

Role of the Primary Care Provider in the Evaluation and Treatment of Eating Disorders

Ovidio Bermudez, MD, FAAP, FSAM. CEDP

Medical Director

Laureate Eating Disorders Program

Tulsa, OK

800.322.5173 or 918.491.3702

www.laureate.com



Disclosures

- In the past 12 months, I have had no relevant financial relationships with the manufacturers of any commercial product or providers of commercial services discussed in this CME activity. I do not intend to discuss an unapproved or investigative use of a commercial product or device in my presentation.

Objectives

- Participants will be familiarized with disordered eating and eating disorders
- Participants will be able to discuss the importance of early recognition in the care of eating disorders
- Participants will be able to recognize the importance of timely intervention for eating disorders

Historical Perspective



Lasegue (1873): "...An inexhaustible optimism, against which supplications and menaces alike are of no avail: 'I do not suffer and must then be well...'. So often have I heard this phrase repeated by patients that now it has come to represent for me a symptom-almost a sign...The whole disease is summed in this intellectual perversion."

Historical Perspective

- Gull (1874):
“...Relations and friends are generally the worse attendants...”

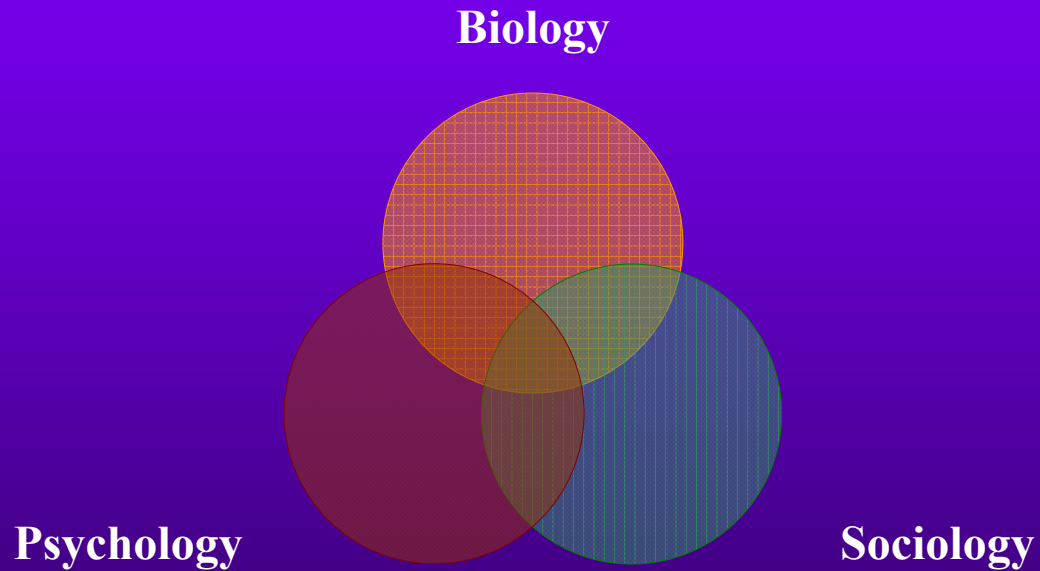


Causes of AN

A Historical View

- 1920's: pituitary disease
- 1930's: metabolic disorder of psychological origin (psychosomatic)
- 1940-50's: fear of impregnation (Freud)
- 1960-70's: anorexigenic families
- 1980-90's: childhood trauma
- 2000's: neurobiology
- Today: latent vulnerability and gene x environment interaction

Eating Disorders



**Spectrum of Eating Problems
in the General Population**

**Body Dissatisfaction
(Normative Discontent)**

**Disordered
Eating**

**Diagnosable Eating
Disorders**

Dieting

Obsessiveness

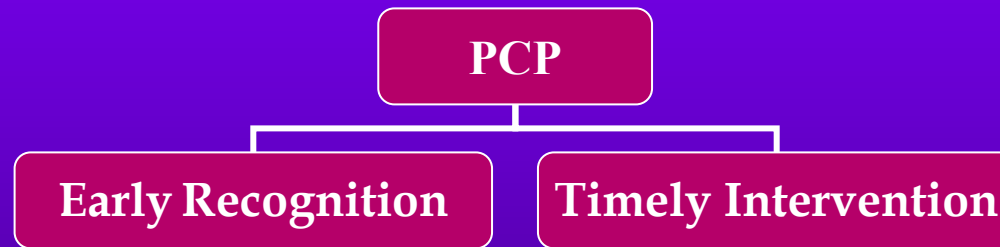
What is an disordered eating?

- Disordered eating
 - can occur as an acute response to life situations or may even become a habit
 - can lead to chronic dieting, obsession with food and weight, weight changes, nutritional problems, and poor self-image
 - it rarely leads to severe medical conditions or emotional problems that interfere with relationships, friends, family, school or work
 - education and counseling can be helpful

What is an eating disorder?

- An eating disorder is a serious mental illness where there is a severe disturbance in eating behaviors
- Eating disorders with diagnostic criteria (DSM IV - TR, 2001)
 - **anorexia nervosa**
 - **bulimia nervosa**
 - **eating disorder not otherwise specified**
 - **binge eating disorder** (proposed criteria)

Medical Care of Eating Disorders



Early Recognition

- Routinely screening for eating disorders related attitudes and behaviors at annual check ups
- Ongoing monitoring of weight, height, BMI
- Careful attention to S & S of eating disorders
- Further attention to any evidence of inappropriate dieting, excessive wt concerns, wt loss, or failure to increase wt and ht as expected

Early Recognition

- Failure at early recognition can result in increase severity of the illness and difficulties in treatment
- In cases of referrals by concerned parents, school personnel, or peers, it is most likely that the patient has an eating disorder
 - 50% / 75% rule

Early Recognition - Risk Factors

- Family history
 - eating disorders or obesity
 - affective disorders or alcoholism
- Parental abnormal eating behaviors and weight
- “visual sports” like ballet, gymnastics, modeling
- Personality traits like perfectionism, overachievement
- Physical or sexual abuse
- Low self-esteem
- Body image dissatisfaction
- h/o excessive dieting, disordered eating, compulsive exercise

Early Recognition - Risk Factors

- Children and adolescents engaged in pathologic dieting are 7 times more likely to develop disordered eating.
- Pathologic dieting was a sensitive predictor of those who went on to develop an ED

Patton et al, Onset of eating disorders: population based cohort over 3 years. BMJ. 1999;318:765-768.

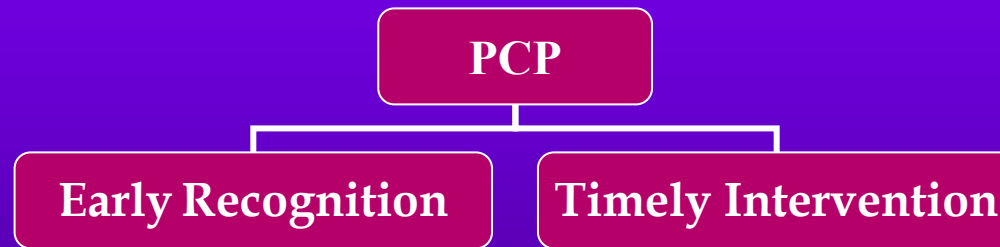
Dieting as a precipitating factor

- **Affective response to starvation**
 - Irritability
 - Anxiety
 - Obsessiveness
 - Depression

Early Recognition - Warning Signs

- dieting
- expression of body/self dissatisfaction
- emotional/secretive eating
- obsessive food thoughts
- guilt after eating
- fear of fatness / avoidance of food
- over-exercising
- poor social functioning

Medical Care of Eating Disorders



Timely Intervention - Tasks

1. Rule out non-eating disorder etiology for S & S (organic and/or psychiatric)
2. Establish the diagnosis
3. Determine if to treat or to refer

Initial Evaluation of Eating Disorder

- ED or not ED?, that is the first question.

Eating Disorders

Differential Diagnosis

- Medical
 - **ibs**, malabsorption, pud, **ger**, achalasia, **gastroparesis**
 - malignancies
 - **thyroid disease**, hypopituitarism, Addison's
 - **diabetes mellitus**
 - chronic infections (HIV, TB, **sarcoidosis**)
 - central nervous system disease (space occupying lesions, ↑ icp)
 - collagen vascular disease (**SLE**, **JRA**)

Eating Disorders

Differential Diagnosis

- **Psychiatric**
 - **depression**
 - **anxiety and phobias**
 - **obsessive-compulsive disorder**
 - **substance abuse**
 - **psychosis**

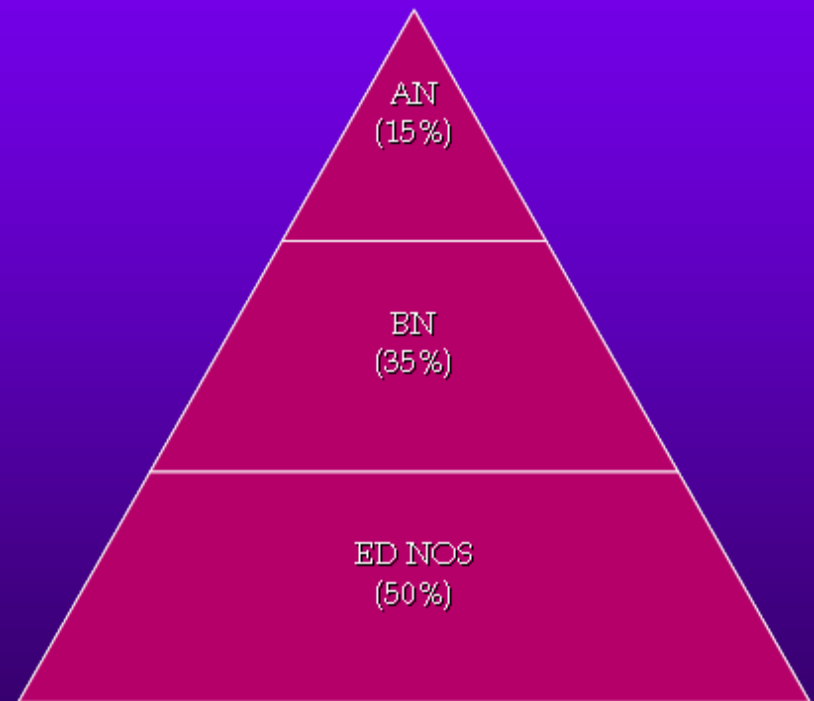
Timely Intervention

Establishing a Diagnosis

- DSM-PC, Child and Adolescent Version
 - spectrum of
 - dieting
 - disordered eating
 - eating disorders
- DSM-IV TR (2001)
 - Anorexia Nervosa
 - Bulimia Nervosa
 - Eating Disorder Not Otherwise Specified

ED NOS

- Prevalence: most common eating disorder diagnosis made by clinicians



ED NOS

- Definition: residual category for those eating disorders other than AN or BN
- These patients experience the same medical and psychological consequences

ED NOS

- Clinical features:
 - Can be viewed as belonging to 2 groups
 - Those who do not meet the precise diagnostic criteria for AN or BN but have a similar clinical presentation
 - Those whose clinical features are combined in a different way (“atypical” or “mixed” cases)

Timely Intervention Tasks

- Determine severity of illness
- Established treatment team
- Establish treatment plan and goals
- Ongoing assessment for most appropriate level of care

Ongoing Management

Establish Severity of Illness

- Medical Assessment
- Nutritional Assessment
- Psychosocial /Psychiatric Assessment

Eating Disorders

Severity of Illness

- **Mild or early**
 - 85-95% IBW and stable VS
 - food plan 3m/3s; 1200-1500 Kcal/day
 - referral to dietician to gradually increase calories once to twice per week
 - psychotherapy
 - treatment agreement (verbal) or contract (written)

Eating Disorders

Severity of Illness

- **Mild or early**

- If bradycardic restrict activity
- If failure to weight recover add liquid supplements and restrict activity
- See weekly and increase parental supervision of meals if continued failure to improve

Eating Disorders

Severity of Illness

- Moderate or established
 - 75-85% IBW, +/- VS or laboratories abnormalities
 - weekly wt checks
 - full treatment team mandatory
 - activity restriction until wt gaining trend and stable VS
 - establish wt goal safe for activity
 - written contract with wt target line, hospitalization wt
 - +/- liquid supplements

Eating Disorders

Severity of Illness

- Moderate or established
 - If further deterioration, hospitalize
 - If failure to progress, discuss details of hospitalization
 - If still failure to progress, hospitalize

Eating Disorders

Severity of Illness

- Severe

- < 75% IBW, medically unstable, pulse < 50, +/-dehydration
 - hospitalize
 - re-feeding, PO or ND
 - purge precautions, no exercise, bed rest if necessary
 - monitor closely for re-feeding syndrome
 - daily psychotherapeutic support
 - discharge criteria: established wt recovery to minimum wt, normal vital signs and laboratory studies

Hospitalization Criteria

Anorexia Nervosa

- < 75% IBW or ongoing wt loss with intensive management
- refusal to eat and / or drink
- body fat < 10%
- HR < 50 bpm (daytime) or 45 bpm (night time)
- SBP < 90
- orthostasis: > 20 bpm and / or > 10 mm Hg
- temperature < 96 degrees F
- arrhythmia

Hospitalization Criteria

Bulimia Nervosa

- syncope
- $K^+ < 3.2$ mmol/L
- $Cl^- < 88$ mmol/L
- esophageal tears / hematemesis
- cardiac arrhythmias or $QTc > 430$ ms
- hypothermia
- intractable vomiting
- suicide risk
- failure to respond to outpatient treatment

Positive Predictors of Outcome

- BN better than AN
- AN, purging type better than AN, restricting type
- short duration of illness
- higher discharge wt after hospitalization (>90% of IBW)

Negative Predictors of Outcome

- long duration of illness
- low body wt at time of initial treatment
- creatinine > 1.5
- premorbid obesity (for BN)
- premorbid asociality
- compulsion to exercise
- disturbed family relationships

Outcome of Disease Course in AN

- mortality 5.6% per decade of disease
- frequent wt fluctuations
- 10-31% with poor outcome
- prolonged time to full recovery (average 6 years)
- 50% may develop BN
- risk for depression, anxiety, alcohol abuse
- 45% never marry

Outcome of Disease Course in BN

- Mortality unknown
- 50% in full recovery within 2 years
- frequent relapses after recovery
- 20-46% may have ED symptoms 6 years after treatment
- 55% develop mood disorders
- 42% develop substance abuse disorders

Eating Disorders: State of the Art

- Eating Disorders are serious mental illnesses, not a lifestyle choice
- The state of the field is more art than science (but we are doing better)

Excess Mortality, Causes of Death, and Prognostic Factors in AN

Papadopoulos et al, BJP 2009

- N=6003, retrospective 30 years (1973-2003), 256 deaths, average age of death was 34 years, (suicide 32%, anorexia 19%, other causes 38%)
- AN patients were at heightened risk of death, not only after hospitalization but many years later.
- The long term risk of death came not just from AN but from other causes

Excess Mortality, Causes of Death, and Prognostic Factors in AN

Papadopoulos et al, BJP 2009

- Compared to the general population, AN patients were more likely to have died due to
 - Psychoactive substance abuse - 19 times
 - Suicide - 14 times
 - Respiratory illness - 12 times
 - Urogenital diseases - 11 times
 - Gastrointestinal diseases - 5 times
 - Cardiovascular diseases - 2 times
 - Cancer - 2 times
 - All causes of death - 6 times

Excess Mortality, Causes of Death, and Prognostic Factors in AN

Papadopoulos et al, BJP 2009

- Patients admitted 1973-1979 had higher mortality rate than those admitted from 1987-2003

- The goal of treatment is personal growth in your emotional, cognitive, spiritual, behavioral, and relational being. It is occasionally exhilarating, often frustrating, and at times painful – just like life...

