I SUSPECT THAT MY PATIENT HAS AN EATING DISORDER: WHAT NOW?

Eating disorders are complex illnesses which have serious long-term medical and psychological complications. As a primary care provider, your role in the assessment and management of patients with eating disorders is essential. You are a vital link in the circle of care for these patients, yet many primary care providers feel that they lack expertise to work with these patients effectively. The purpose of this handout is to provide you with some tips about diagnosis and management, and resources for further information.

SCREENING

A useful tool is the Screen for Disordered Eating,* which is comprised of the following questions:

1. Do you often feel the desire to eat when you are emotionally upset or stressed?
2. Do you often feel that you cannot control what or how much you eat?
3. Do you sometimes make yourself throw up (vomit) to control your weight?
4. Are you often preoccupied with a desire to be thinner?
5. Do you believe yourself to be fat when others say you are thin?

A "yes" response to 2 or more questions is a positive screening result and indicates that further evaluation is warranted. As individuals with eating disorders often downplay or hide their symptoms, it is essential to be vigilant and to ask questions about weight, food, and dieting in a sensitive manner.

* Maguen, S., Hebenstreit, C., Li, Y., Dinh, J. V., Donalson, R., Dalton, S., Rubin, S., & Masheb, R. (2018). Screen for Disordered Eating: Improving the accuracy of eating disorder screening in primary care. *General Hospital Psychiatry, 50*, 20–25. http://dx.doi.org/10.1016/j.genhosppsych.2017.09.004

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DIAGNOSIS

Consult the DSM-5 for a detailed diagnostic approach. Note that there are considerable differences between the DSM-4 and the DSM-5, published in 2013, in diagnostic criteria for eating disorders.

Here are some tips for diagnosing the more common eating disorders:

Anorexia Nervosa (AN): A consistent deficit in energy intake resulting in a significantly lower body weight or a lack of expected weight gain. This is associated with a disturbance in body image, and an intense fear of gaining weight.

Bulimia Nervosa (BN): Recurrent episodes of binge eating followed by inappropriate compensatory behaviours (e.g. vomiting, fasting, excessive exercise, laxative use), occurring on average at least once weekly for 3 months, and associated with a disturbance in body image.

Binge Eating Disorder (BED): Recurrent episodes of binge eating without compensatory behaviour, associated with a sense of loss of control and feelings of marked distress, occurring at least once weekly for 3 months.

Otherwise Specified Feeding or Eating Disorder (OSFED): Replaces Eating Disorder Not Otherwise Specified in the earlier DSM editions; disordered eating patterns that do not meet full diagnostic criteria for AN, BN, or BED. An example is atypical AN, in which all criteria for AN are met, but the individual's BMI is "normal" or high.

PHYSICAL EXAM

- Vital signs: Supine and standing heart rate and blood pressure; an orthostatic drop in systolic BP of ≥20 bpm or diastolic BP of ≥10 bpm, or a rise in HR of ≥30 bpm is concerning and may warrant IV fluids and further investigations.
- Oral temperature.
- Measure height, weight, and BMI; for children and adolescents, plot a growth chart.
- Cardiovascular system: heart rhythm, heart sounds, murmurs, JVP, peripheral edema.
- Head and neck: Russell's sign (calluses on dorsum of hand(s)), dentition.
- Skin: dry skin, lanugo.

MEDICAL MONITORING

It is important to monitor your patient with an eating disorder. Frequency of monitoring depends on the severity of the condition.

DSM-5 severity specifiers

AN: Mild: BMI >17;
Moderate: BMI 16–17;
Severe: BMI 15–16;
Extreme: BMI <15.

IMPORTANT CAVEAT: Keep in mind that AN is possible in someone with a "normal" or elevated BMI. If your patient's weight is dropping rapidly yet still "normal" or high, and they are exhibiting eating disorder symptoms (e.g. very limited intake of food and/or fluids, fear of weight gain) and symptoms of medical instability (postural hypotension, palpitations, chest pain), then this person has atypical AN and faces all the risks of a serious eating disorder.

BN: Mild: 1–3 purging episodes/week;
Moderate: 4–7 episodes/week;
Severe: 8–13 episodes/week;
Extreme: ≥14 episodes/week.

With BN, the most risky complication is hypokalemia, leading to cardiac compromise. They may also have other electrolyte disturbances.

Initial tests:

Lab work

- CBC
- electrolytes – Na, K, Ca, PO4, Mg, Cl
- creatinine
- fasting glucose
- liver function tests
- TSH and T4
- amylase
- ferritin
- vitamin B12

ECG

Possible findings

- bradycardia
- arrhythmias
- non-specific ST changes
- prolonged QT interval
- U waves with hypokalemia

Here are some important tips for monitoring patients with eating disorders:

monitor postural vital signs and ask about episodes of dizziness, fainting, chest pain, heart palpitations, and GI symptoms (e.g. vomiting blood or blood in stool)

ask about the frequency and severity of symptoms and note any changes in severity of the patient's condition

offer to take a "blind weight", whereby the patient steps on the scale backwards and you record the weight without revealing the number – the experience of being weighed can be highly distressing for someone with an eating disorder

assess for amenorrhea and other menstrual irregularities

order electrolytes, creatinine, and an ECG at least monthly in patients with active BN

any electrolyte deficiencies should be corrected – work with your local pharmacist if you have questions regarding doses

keep in mind that lab results may be normal even with significant malnutrition

consider ordering a baseline bone mineral density test in underweight patients at risk for osteoporosis

assess for psychiatric risk – depression, anxiety, substance abuse, and self-harm are common among individuals with eating disorders, and a significant proportion of deaths in patients with AN are due to suicide

WHEN AND WHERE TO REFER

Refer your patient to emergency services at your local hospital when symptoms become acute. If intake of food or fluids is seriously inadequate the patient may need fluid resuscitation. Patients with very low BMIs may need hospital admission for tube feeding. Symptoms such as postural hypotension, palpitations, or chest pain may indicate cardiovascular instability. If the patient expresses thoughts of self-harm or suicidal ideation, then urgent psychiatric referral is indicated.

For less acute situations, consider referrals to eating disorder programs in your area. Do not wait until your patient becomes unstable. Early intervention has been shown to result in better outcomes. Also, it is easy to underestimate the severity of an eating disorder. The patient may have a "normal" weight and may deny symptoms of instability, yet may be suffering from a serious eating disorder.

Eating disorder treatment is critically underfunded, and so waiting lists for treatment can be long. However, most treatment programs will get your patient in for an assessment fairly quickly, even if there is a long wait list for the treatment itself. The assessment can help you monitor the patient while on the wait list.

TIPS FOR COMMUNICATING WITH YOUR PATIENTS

People with eating disorders are often ambivalent about getting treatment. Eating disorder behaviours can serve as ways of coping with distress (perhaps painful emotional experiences, confusion about identity, a need for control) – so for your patient, the idea of getting free of the eating disorder can be frightening. Validating your patient's ambivalence yet encouraging a proactive approach to treatment is important. Using a motivational interviewing approach can help to address ambivalence and build motivation for recovery.

OTHER RESOURCES

Clinical guidelines and tools

Eating Disorders: A Guide to Medical Care, 3rd edition by the Academy of Eating Disorders
www.aedweb.org/resources/publications/medical-care-standards

- a concise guide to critical points for early recognition and medical risk management developed by an international group of eating disorder experts

Eating Disorders Toolkit for Primary Care Practitioners by Jessica Callin and Mary Lamoureux
cfe.keltyeatingdisorders.ca/res/eating-disorders-toolkit-primary-care-practitioners-bc

- a handy resource for promoting early recognition and prevention of medical morbidity and mortality associated with eating disorders and improvement of patient engagement

Clinical Practice Guidelines for the BC Eating Disorders Continuum of Services by Josie Geller, Shawna Goodrich, Kathy Chan, Sarah Cockell, and Suja Srikameswaran
cfe.keltyeatingdisorders.ca/res/clinical-practice-guidelines-bc-eating-disorders-continuum-services-1

- a comprehensive resource that covers the clinical management of EDs at all levels of care, from primary care to acute hospital treatment

Putting Eating Disorders on the Radar of Primary Care Providers by the Central West Eating Disorder Program
www.shared-care.ca/files/Eating_Disorders_Toolkit.pdf

- a comprehensive resource containing tools, guidelines, and practical tips for you, as well as handouts for patients and their loved ones

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National Eating Disorder Information Centre (NEDIC)

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- maintains a website with a wealth of information and educational resources for professionals and individuals with eating disorders, including a searchable directory of programs and services located in Canada; operates the country's only eating disorder-specific toll-free helpline and instant chat service

Body Brave

Body Brave

www.livingbodybrave.com

- a Hamilton, Ontario-based charitable organization providing in-person and on-line support for people with eating disorders; its Instagram account, @bodybravecanada, features body-positive messaging and may be a tool for engaging patients who are ambivalent about treatment