Update on Eating Disorders
Beth Kotarski, MSN, CRNP-BC

Objectives
- Define eating disorders (ED)
- Describe updates to Diagnostic and Statistical Manual of Mental Disorders
- Recognition of risks in primary care population
- Identify physiologic changes of ED
- List medical complications of ED
- Screening Tools
- Management guidelines
- Role of the team members

Definition and Updates
- Anorexia Nervosa:
  - Intense fear of gaining weight or becoming “fat.”
  - Disturbance in the way one’s body weight or shape is experienced, and/or undue influence of body weight or shape on self-evaluation.
  - Denial of seriousness of the current low body weight.
  - May restrict with or without purging.
- DSM IV vs. V — changes to note:
  - Old – had “refusal” to maintain IBW—often stated as 85%. That is gone.
  - Old – had amenorrhea in criteria—deleted as not helpful.
  - New criteria focus on behavior—not just focused on fear of weight gain.
Definition and UPDATES Continued

- Bulimia Nervosa:
  - Recurrent episodes of binge eating characterized by both:
    1. Eating a larger amount than most people do in a DISCRETE period of time, and ...
    2. Sense of lack of control during the episode
  - Recurrent compensatory behavior such as vomiting, laxatives, diuretics, fasting, excessive exercise, medication use after an episode.
  - Old criteria: occurrence at least 2 times a week for 3 months.
  - New DSM V criteria: just once a week for 3 months.

Definitions and Updates

- Diabulimia:
  - The deliberate misuse of insulin in Type I diabetics to control weight gain and induce weight loss.
  - Binging at least once a week for 3 months
  - Exercise more than necessary to stay fit.
  - Patients have distorted body image, intense fear of gaining weight on insulin
  - Suspect in patients with recurrent DKA, unexplained weight loss, frequent requests to switch meal-planning approaches, frequent severe low blood sugar episodes
  - Girls and young women with Type I diabetes have 2x the risk of developing an eating disorder as their peers.

Definition and Updates, continued

- Binge Eating Disorder
  - Went from being categorized under “Disorders needing further research” into its own diagnostic label in DSM V.
  - Recurring episodes of eating significantly more food in a short period of time than most people would under similar instances.
  - Feeling lack of control.
  - No compensatory behavior
  - Typically obese
  - May have guilt, disgust or embarrassment and binge alone to hide behavior. Marked distress. Occurs at least once* (old criteria was twice) a week over a three month period.
Scope of Problem/At Risk patients

- Stats:
  - Anorexia is the third most common chronic illness among adolescents.
  - 95% of those who have eating disorders are between the ages of 12 and 25.8
  - 25% of college-aged women engage in bingeing and purging as a weight-management technique.
  - The mortality rate associated with anorexia nervosa is 12 times higher than with all causes of death for females 15-24 years old.
- 10-15% patients are male gender
- Highest mortality rate of ANY mental disorder:
  - 4%-8% AN, 3.9% BN, 5.2% for BED

Assessing our patients

- At risk pops: Culture alone predisposes vulnerable groups.
- Adolescents. Early DX linked to better outcomes.
- Athletes—judged sports, elite athletes, aesthetic sports—perfectionism, high expectations, competitiveness, measuring of weight/weigh-ins, repetitive exercise routines, dieting.
- Mental health risks: (eating disorders rarely walk alone)
  - Anxiety
  - OCD
  - Depression (50% meet depression criteria)
  - Trauma (crisis intervention access?)
  - Self mutilation
  - Anyone!

A Word on Body Image...

- Body image is learned.
- Society’s norms about how a certain gender, occupation, athlete-type should look can influence body image formation
- Vulnerable: adolescents—growth is dramatic and can feel out of one’s control.
- Peer group can influence control over appearance.
  - Careful how we put value judgments to body types... (Nice and thin, big and strong...)
- Focus on feelings and levels of abilities, not physical attributes.
- Never comment on a person’s appearance as good or bad.
Assessing our Patients

- Ask About:
  - History of weight fluctuations; low weight/high weight, desired weight
  - Actions taken to maintain, control, or alter weight
  - Dieting
  - Laxatives, enemas, diuretics, appetite suppressants, supplements
  - Vomiting
  - Excessive exercise
  - Periods of binge eating or feeling a lack of control over food intake
  - Comfort with current weight/shape/other body parts

Assessment

- Report of typical daily food and water intake
- Exercise habits (how much? how often? why?)
- Menstrual history—menarche and thelarche
- Family history of eating disorders, depression, obesity, and chemical dependence
- Remember: ED never walks alone—OCD, Dissociative Identity Disorder, anxiety/depression

Patients will be sensitive about weight. Check weight in a pt. who is in gown after they void, and facing away from the scale, if possible. When possible, do not make comments about their weight or appearance.

Assessment

- Consider Eating Disorders for Patients with:
  - Amenorrhea
  - Reflux/regurgitation
  - Chronic constipation
  - Bradycardia
  - Syncope
  - Dehydration
  - Hypoglycemia
  - OCD
  - Substance use
  - Depression
Recognition of Signs

- Possible Presentation of Patient
  - Self report/referral from friend/coach/parent/—overtly thin.
  - Not so obvious:
  - Fainting episode(s)
  - No periods/wishes OCP’s
  - Complaints of GI distress/fatigue/weakness
  - New vegan or veg. diet—requests “iron check”
  - Athletes with “poor performance”
  - Chronic constipation/diarrhea/ reflux
  - Mental health concern/trauma/cutting/self mutilation

Physical Assessment—AN

- Thin-emaciated sallow, pale
- Flat affect, not particularly concerned or engageable
- Dry skin, lanugo, dull-brittle hair, hypercarotenemic
- HEENT—halitosis
- Breast atrophy
- Cardiac: MVP, arrhythmias
- Abdomen: scaphoid, palpable stool loops,
- Extremities—scaly, edema, calluses on the dorsum of hand
  (Russell’s sign), Raynaud’s

Physical assessment--BN

- Normal weight to slightly over normal
- Vital signs normal to slightly > bp
- Skin—normal to dry, subconjunctival hemorrhage, petechiae around eyes.
- HEENT—mouth exam—dental caries, gingivitis, halitosis, parotitis, pharyngeal ulcerations/injuries
- Abd: distended, tender epigastrium
- Laxative dependency/incontinence
- Russell’s sign
Medical Complications of Anorexia Nervosa

Medical Complications arise from the behaviors of bingeing, purging, and starving.

- Starvation induces protein and fat catabolism
- Increase risk with severity of weight loss
- Increase risk with length of illness
- Most complications resolve with weight gain, although some may be irreversible. (i.e., bone loss)
- Reproductive health may be impaired for longer periods of time post recovery/remission.

Medical Complications of Bulimia Nervosa

- May affect different organ systems—some irreversible
- Depend on method of purging—vomit, laxative
- Depend on frequency of purging
- GI and mouth/teeth involvement
- Most resolve with discontinuation of purging

Management in Primary Care

- Screening early—all high risk groups should get screened—no one tool, but online tools available.
- Do you make yourself sick because you feel full?
- Do you worry you will lose control over how much you eat?
- Do you restrict what you eat or who you eat with?
- Would you say that food dominates your life?
- SCOFF and others

Alter questions for children 11-14. Ask about snacks—what kinds of snacks do they eat and drink?

Do they like to eat with friends?
A word about primary care

- DO YOUR JOB—take one for the team—save a life.
- Early intervention is the only hope.
- Don’t allow patients or their families to tell you it is IBS. IBS does not produce constitutional symptoms.
- Patients present looking bad but feeling great—shouldn’t that raise the red flag?
- Don’t be swayed—have your plan in place ahead of time.
- Stay focused on the danger. If a patient had a 3 month weight loss and went from 93% IBW to 72% IBW, that should tell you they need immediate and intense therapy.
- Scare the family, not the patient.

Important physical parameters

- High risk thresholds: when to send to ER will vary. All based on physical trends. HR of 49 may be a stable one for a long-time AN. Sudden dizziness or fainting—may not.
  - Vital signs:
    TEMP *, pulse, bp, orthostatic signs > 20 bpm pulse or 10 bp
    temp below 97
    heart rate less than 40 bpm
  - Lab parameters:
    K < 3.2*, Chloride <88, Phosphorous <3*, Magnesium < 1.8*
    * Refeeding Syndrome vs. Refeeding therapy*

Primary care concerns

- Immunity—annual vaccine for flu, update on all vaccines
- Bone loss—
  * what role leptin plays in osteogenesis
  calcium and Vitamin D
- Reproductive health
  hormonal contraception/replacement debate
- Kidney failure/ Death
Department of Justice/OCR and ADA revisions
- August, 2011
- Revision to the ADA Title II (public) and section 504 (private) regulations:
  - "Direct threat: A significant risk to the health or safety of OTHERS that cannot be eliminated by a modification of policy or practice or provision of aids or services."
  - "As applied to public and private institutions, direct threat IS NOW limited in its application to harm to OTHERS only." (OCR).
  - Support patients getting the rights they deserve.

What CAN we do?

Begin the Discussion
- Frank awareness, discussion and screening
- Screening for all patients
- Discussions with caregivers/family members—treatment of whole family
- Team approaches
- Why body image matters—link between body satisfaction and behaviors.
- Model language and body acceptance to patients
- Emphasize abilities, not appearance. Compliments should not be appearance driven. (You look—happy, rested, well, etc)
Treatment modalities

- Medications—why vs. why not?
- Team management
  - medical—all medical team
  - psychological—individual and group
  - nutritional—RD with specialty
  - family—some treatments based on family (Maudsley)
  - other?—spiritual advisor, coach, teammates, etc.
- Inpatient vs. Outpatient

Nutritional Therapy

- Nutrition education that explores underlying issues of eating disorders
- Learning to utilize healthier coping mechanisms
- Tools and alternative behaviors to replace old unhealthy behaviors
- Adapting to a healthier lifestyle
- Outpatient dining programs. (Eat “forbidden foods” and face anxieties, become comfortable with the process, and trust variety.)
- Registered dietitian who works just with ED—don’t refer to an RD assuming they are experts.

Nutrition Therapy vs. Psychotherapy

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<thead>
<tr>
<th>Nutrition Therapy</th>
<th>Psychotherapy</th>
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<tbody>
<tr>
<td>Short Term</td>
<td>Open-ended/Long term</td>
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<tr>
<td>Content Based</td>
<td>Process Based</td>
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<tr>
<td>Goal Oriented</td>
<td>Relationship Oriented</td>
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<tr>
<td>Improve knowledge/skills</td>
<td>Resolving deeper issues</td>
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<tr>
<td>Addresses thoughts/feelings behavior related to food/weight</td>
<td>Addresses all thoughts/feelings</td>
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<tr>
<td>Success measured</td>
<td>objectively</td>
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<td>Success measured subjectively</td>
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Other Treatment Options and Recovery

- Expectations about recovery—ongoing and chronic. ("recovery vs recovered")
- Recovery takes an average up to 7 years.*
- Discharge plan from other treatment place should involve primary care.
- Outpatient care—ongoing therapy—DINE programs
- Reentry recommendations should involve discharge plans from treating facility and new goals for continuing care at college.

Resources

- NEDA (National Eating Disorders Association) http://www.nationaleatingdisorders.org
- National Association of Anorexia Nervosa and Associated Disorders www.anad.org
- National Institute of Mental Health http://www.nimh.nih.gov