WELCOME!

Today’s Topic:
Eating Disorders

How do I identify eating disorders in my patients and how can I start helping them?

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EATING DISORDERS: An introduction for clinicians

Megan Riddle, MD PhD MS
GENERAL DISCLOSURES

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SPEAKER DISCLOSURES

✓ Any conflicts of interest?
OBJECTIVES

• Understand the importance of recognizing and diagnosing eating disorders
• Review eating disorder diagnoses and discuss how to screen
• 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

http://images.suite101.com/2553402_com_119900915_.jpg
**Anorexia nervosa**

- Restriction of energy intake
- 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 3 mo
- 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 form 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

https://alternefit.wordpress.com/2011/10/02/picky-eaters-can-i-get-them-to-eat/
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 140lbs; Ht 5’6”; BMI 22.6
• 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
  - Polyuria
  - Sore throat
  - Fatigue
  - Amenorrhea
  - Cold intolerance
  - Constipation
  - Dizziness
  - Changes in weight
  - Bloating
  - Palpitations
  - Fertility issues
  - Polydipsia
  - Heart burn
  - Stress fractures
  - Changes in weight
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?

Frequency/Duration
- Vomiting?
- Diet pills?
- Diuretics?
- Laxatives?
- Exercise?
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
• 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 \textit{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

https://s-media-cache-ak0.pinimg.com/736x/98/59/83/985983d89e0508230c7b9bd2e68af499.jpg
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
- Psychiatrist
- Primary Care Physician
Whether a patient should be hospitalized for treatment depends on a number of factors:
- Medical stability
- Comorbid psychiatric issues
- Willingness to engage in treatment

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
CARE CONTINUUM

Outpatient
- >85% IBW
- Medically Stable
- Very Motivated
- Can modify behavior independently

Intensive outpatient
- >80% IBW
- Medically Stable
- Good motivation
- Modify with mild support

Partial Hospital
- >75% IBW
- Minimal medical monitoring
- Partial motivation, cooperates
- Needs significant structure

Residential
- >70% IBW
- Doesn’t need IVFs, daily labs
- Poor motivation
- Needs 24hr supervision, possible NG

Inpatient
- <70% IBW
- Fluids, daily labs, tele
- Poor motivation
- Needs 24hr supervision
TREATMENT: AN UPHILL CLIMB

Pharmacology

Psychotherapy

Eating disordered behaviors

Weight restoration
TREATMENT: AN UPHILL CLIMB

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TREATMENT: AN UPHILL CLIMB

- Pharmacology
- Psychotherapy
- Eating disordered behaviors
- Weight restoration
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**

[Links]
https://advocateglobalhealth.wordpress.com/eating-disorders/bulimia-nervosa/
PHARMACOLOGY: ANOREXIA NERVOSA

• 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
STEP AWAY FROM THE PRESCRIPTION PAD...

Recovering.....
Please Wait
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

http://www.npr.org/sections/health-shots/2015/12/23/460719043/fda-approval-could-turn-a-free-drug-for-a-rare-disease-pricey
CASE: SARA

• Sara begins 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
RECOVERY

Recovery has it’s ups and down (literally)
RECOVERY

- Yes, these patients do get better

Based on reviews by Steinhausen 2002 & 2009
RECOVERY: ANOREXIA NERVOSA

• It just takes time...in years!
• Favorable outcomes associated with shorter duration of illness prior to treatment

(Steinhausen 2002)
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!

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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/
SELECTED REFERENCES