Identification and engagement of patients with Eating Disorders

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Talk Outline

1. Eating Disorders – setting the scene, statistics, classification
2. History, screening questions
3. Role of the GP, investigations, challenges faced by GP's

Eating Disorders (ED) –setting the scene

- Eating disorders (ED) represent severe and often chronic psychiatric illnesses, posing both serious risk to their sufferers and challenges to treating professionals.
- People who have an ED are difficult to treat with recovery rates being low. The burden of care for families is also significantly high as the illness trajectory for those with an ED is often prolonged, with an average duration of 5-7 yrs. .
- There has been a notable increase in disordered eating behaviours in Australia between 1995 and 2005.
- ED are estimated to affect approximately 9% of the total population with prevalence in any one year of around 2.94% in males and 5.11% in females.
- Carry the highest mortality rate of any psychiatric illness 10-20%.
- 50% due to suicide & 50% due to secondary physical complications (cardiac failure).

ED -statistics

- Anorexia Nervosa is the 3rd most common chronic illness for adolescent girls in Australia (after obesity and asthma).
- Only between 5% and 15% of people receive any treatment for their ED in any given year. Furthermore, for those who do receive treatment, much is not evidence based, and of undemonstrated efficacy.
- Under 18 more likely to have good outcomes than adults aged 18-39, who in turn were more likely to have good outcomes than adults aged 40 or over.
- The financial cost relating to the impact of ED in 2014 was $19.8 billion, or $20,970 per person with a prevalence of over 945,000.
- The cost of treatment for episode of Anorexia Nervosa second only to cardiac artery bypass.

Eating Disorders

Anorexia Nervosa

– Restriction of Energy intake
→ significantly low body weight
→ less than minimally expected wt

– Intense fear of weight gain / fatness
→ behaviour that interferes with wt gain, despite low wt

– Disturbance in body image
→ self evaluation unduly influenced by body weight / shape
→ persistent lack of recognition of seriousness of low wt

Binge Eating Disorder

- Recurrent Binge-eating
- Abnormal eating behaviour with marked distress / guilt
  → Frequency ≥ 1 / week for 3 months
- Absence of:
  → compensatory behaviours
  → Anorexia Nervosa
  → Bulimia Nervosa

Bulimia Nervosa

- Recurrent Binge-eating
- Inappropriate compensatory weight control behaviours → Frequency ≥ 1 / week for 3 months
- Self-evaluation unduly influenced by body weight / shape
- Absence of Anorexia Nervosa

Other Specified Feeding & Eating Disorders - OSFED

Mixed behaviours / presentation, but serious illness:

→Atypical AN (AAN) – 'normal' weight AN
→Sub-threshold BN
→Sub-threshold BED
→Purging Disorder
→Night Eating Syndrome

History

Professor Peter Beumont, a leading eating disorder specialist in Australia, notes:

'Generally, clinicians should assume that anyone who is underweight or exhibits rapid weight loss has a dieting disorder unless proven otherwise.'

History

- dietary restriction
- weight loss
- inability to restore weight
- body image disturbance
- fears about weight gain
- binging
- purging
- excessive exercise
- early satiety
- constipation
- use of laxatives, diuretics, or medications to lose or maintain low weight

History

- disturbed eating behaviours, e.g. eating apart from others, ritualistic patterns of eating such as prolonged meal times and division of food into very small pieces
- assess nutritional and fluid intake and adequacy of main meals and snacks consumed
- collateral sources of information such as family members and other clinicians involved in the person's care should be utilised. The perspective of others is especially important given that symptom minimisation, poor insight or genuinely poor understandings of the seriousness of symptoms are common aspects of anorexia nervosa

History

If a person is brought to the clinician's attention by a parent or spouse who is concerned that their loved one has an eating disorder, it is generally the case that the relative's assessment is correct.

Very rarely do relatives make a mistake in the recognition of these disorders.

History

- history of fainting, light-headedness, palpitations, chest pain, shortness of breath, ankle swelling, weakness, tiredness and amenorrhoea or irregular menses
- Assessing psychiatric comorbidity eg. anxiety, depression, substance misuse, suicidality, personality disorders, anxiety disorders and deliberate selfharm

History

- Assessing cognitive changes due to starvation such as slowed thought processing, impaired short-term memory, reduced cognitive flexibility and concentration and attention difficulties
- Considering possible predisposing and precipitating factors including a family history of eating disorders, early attachment and developmental difficulties, premorbid obesity, interpersonal problems, and dieting or other causes of rapid weight loss
- Rapid weight loss from any cause, including physical illness, can trigger cognitive changes including obsessive thinking about food, in turn precipitating and perpetuating the symptoms of anorexia nervosa

Screening questions

Have you lost any weight recently?

Are you trying to lose weight?

What is the most you've ever weighed and when, the least weighed and when?

What is your ideal weight?

What have you eaten over the last 24 hours?

What size portions of each item did you eat?

Do you skip breakfast, lunch, or dinner?

Do you have any 'feared' foods?

Are you restricting or eliminating any food groups?

What diets have you tried?

Screening questions

Have you used laxatives, diuretics, caffeine or diet pills?
Ascertain the frequency, duration of use, and day of last use.

Do you ever eat in secret?

Have you ever 'binged', and if so, what constitutes a 'binge'?

How much and what kinds of foods are consumed?

Are there any triggers?

How often do 'binges' occur?

Do you vomit after eating?

Screening questions

Do you try to control weight or shape through exercise?

- What type of exercise do you use for this purpose?
- How much, how often, what levels of competition, and how much stress do you feel if a work out is missed? (Extreme distress over missed exercise is a warning sign of a potential eating disorder)
- Do you exercise alone or with others? Do they enjoy exercise or is it a chore?
- Have you changed behaviours to increase incidental exercise? That is, walk instead of drive/catch a bus? stand instead of sitting?, excessive fidgeting or movement, pacing?

Exercise should be enjoyable, varied and social.

If the patient is underweight (BMI < 17.5), purging, exercising excessively, or there is cardiovascular or electrolyte abnormalities or significant musculoskeletal overuse symptoms advise stopping all exercise.

Depending upon the individual a light program of weight training and stretching may be acceptable.

All exercise should be prohibited if BMI is <15

BMI

Body Mass Index (BMI) can also be calculated for those 18+ years only (For adolescents under 18 years, paediatric tables apply):

BMI < 16 consider immediate referral to specialist

BMI< 18 very underweight

BMI 18-20 underweight

BMI 20-25(27) normal weight range

BMI 27-30 overweight BMI > 30 obese

Investigations

Medical Monitoring in Eating Disorders Summary Chart 6 Sept 2013 HANDOUT DRAFT.pdf

Role of GP

- Detection and diagnosis with early referral to specialist services
- Monitoring of physical health
- Continuity of Care for the patient and family and carers were possible

- Treatment (both pharmacological and non-pharmacological)
- Acting as case manager where appropriate or secondary referral
- Collaborating with self-help groups and community agencies

- Managing chronic patients

General principles for treatment of all Eating Disorders

- Person-centred informed decision-making
- Involving family and significant others
- Recovery-oriented practice
- Least restrictive treatment context
- Multidisciplinary approach
- Stepped and seamless care
- A dimensional and culturally informed approach to diagnosis and treatment

Our ED comprehensive service

3 tiers

1. Outpatients – Vinay Garbharran & Kim Hurst

2. Day Program

3. In-patients