EATING DISORDERS:
An introduction for clinicians

Megan Riddle, MD PhD MS
Nothing to disclose
GENERAL DISCLOSURES

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OBJECTIVES

• Understand the importance of recognizing eating disorders
• Describe key features of eating disorders and review the importance of screening
• Describe the components of eating disorder treatment

WHY TALK ABOUT EATING DISORDERS?

• Eating disorders have a high morbidity and mortality
• 30 million people in the US have eating disorders
• Often go unrecognized
  – Only 1 in 10 of bulimia patients are diagnosed
Anorexia nervosa

- Restriction of energy intake leading to low body weight
- Intense fear of weight gain or behaviors that interfere with weight gain
- Excess concerns about weight and shape

Bulimia nervosa

- Recurrent binge episodes associated with eating an excess amount in a discrete period and lack of control
- Compensatory behaviors to prevent weight gain
- Binge eating and purging occur on average at least weekly for 3mo
- Excess concerns about shape and weight

http://images.suite101.com/2553402_com_119900915_.jpg
https://advocateglobalhealth.wordpress.com/eating-disorders/bulimia-nervosa/
**Binge Eating Disorder**

- Recurrent binge episodes associated with eating an excess amount in a discrete period and lack of control
- **No** compensatory behaviors to prevent weight gain
- Binge eating occurs on average at least weekly for 3mo

**Avoidant/Restrictive Food Intake Disorder**

- Eating disturbance (i.e. concern about eating certain food types/textures) that prevents patient from meeting nutritional needs leading to:
  - Weight loss
  - Nutrient deficiency
  - Dependence on supplements/feeding tube
  - Interference with psychosocial
- Not in the setting of AN or BN or explained by other medical condition
THE CASE: SARA

• Sara is a 28yo woman who newly presents to your clinic for fatigue
• On her new patient screener, she reports a PMHx of anxiety
• Vitals:
  – BP 110/70; P 87
  – Wt 145lbs; Ht 5’6”; BMI 23.4
• PHQ9: 5 (mild depression)
• GAD7: 8 (mild to moderate anxiety)
THE CASE: SARA

• Increasingly tired over the past 2 months, but denies all other physical symptoms
• Asked if she’s made any changes recently, she says she’s had a lot of stress at work, but is pleased to report she is trying to take good care of herself, losing weight by increasing her exercise and eating “better”
• “I’m wanting to be healthier”
THE CASE: SARA

• Physical exam is wnl
• Lab work, including CBC, BMP, LFTs, TSH, UPreg, UA are all wnl
• She returns for a follow up visit in a month, still struggling with fatigue
• Vitals:
  – BP 110/75; P 85
  – Wt 135lbs; Ht 5’6”; BMI 21.8
MAKING A DIAGNOSIS

• “Eating disorder” is rarely the chief complaint (unless they are dragged in by a worried family member)

• Instead...

  - Fatigue
  - Cold intolerance
  - Amenorrhea
  - Constipation
  - Polyuria
  - Sore throat
  - Dizziness
  - Changes in weight
  - Bloating
  - Palpitations
  - Fertility issues
  - Polydipsia
  - Heart burn
  - Stress fractures
MAKING A DIAGNOSIS

Anorexia nervosa
• Usually related to organ dysfunction due to malnutrition and the person being underweight
• Starvation affects all organs of the body

Bulimia nervosa*
• Usually related to the type of purging used, frequency, and duration

*Of note, patients with AN, binge/purge type, can have these issues as well
MAKING A DIAGNOSIS

Anorexia nervosa

**Cardiac:** Bradycardia, Orthostatic hypotension, Syncope, Arrhythmias, CHF, Sudden death

**GI:** Gastroparesis, GERD, Abnormal Liver Function Tests SMA Syndrome

**Endocrine:** Menstrual irregularity, Hypothalamic and thyroid dysfunction, Osteoporosis, Glucose dysregulation, Low Testosterone (in men), Hypercholesterolemia

**Electrolytes:** Usually normal Hyponatremia, Hypophosphatemia

Bulimia nervosa

**Cardiac:** Arrhythmia, Ipecac-induced cardiomyopathy

**GI:** GERD, Odynophagia, Dysphagia, Hoarseness, Hematemesis, Diarrhea, Cramping, Hematochezia

**Endocrine:** Menstrual irregularity, PCOS

**Electrolytes:** Hypochloremia Hypokalemia, Metabolic alkalosis, Hyponatremia
WHO TO SCREEN?

• Preteens and Adolescents: ALL
• Adults: high risk
  – Young adults
  – Women under stress
  – Rapid changes in weight or asking about weight loss
  – Athletes
  – Positive Family History

You need to ask!
EATING DISORDERS: QUICK SCREEN

• Eating Disorder Screen for Primary Care
  ✔ Are you satisfied with your eating patterns? (No is abnormal)
  ✔ Do you ever eat in secret? (Yes is abnormal)
  ✔ Does your weight affect the way you feel about yourself? (Yes is abnormal)
  ✗ Have any members of your family suffered with an eating disorder? (Yes is abnormal)
  ✔ Do you currently suffer with or have you ever suffered in the past with an eating disorder? (Yes is abnormal)

• Two abnormal questions gives sensitivity 100% and specificity 71%
  (Cotton et al, 2003)
MAKING A DIAGNOSIS

**Eating behaviors**
- Walk me through a typical day.
- Are others concerned?
- Food rituals?
- Do you feel you eat too much or too little?

**Purging behaviors**
- Frequency/Duration
- Vomiting?
- Diet pills?
- Diuretics?
- Laxatives?
- Exercise?

**Body shape & weight**
- Highest weight?
- Lowest weight?
- Ideal weight?
- Are you trying to lose weight? How much have you lost?

**Life Impact**
- How does this affect your life?
- How is it helpful?
- Does it cause problems?
THE CASE: SARA

• Sara reports she been gradually restricting her diet and now eats about 800 kCal/day
• She’s lost 20lbs in the last 3mo
• She has been running 5 miles daily
• Her highest weight was 160lbs, lowest weight 95lbs and goal weight is 110lbs (BMI 17.8)
• She wants to keep losing weight, but is concerned she can’t keep this up

Diagnosis?
DIAGNOSIS?

• Restriction of energy intake leading to weight loss *but with normal BMI*

• Intense fear of gaining weight or of becoming fat

• Excess worry about weight and shape
DIAGNOSIS?

• Other specified feeding and eating disorder (OSFED)

• Atypical Anorexia: All criteria for anorexia nervosa are met, except - despite significant weight loss - weight is within or above the normal range

• Others in this group: Bulimia or BED of low frequency/short duration
A NOTE ON RAPPORT

• It can be difficult to start the conversation, particularly when the patient is in denial about the severity of the illness
• Convey genuine empathy and curiosity while avoiding judgement
• Check your emotional reaction
  • We all have preconceived notions about patients with eating disorders
  • We all have our own relationship with food, weight and our body
EATING DISORDER DO’S AND DON’TS

• Do:
  – Share your concern with the patient
  – Acknowledge the emotional distress gaining weight and not bingeing and purging brings

• Don’t:
  – Reduce this to “you just need to eat more”
  – Make weight and shape comments as the patient begins to recover
  – “You look good” or “You look so much healthier” will be heard by the patient as “You’ve gained so much weight” and “You’re fat”

Don’t forget:
This is a mental illness, not a choice
DIAGNOSE AND THEN?

• Once you have identified a patient with an eating disorder, you need to take steps to get them the treatment they need
• Earlier diagnosis and treatment is associated with better outcomes
TREATMENT TEAM

- Therapist
- Registered Dietitian
- Patient
- Primary Care Physician
- Psychiatrist
CARE CONTINUUM

• Whether a patient should be hospitalized for treatment depends on a number of factors
  • Medical stability
  • Comorbid psychiatric issues
  • Willingness to engage in treatment

Outpatient  Intensive outpatient  Partial Hospital  Residential  Inpatient medical or psychiatric ward

Difficult to access for those on Medicaid
CARE CONTINUUM

- **Outpatient**: >85% IBW
- **Intensive outpatient**: >80% IBW
- **Partial Hospital**: >75% IBW
- **Residential**: >70% IBW
- **Inpatient**: <70% IBW
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<thead>
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<th>CARE CONTINUUM</th>
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<tbody>
<tr>
<td><strong>Outpatient</strong></td>
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<tr>
<td>▶️ &gt;85% IBW</td>
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<tr>
<td>Medically Stable</td>
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<tr>
<td>Very Motivated</td>
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<tr>
<td>Can modify behavior independently</td>
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<tr>
<td><strong>Intensive outpatient</strong></td>
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<tr>
<td>▶️ &gt;80% IBW</td>
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<tr>
<td>Medically Stable</td>
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<tr>
<td>Good motivation</td>
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<tr>
<td>Modify with mild support</td>
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<tr>
<td><strong>Partial Hospital</strong></td>
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<tr>
<td>▶️ &gt;75% IBW</td>
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<tr>
<td>Minimal medical monitoring</td>
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<tr>
<td>Partial motivation, cooperates</td>
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<tr>
<td>Needs significant structure</td>
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<tr>
<td><strong>Residential</strong></td>
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<tr>
<td>▶️ &gt;70% IBW</td>
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<tr>
<td>Doesn’t need IVFs, daily labs</td>
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<td>Poor motivation</td>
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<tr>
<td>Needs 24hr supervision, possible NG</td>
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<tr>
<td><strong>Inpatient</strong></td>
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<tr>
<td>▶️ &lt;70% IBW</td>
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<tr>
<td>Fluids, daily labs, tele</td>
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TREATMENT: AN UPHILL CLIMB

Pharmacology

Psychotherapy

Eating disordered behaviors

Weight restoration
TREATMENT: AN UPHILL CLIMB

- Pharmacology
- Psychotherapy
- Eating disordered behaviors
- Weight restoration
TREATMENT: AN UPHILL CLIMB

- Weight restoration
- Eating disordered behaviors
- Psychotherapy
- Pharmacology
WEIGHT RESTORATION

• Increase caloric intake
  – Starts at ~1200-1400kCal/day
  – Gradually increased to 3,000-4,000kCal/day depending on rate of weight gain

• Target weight gain:
  – 0.5-1lb/wk outpatient
  – 2-3lb/wk inpatient

• Working with a nutritionist is key
EATING DISORDERED BEHAVIORS

• Safe/unsafe foods
• “Allergies”
• Portioning
• Pacing
• Excess exercise
• Purging
• Timing of meals
• Fluid intake
• Rituals
• Hunger/satiety cues
EATING DISORDERED BEHAVIORS

• Structured meal plans
  – Expand the quantity and variety of food
• Support and accountability around meals
  – Keeping a food record
  – Recruiting family members
  – Meal support at IOP, PHP, residential
  – Meals with outpatient therapy sessions
• Exposure to restaurants, grocery stores, cooking
• Plan for allowable exercise
ANOREXIA NERVOSA: ADOLESCENTS

- Family Based Therapy has the most robust evidence
  - Caregivers take control of eating choices
  - Teaches the family how to support the child as food habits are normalized
ANOREXIA NERVOSA: ADULTS

• No one therapy has proven to be superior

• Nutritional counseling + Therapy is better than nutritional counseling alone

• Bottom Line: Get the patient into therapy, preferably with someone experienced in eating disorder treatment
BULIMIA NERVOSA & BINGE EATING

• Good evidence that Cognitive Behavioral Therapy is the most effective intervention

The Cognitive Triangle

THOUGHTS

FEELINGS

BEHAVIOR

https://advocateglobalhealth.wordpress.com/eating-disorders/bulimia-nervosa/
PHARMACOLOGY

- Anorexia nervosa
  - Medications generally have limited efficacy
  - No FDA approved meds
  - Antidepressants
    - May help prevent relapse, but are ineffective at low weight
  - Antipsychotics
    - Have mixed evidence

http://www.npr.org/sections/health-shots/2015/12/23/460719043/fda-approval-could-turn-a-free-drug-for-a-rare-disease-pricey
STEP AWAY FROM THE PRESCRIPTION PAD...
PHARMACOLOGY

• Bulimia nervosa
  – SSRIs are 1st line - Fluoxetine is FDA approved
  – Avoid bupropion due to increased seizure risk
  – Evidence for topiramate

• Binge eating disorder
  – SSRIs are 1st line
  – Lisdexamfetamine (Vyvanse) is FDA approved
  – Evidence for topiramate
CASE: SARA

• Sara starts seeing a therapist and nutritionist weekly
• She is started on sertraline to treat her anxiety
• After a month, despite compliance with appointments, she has trouble following meal plans, continuing to restrict and lose weight
• She starts in an IOP program with increased meal support and starts making progress
Recovery has it’s ups and down (literally)
RECOVERY

• Yes, these patients do get better

Based on reviews by Steinhausen 2002 & 2009
It just takes time...in years!

Favorable outcomes associated with shorter duration of illness prior to treatment

(Steinhausen 2002)
RESOURCES

• Local treatment programs (also have sites around the country)
  – Eating Recovery Center (IOP, PHP, Residential, also ACUTE in Denver): does free screenings and helps connect with appropriate level of care
    https://www.eatingrecoverycenter.com/
  – Emily Program (IOP, PHP, Residential):
    https://www.emilyprogram.com/
  – Center for Discovery (IOP, PHP, Residential):
    http://www.centerfordiscovery.com/

• Websites – resources for patients, parents, professionals
  – https://www.nationaleatingdisorders.org/
  – http://www.anad.org/
  – http://www.something-fishy.org/
CONCLUSIONS

• Screen!

• Early treatment is associated with better outcomes

• Weight restoration is key for AN, followed by therapy and ongoing nutritional support

• SSRIs & CBT are best supported for BN & BED

• These patients get better – be patient!
SELECTED REFERENCES