Managing adults with Eating Disorders in primary care

GP session, Feb 2017

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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
<table>
<thead>
<tr>
<th>ANOREXIA NERVOSA</th>
<th>BULIMIA NERVOSA</th>
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<tbody>
<tr>
<td>Characteristic over-evaluation of shape and weight,</td>
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<tr>
<td>morbid fear of weight gain, distorted body image</td>
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<tr>
<td>Active maintenance of unduly low body weight - BMI &lt; 17.5</td>
<td>Extreme methods of weight control but BMI &gt; 17.5</td>
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<tr>
<td>Amenorrhoea (unless on OCP)</td>
<td>Recurrent binge eating - ≥ 2x/week for ≥ 3/12</td>
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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 binging
- 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:

<table>
<thead>
<tr>
<th>Outcome</th>
<th>AN</th>
<th>BN</th>
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<tbody>
<tr>
<td>No eating disorder</td>
<td>50%</td>
<td>60%</td>
</tr>
<tr>
<td>ED-NOS</td>
<td>15%</td>
<td>20%</td>
</tr>
<tr>
<td>Crossover AN↔BN</td>
<td>30%</td>
<td>1%</td>
</tr>
<tr>
<td>Persisting index disorder</td>
<td>10%</td>
<td>20%</td>
</tr>
<tr>
<td>Death</td>
<td>10%</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>
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... sick, control, one stone, fat, food (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 deception (e.g., 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)
MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa

October 2010
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 → 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

- Contemplation: weighing up the pros and cons of change
- Active change: putting decisions into practice
- Maintenance: actively maintaining change
- Relapse: return to previous pattern of behaviour
- Precontemplation: sees no problem but others disapprove
- Optimal state
- Premature exit
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