Managing Eating Disorders in primary care

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Clinical Eating Disorders

- Anorexia nervosa
  - "pure" restrictors
  - binge/purgers
- Bulimia nervosa
- ED variants not quite AN or BN
- Binge Eating Disorder

not morbid obesity

Epidemiology

About 5% life time risk in women

On your list of 10 000 you are likely to have

- 4 pts with AN
- 18 pts with BN
- 10% of adolescent girls in your practice will have used wgt control methods other than dieting, eg vomit, laxative misuse, XS exercise

Assumptions at assessment

The doctors' s:-

- This pt wants 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 a time waster

Managing the mixed feelings…

- Explore and acknowledge their concerns – be curious
- Slow down, take the heat out, plan for the long game
- Assume ambivalence
- 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 (don't say "its all fine"), 2nd weighing?
- 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 (reassure you can still keep confidentiality)
- 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
- Discuss/refer
- Balance your duty of care with efforts to engage and respect for her confidentiality

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 weighing (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, several times daily
- 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 (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. Repeat 2 yearly prn
  - TFTs at assessment
  - Sex hormones and pelvic USS if amenorrhoea persists after wt restoration

Guidelines on medical risk management in eating disorders

- 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)
- (Not addressed in NICE)

SYSTEM	Test or Investigation	Concern	Alert
Nutrition	BMI	<14	<12
	Weight loss/week	>0.5kg	>1.0kg
	Skin Breakdown	<0.1cm	>0.2cm
	Purpuric rash		++
Circulation	Systolic BP	<90	<80
	Diastolic BP	<70	<60
	Postural drop (sit–stand)	>10	>20
	Pulse Rate	<50	<40
Musculo-skeletal (squat and sit-up tests)	Unable to get up without using arms for balance		++
	Unable to get up without using arms as leverage		++
	Unable to sit up without using arms as leverage		++
	Unable to sit up at all		++
Temperature		<35C <98.0F	<34.5C <97.0F
Bone Marrow	WCC	<4.0	<2.0
	Neutrophil count	<1.5	<1.0
	Hb	<11	<9.0
	Acute Hb drop		++
	(MCV and MCH raised - no acute risk)		
	Platelets	<130	<110
Salt/water Balance	K+	<3.5	<3.0
	2. Na+	<135	<130
	3. Mg++	0.5-0.7	<0.5
	4. PO4--	0.5-0.8	<0.5
	5. Urea	>7	>10
Liver	Bilirubin	>20	>40
	Alkpase	>110	>200
	AsT	>40	>80
	ALT	>45	>90
	GGT	>45	>90
Nutrition	Albumin	<35	<32
	Creatinine Kinase	>170	>250
	Glucose	<3.5	<2.5
Differential Diagnosis	TFT, ESR		
ECG	Pulse rate	<50	<40

CR162

MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa

October 2010

COLLEGE REPORT

Managing the risk

- Collaborative with pt/carers… "what can happen to help *you* avoid having to come in to hospital?"
- Level of medical (and psych/soc) risk? Stable or increasing?
- Level of response
  - call and discuss with ED team (STEPs – 0117 414 6645) – leave your mobile!
  - refer First Step in Bristol, MH team generic referral elsewhere
  - 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)

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
- Possible primary care management for BN
  - SSRIs (though evidence limited)
  - Guided Self-Help (?delivered by IAPT)
- Refer for very low weight, rapid wt loss, severe compensatory behaviours, physical complications, abnormal chemistry/ECG
- Medical emergency $\rightarrow$ refer to medical take (*and* refer to MHS)

RCT evidence

- BN - 60% recover with CBT
- Fairburn's CBT-Enhanced, targets core psychopathology of all EDs, includes AN
  - 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

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
- Remind then insurance invalid if driving against medical advice
- “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. No parental anxiety/monitoring/support
- 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