A Guide to Spotting Eating Disorders in Primary Care and What You Should Be Doing.

Why is this SO Important?

- Of **all** mental illnesses, anorexia nervosa (AN) has the **highest mortality rate**
- By the time 'obvious' signs of eating disorders (EDs) have manifested, it is likely the behaviours are so ingrained in patients that treatment is harder and less successful
- **Early intervention is a critical factor in determining the success of treatment for EDs**
- The role of the primary care professional is to **identify** EDs, do initial biochemical **investigations** and **refer early** for assessment
- Use this guide on placement or at work when seeing patients
- It will help you know when to consider an ED as a diagnosis even when **disordered eating is not the presenting complaint**, the **signs and symptoms** to look out for, how you **can explore the diagnosis** and when you should be **referring patients** for further assessment

Anorexia Nervosa (AN)

- **Restriction** of energy intake relative to requirements, leading to low body weight
- Intense **fear of gaining weight** or **becoming fat**
- **Disturbance in body image**
- Atypical AN:
  - All criteria met for AN **except** significant weight loss; weight remains normal

Bulimia Nervosa (BN)

- Recurrent episodes of **binge eating***
- Recurrent inappropriate **compensatory behaviors** to prevent weight gain: vomiting, exercising, laxative misuse or fasting
- Over concern regarding shape and weight

* Consumption of unusually large amounts of food in a brief period of time with feelings of loss of control

Binge Eating Disorder (BED)

- **Recurrent** and **persistent** episodes of **binge eating**
- Episodes of binging associated with 3 or more of:
  - **Eating faster** than normal
  - Feeling **uncomfortably full**
  - Eating **large amounts** of food when **not hungry**
  - **Eating alone** due to **embarrassment** of food consumption
  - Feeling **disgusted** with oneself
- **Distress** regarding binge eating
- **Absence** of regular compensatory behaviours

EDs do not discriminate; they can affect anyone

The A- Z of ED Signs and Symptoms

Appetite change
Bradycardia, **B**eau Lines
Cold Intolerance
Distorted body image
Excess fine body hair
Fear of fatness
Growth Restriction
Hair thinning; **H**ypotension
Inappropriate dress for the weather
Jittery due to anxiety
Knuckle calluses
Low body weight
Mood changes
New dieting behaviour
Obsessive behaviour
Poor concentration
Quality of life reduced
Rigid exercise regime
Social withdrawal
Tooth discoloration
Unexplained hypokalemia
Vomiting
Water intake is excessive
Xerosis (dry skin)
Yellowing of the skin
Zzzz due to insomnia

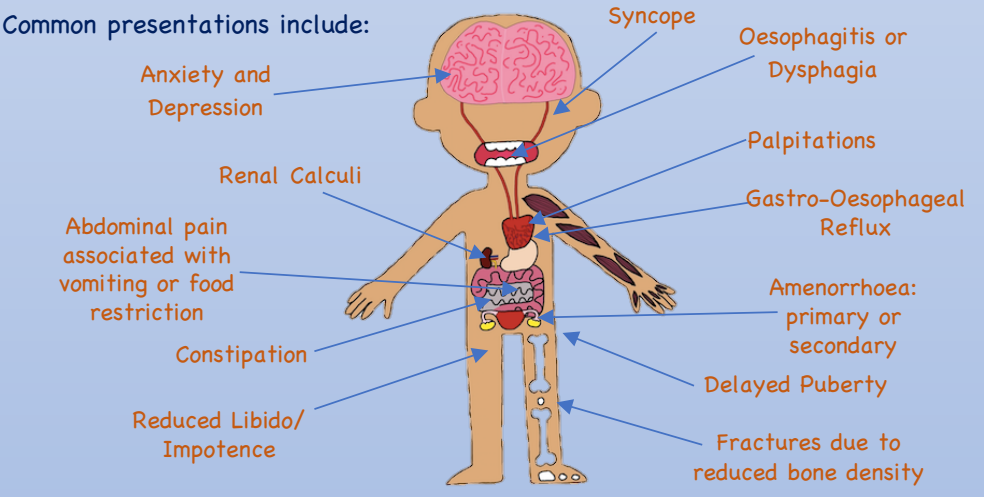
Looking a 'healthy weight' doesn't automatically rule out the diagnosis

Red Flags

- Hypothermia
- BMI below safe range
- <40 bpm or postural tachycardia
- Hypotension (may be orthostatic)
- Failure of Sit up – Squat – Stand
- Prolonged QTC >450ms

Patients with EDs are unlikely to present complaining of disordered eating… in fact a study has shown, people suffering with an ED attend their GPs frequently with other presenting complaints prior to diagnosis

Common presentations include:



Keeping EDs in mind as a differential will help you pick up cases **earlier**

What questions should you ask to explore the possibility of an ED diagnosis?

SCOFF Questionnaire

Five simple questions can give you a good starting point for questioning:

1. Do you make yourself **S**ick because you feel uncomfortably full?
2. Do you worry you have lost **C**ontrol over how much you eat?
3. Have you recently lost more than **O**ne stone in weight (7.7kg)?
4. Do you believe yourself to be **F**at when others say you are thin?
5. Would you say that **F**ood dominates your life?

Two or more positive answers indicate further questioning and examination **BUT** do not rely solely on these questions to determine whether or not people might have an ED

If you think the patient may be suffering from AN or BN, these questions can be used to explore the diagnosis further….

- Have you set yourself **strict rules** around food?
- How do you feel about **social events** involving food?
- Do you feel you are **less spontaneous** with social situations?
- Do you find yourself **lying** to people about the amount of food you eat?
- Do you find yourself **thinking about food** most of the day?
- Do you find that you are **indecisive** and spend excessive amounts of time in supermarkets **looking at food**?
- Do you have **feelings of guilt** after eating certain foods?
- Do you feel like you have a **constant internal battle** with yourself when it comes to deciding what to eat?
- How often do you **weigh yourself** and how does it make you feel?
- Do you find yourself trying to **falsely justify your food decisions** e.g. saying you don't like something when you do?
- Do you find that you **don't seem to laugh or have fun** anymore?

EDs are not just about the food, they affect all aspects of a patient's life

Other things to explore:

- Family support and history of EDs
- Occupation
- Relationships
- Exercise

If you think the patient may be suffering from BED, these questions can be used to explore the diagnosis further….

- Do you ever find yourself **eating large volumes** of food with the feeling you've **lost control**?
- Do you find yourself **eating in secret**?
- Do you **think about food** most of the day?
- Do you ever feel **embarrassed** about the amount of food you eat?
- Do you **organise your life around food**?
- Do you find yourself **collecting and storing** large amounts of food?
- Do you **lie** to people about the amount of food you eat?
- Do you ever eat until you feel **uncomfortably full**?
- Do you **socially isolate** yourself?
- Have you **previously restricted** your food intake?
- Do you suffer with **mood swings** and **irritability**?
- Do you have feelings of **shame and guilt** after binge episodes?
- How do you feel about **social events** involving food?

What should you do?

If you suspect a patient may be suffering from an ED, you should **REFER IMMEDIATELY** to a community based , age – appropriate ED service for further assessment and treatment
Early referral **should not be delayed** because of lack of 'physical symptoms'
Use MARSIPAN protocols to assess whether low, moderate or high risk in AN

Reassure the patient that a **FULL recovery** is possible and they are not alone

Guidance from – NICE CKS: Eating Disorders

MARSIPAN

Junior MARSIPAN <18s

If signs of severe malnutrition, electrolyte imbalance, dehydration or signs of incipient organ failure, consider emergency admission and acute medical care

What should you be doing whilst awaiting referral?

- Arrange **regular review** to monitor level of mental and physical health risk
- Assess for **biochemical** and **ECG** abnormalities
- Inform patients of **online services** they can access for support and information e.g. **BEAT**
- Encourage patients an appropriate **multi-vitamin supplement**

Investigation	Potential Finding
FBC	Anemia, thrombocytopenia, Leukocytosis
U&Es	Hypokalemia, Hyponatremia
LFTS	Elevated
Glucose	Low
Creatinine	May be elevated development kidney disease
Magnesium Phosphate Calcium	Low

Most people with EDs have normal blood results **BUT** they should be done to check for any complications

Disclaimer: this is not a fully comprehensive guide to EDs and should be used alongside NICE Guidelines

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