHS)

Referral information must include:

- Wt Ht BMI
- Medical investigation results
- Explain in referral letter/form if pt refuses these…

Referral

- STEPs Specialist EDs, ward and MDT based at Southmead, CPNs working in S Glos, BANES, N Somerset. Tel: 0117 414 6645
- In Bristol refer to First Steps Primary Care EDS Fax: 0117 414 6654
- In S Glos, BANES, N Someret refer to local MH new assessment service/PCLS
- Medically unstable pts – call us to discuss, leave mobile, duty worker will return you call

Info and support for sufferers and carers

- Beat provides local meetings, phone support line for pts and carers, excellent website and chat room
- 2 x monthly meeting in Bristol
- Other ED support and carer organisations: SWEDA, ABC
- OA

Helpful approaches… and some evidence

Responsibility vs Power

- change ↔ not change… **the dilemma belongs to the pt, not to you the doctor**
- only pt has it within their power to change/eat/gain wt
- don't assume responsibility without power

Options, always open

- revisit the No Change option
- still an option, whatever the level of crisis and concern
- "but I don't want to stay as I am…"
  → opting in
- be an enthusiastic advocate of change option
- while always acknowledging how difficult it may be, "there is no easy way out of this"
- ?price worth paying ?risk worth taking

Traps to avoid

- **Battles** - one half of mixed feelings externalised

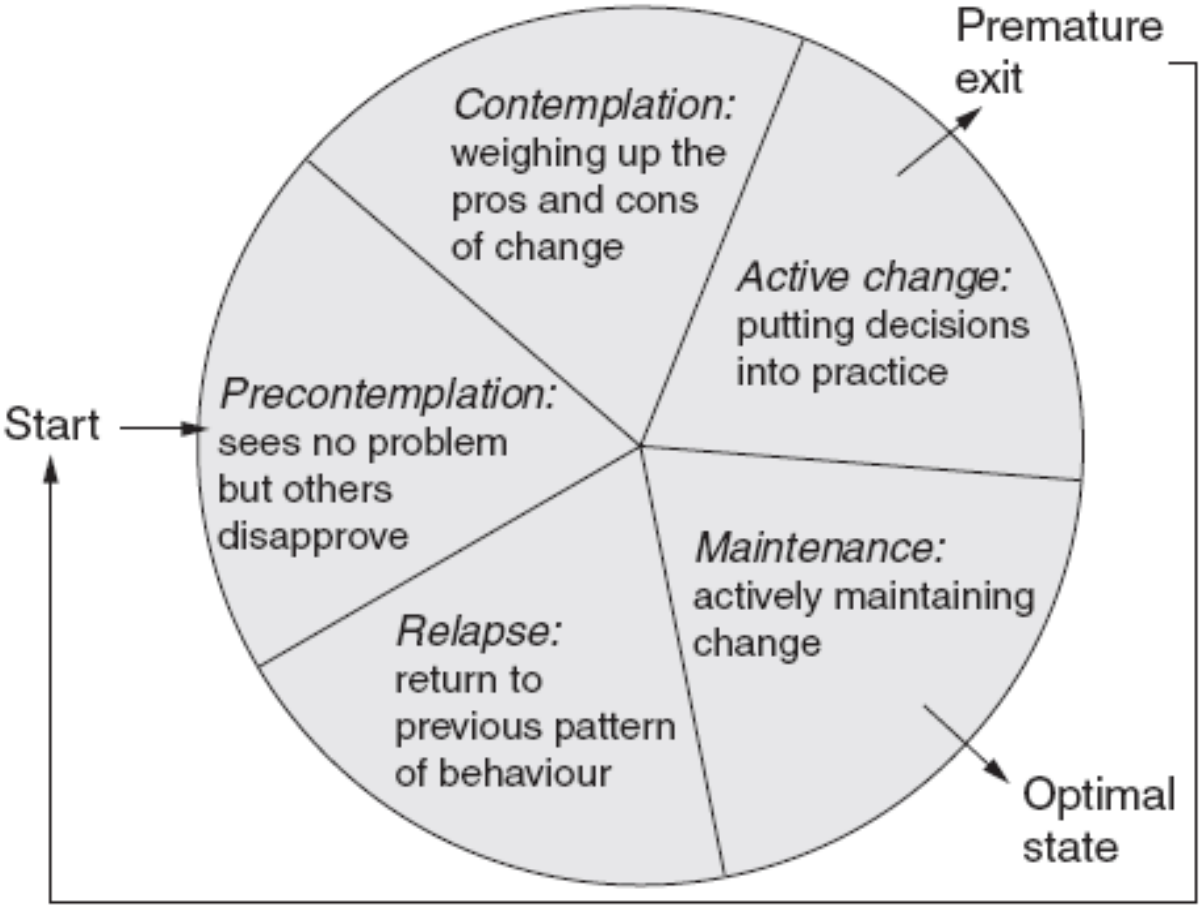
  me the pt vs you the Dr, parent, therapist, ward
- **Colluding –** "don't mention the weight!" pseudotherapy
- **Scare tactics -** instead share info, return to options/dilemma, pts know (on some level) when in trouble… "I guess you realise how unwell you're becoming…"
- **Rescue/over-responsibility/taking over** "we'll get you out of this"
- **The Magic Answer** "things may be fine when you go off to university, make a new start"

Psychoeducation

Key part of eating disorder management - helps to challenge cognitive distortions re eating, shape and weight, and can help enhance motivation

- Physical and psychological effects of low weight and inadequate nutrition (Keyes 1957 Minnesota study)
- Ineffectiveness of compensatory behaviours (vomiting removed ~50% of stomach contents, laxatives deplete fluid/electrolytes, not calories)
- Harder to gain weight than you think
- Energy requirements and energy balance
- Biology of starve/binge cycle... Spring metaphor
- Eating: structured, adequate, regular, challenge notions of “healthy”
- Gets worse before gets better... Bramble patch metaphor

Motivational assessment – the cycle of change



Matching intervention to readiness

- Motivational work if unready – group or individual
- Psychoeducation
- Monitoring, supporting, revisiting her readiness
- beat, self help group, OA
- Action based Rx if ready for change (modest aims are OK)
  - CBT-informed self help programme (Fairburn, Cooper, Treasure & Schmidt), or guided self help (?delivered by IAPT)
  - CBT-informed OP work
  - Day therapy
  - EDU admission
  - Treatments time limited and continued only if behaviour changing

RCT evidence

- BN - 60% recover with CBT
- Fairburn's CBT-Enhanced, targets core psychopathology of all EDs
  - devised for outpatient cases with BMI > 15
  - 75% recovery; 7% drop-out rate
- Specialist Supportive Clinical Management eg MANTRA (Schmidt 2010) may be as effective as CBT for AN
- "Maudsley model" family therapy for under 19yo, better evidence for relapse prevention after inpt wt gain
- ANTOP (Zipfel 2014) multicentre RCT – psychodynamic intervention as effective as CBT for AN, TAU (Germany) also effective

Evidence for medication

AN – No evidence in treatment or relapse prevention of core AN symptoms. SSRI for mood and OCD symptoms, low dose olanzapine for agitation and ruminations

BN – High dose SSRIs (fluoxetine 60mg od) marginally better than placebo in short term, less good than CBT, ↓binge frequency occurs early (2/52), effect independent of mood

BED – SSRIs may ↓binge frequency. Orlistat may ↓weight

But do treat comorbidity

EDs and the DVLA

- No specific guidance from DVLA, so usual common sense advice applies
- Not safe to drive if day to day medical instability eg fluctuating K, Glc, BP
- Not safe to drive if very frail eg tired and weakness on walking, stairs
- Advise pts to inform DVLA of Dx of AN
- Advise pts not to drive if BMI<15, unless…
  - they can demonstrate physical stability eg attending for monitoring, wt and diet maintained though reduced, bloods stable
- “if you stop me driving I’ll walk…”
- “I’ll only pop out for the school run...”

Students with EDs

- Starting afresh, leaving it ED behind, but…
- Sudden major change in living/eating/working/social arrangements
- Lack of routine: term times, exams, placements, weekends
- Delayed help seeking
- Falling between services
  - home VS university
  - CAMHS VS adult services
- Prioritizing study above health
- Need to set clear boundaries (her tutor won't)
- Student disability support services