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Psychiatry and Addictions Case Conference
UW Medicine | Psychiatry and Behavioral Sciences

01/03/2019

WELCOME!

Today's Topic:

Eating Disorders

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

Speaker: Megan Riddle, MD, PhD, MS

PANELISTS:

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EATING DISORDERS:

An introduction for clinicians

Megan Riddle, MD PhD MS

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GENERAL DISCLOSURES

The University of Washington School of Medicine also gratefully acknowledges receipt of educational grant support for this activity from the Washington State Legislature through the Safety-Net Hospital Assessment, working to expand access to psychiatric services throughout Washington State.

SPEAKER DISCLOSURES

- ✓ Any conflicts of interest?

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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

http://www.zastavki.com/pictures/originals/2014/Drawn_wallpapers___Painted_girls_Girl_eating_watermelon_084414_.jpg

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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

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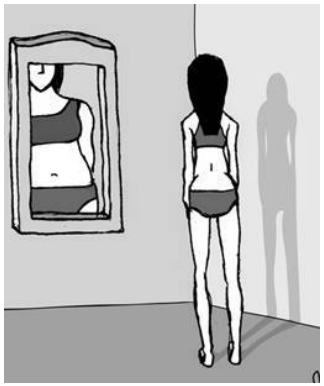
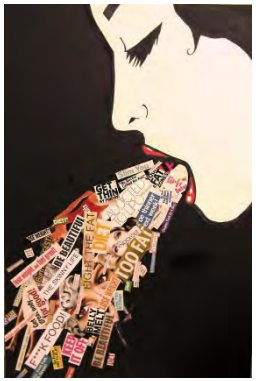
Anorexia nervosa



- 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 3mo
- Excess concerns about shape and weight

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

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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/
http://www.freakingnews.com/Woman-in-Renaissance-Painting-Eating-Donuts-Pics-117495.asp

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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)

https://otrwjam.files.wordpress.com/2013/08/dsc08205-copy.jpg

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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"

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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

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MAKING A DIAGNOSIS

- "Eating disorder" is rarely the chief complaint (unless they are dragged in by a worried family member)
- Instead…

Cold intolerance

Constipation

Amenorrhea

Fatigue

Polyuria

Dizziness

Sore throat

Changes in weight

Bloating

Palpitations

Heart burn

Fertility issues

Polydipsia

Stress fractures

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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

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MAKING A DIAGNOSIS

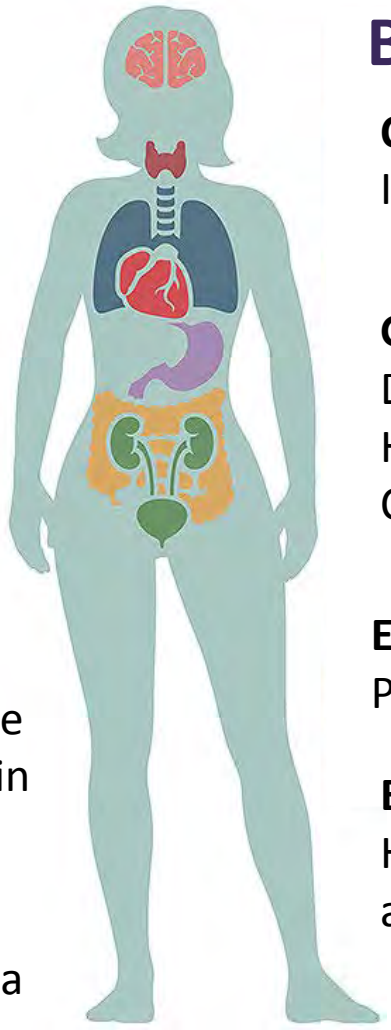
Anorexia nervosa

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

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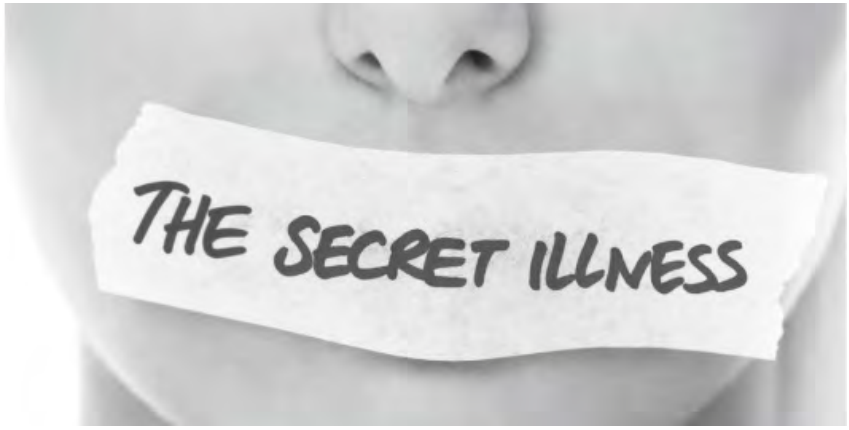
WHO TO SCREEN?

- 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!



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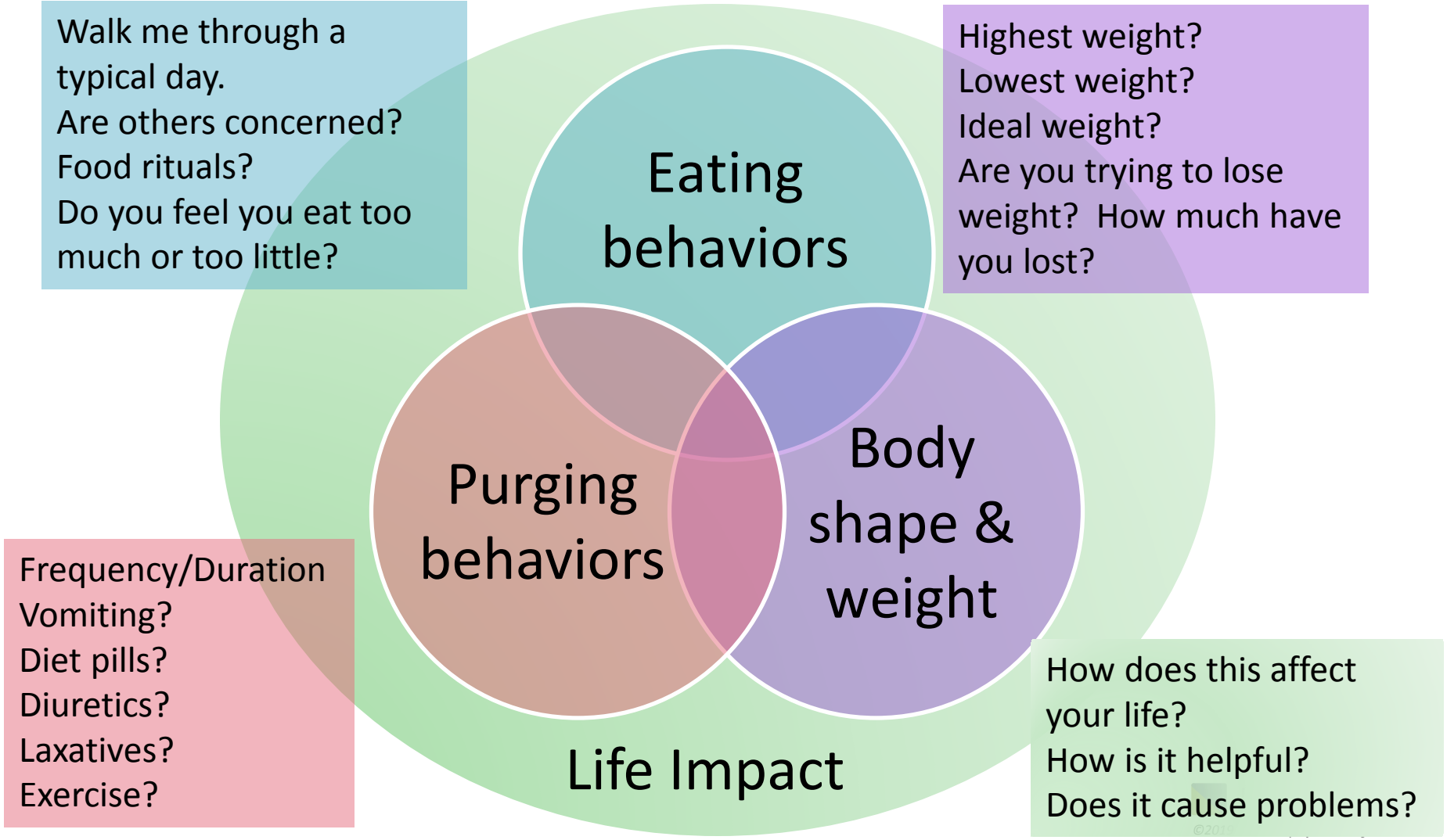
http://az616578.vo.msecnd.net/files/2016/07/01/636029376698418322620701959_Eating%20disorders.jpg

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



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?

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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

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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

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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

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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

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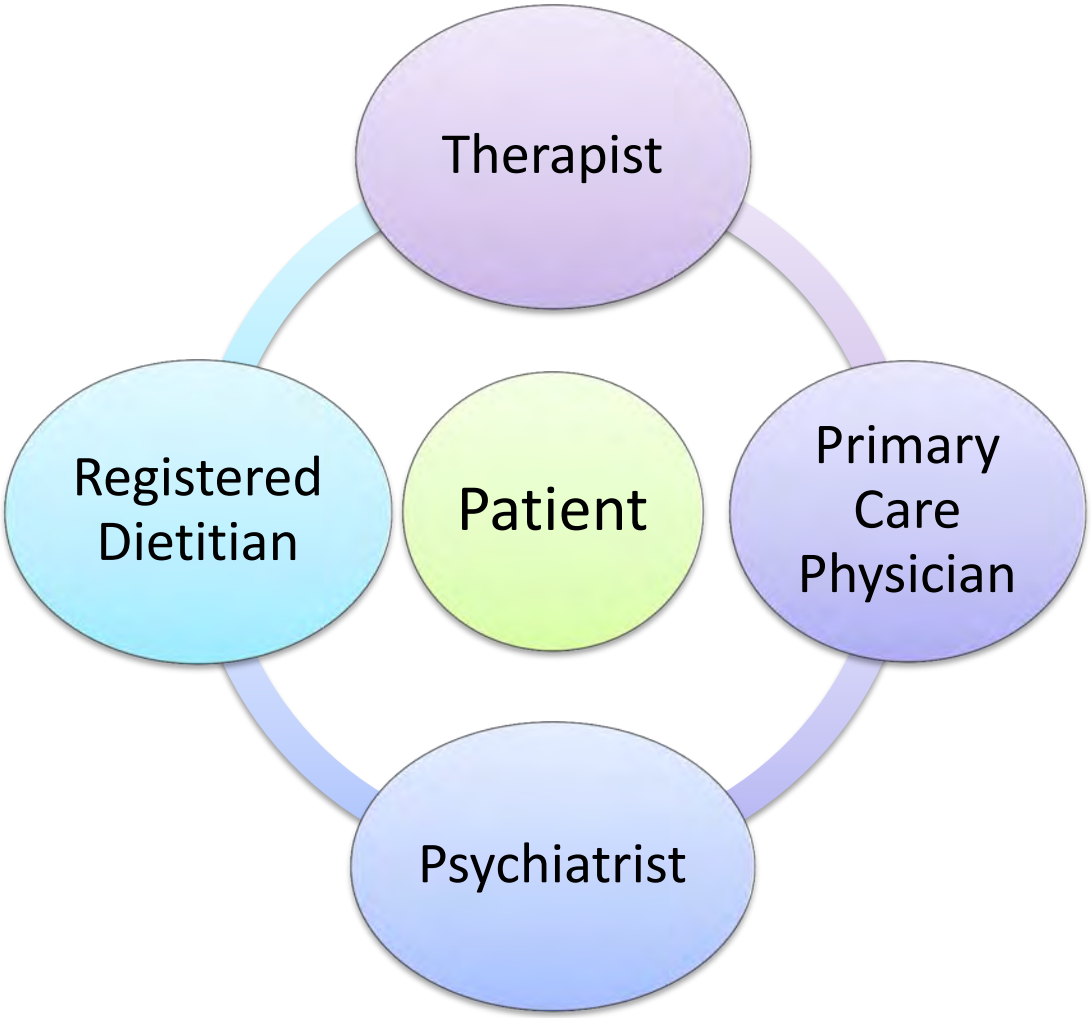
TREATMENT TEAM



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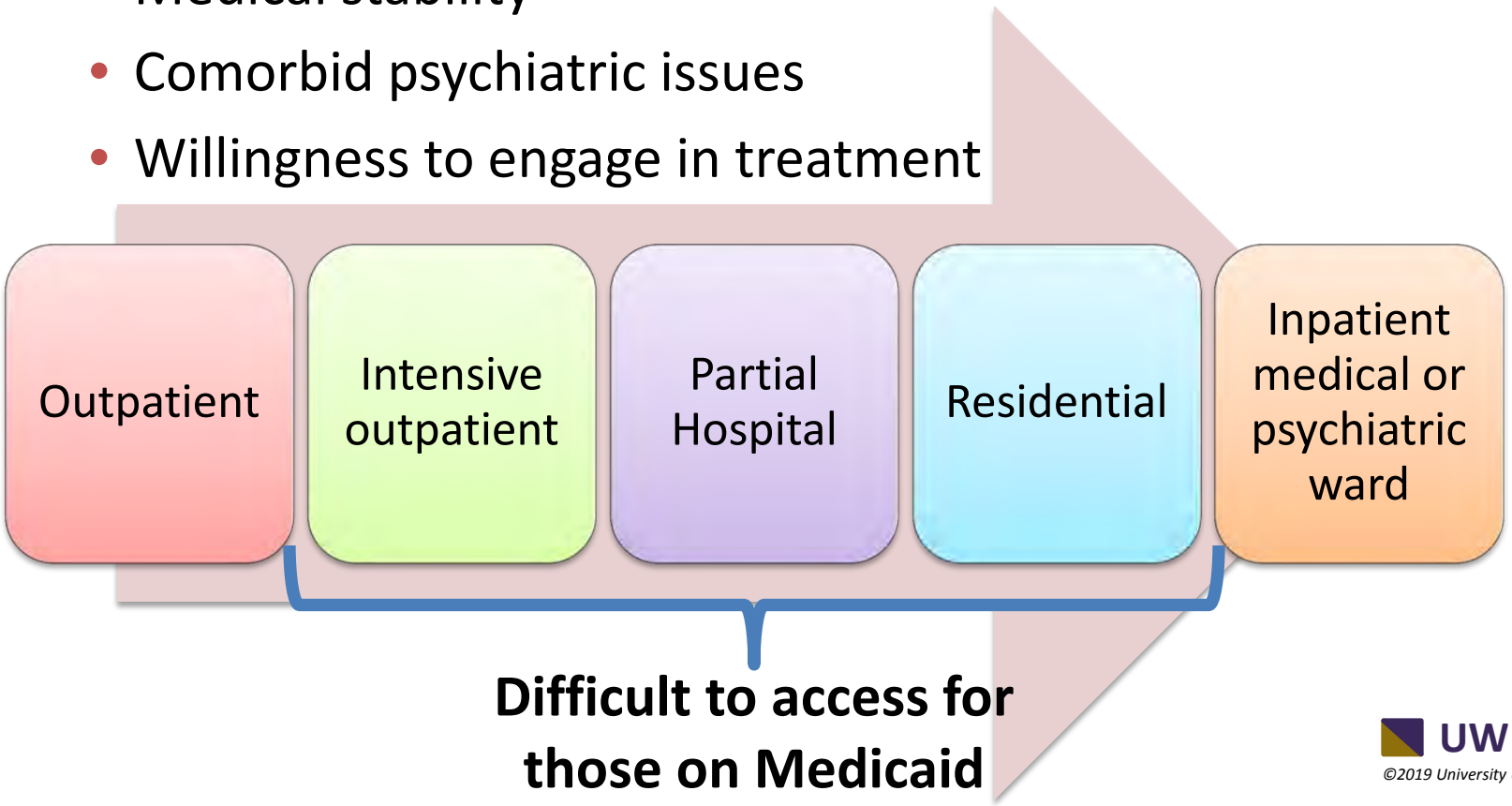
CARE CONTINUUM

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



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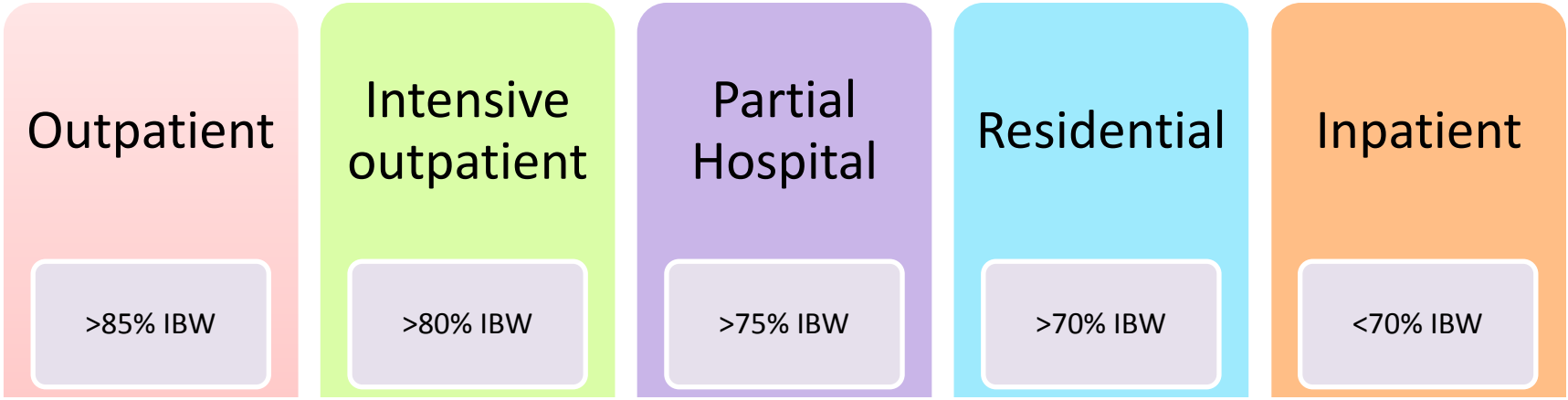
CARE CONTINUUM



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CARE CONTINUUM

Outpatient	Intensive outpatient	Partial Hospital	Residential	Inpatient
>85% IBW	>80% IBW	>75% IBW	>70% IBW	<70% IBW
Medically Stable	Medically Stable	Minimal medical monitoring	Doesn't need IVFs, daily labs	Fluids, daily labs, tele
Very Motivated	Good motivation	Partial motivation, cooperates	Poor motivation	Poor motivation
Can modify behavior independently	Modify with mild support	Needs significant structure	Needs 24hr supervision, possible NG	Needs 24hr supervision

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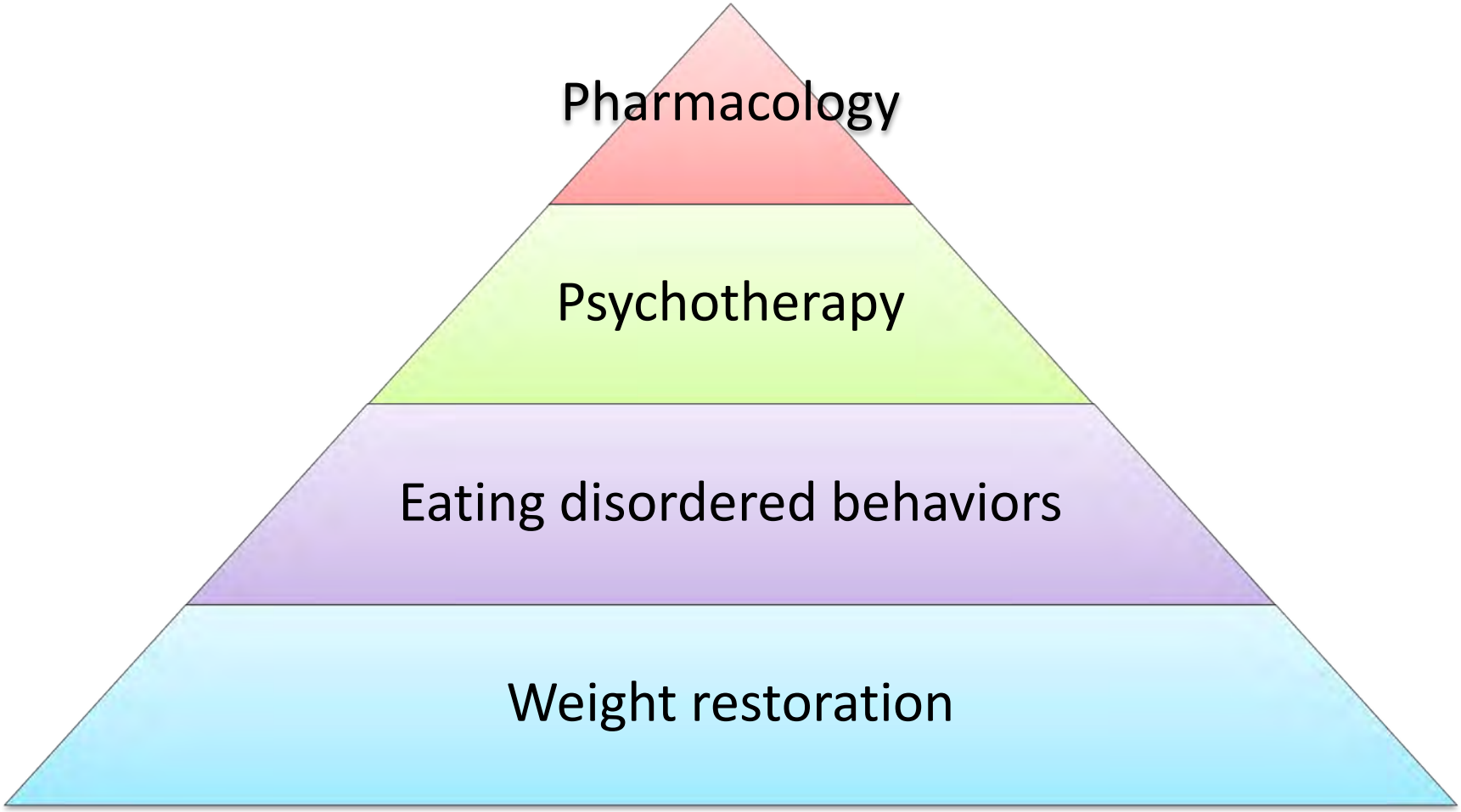
TREATMENT: AN UPHILL CLIMB



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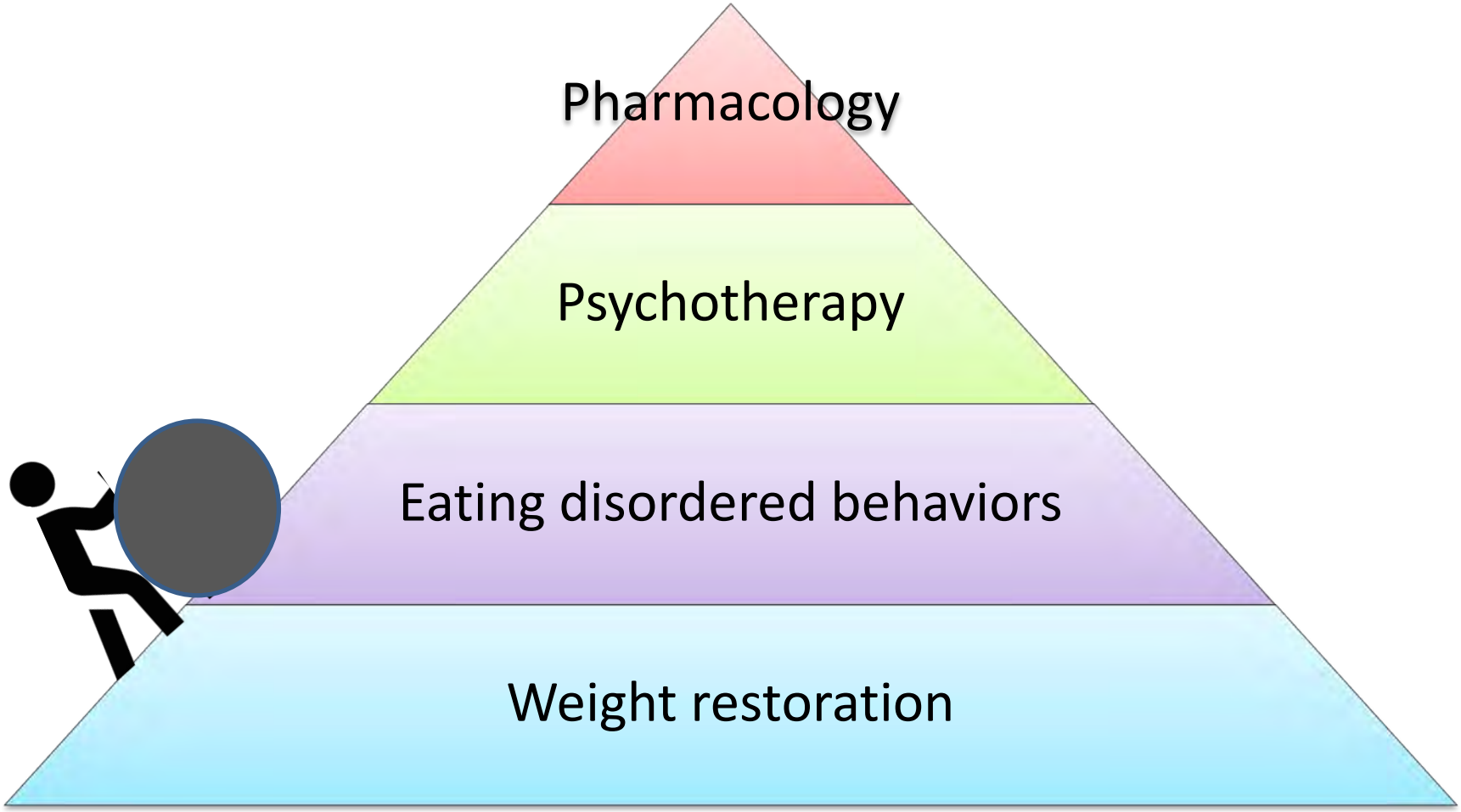
TREATMENT: AN UPHILL CLIMB



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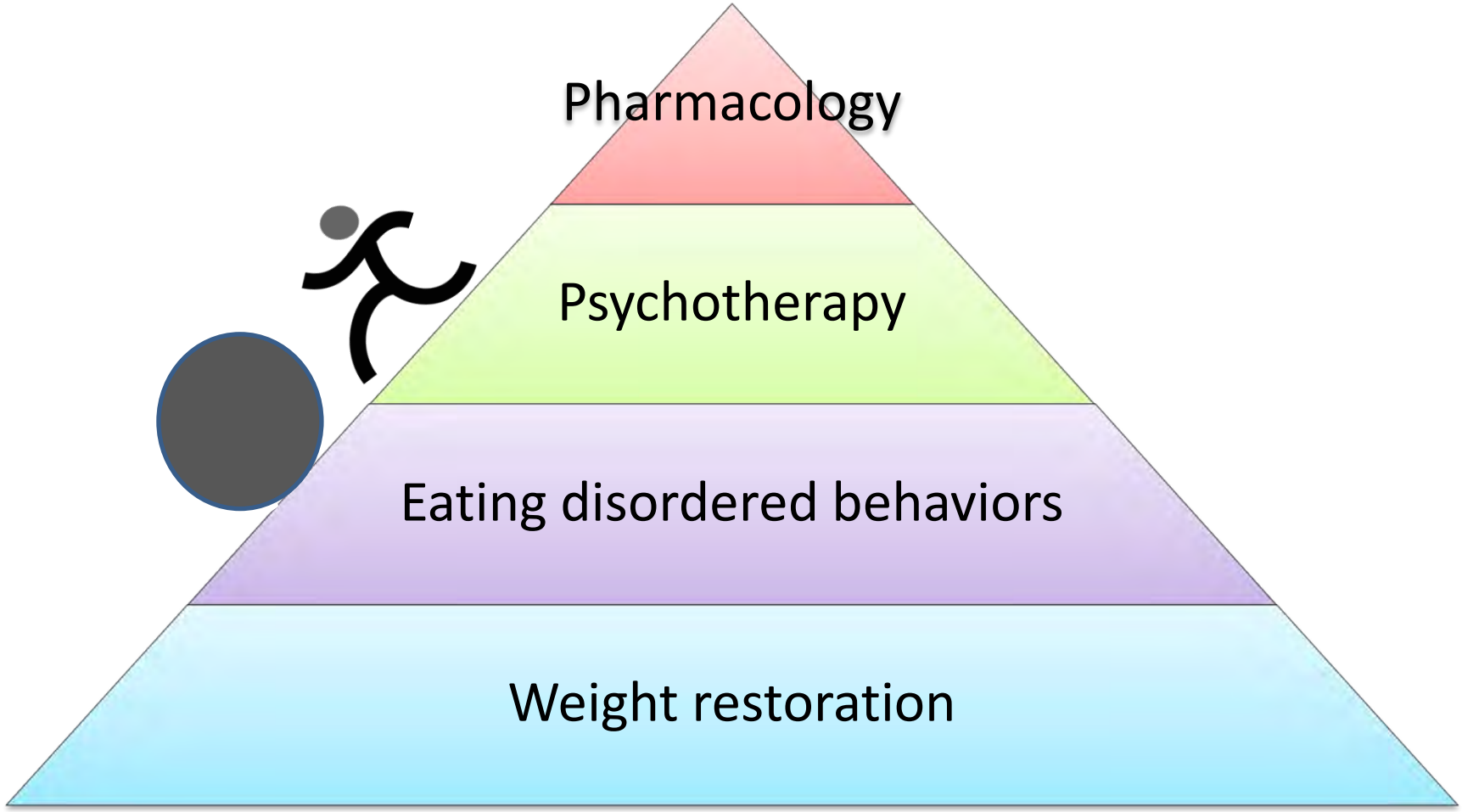
TREATMENT: AN UPHILL CLIMB



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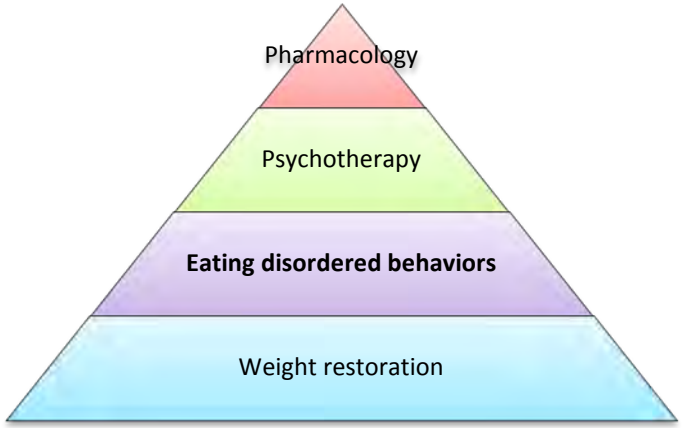
WEIGHT RESTORATION

- 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

http://www.inquiriesjournal.com/article-images/uid-2586-1421527120/90725d.jpg

EATING DISORDERED BEHAVIORS



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

http://www.zastavki.com/pictures/originals/2014/Drawn_wallpapers___Painted_girls_Girl_eating_watermelon_084414_.jpg

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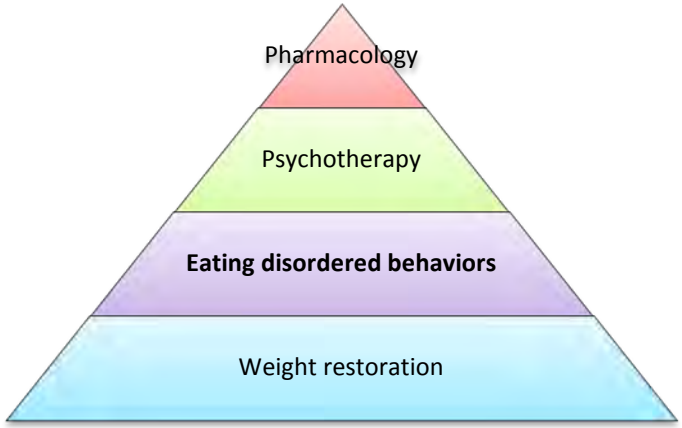
EATING DISORDERED BEHAVIORS



- 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

https://s-media-cache-ak0.pinimg.com/736x/bd/a6/6f/bda66f4b190d4bad1934c75d64156df4.jpg

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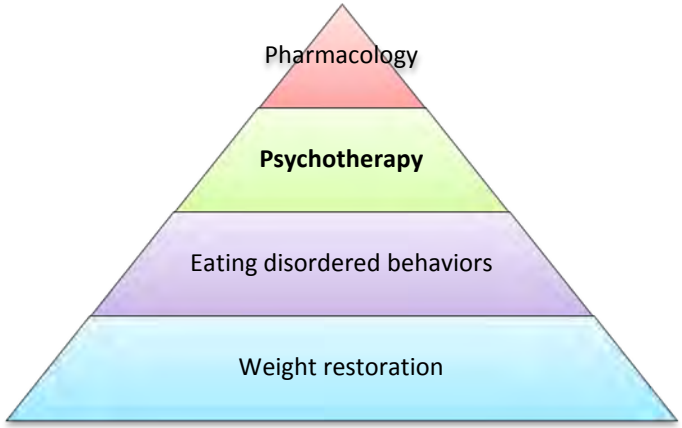
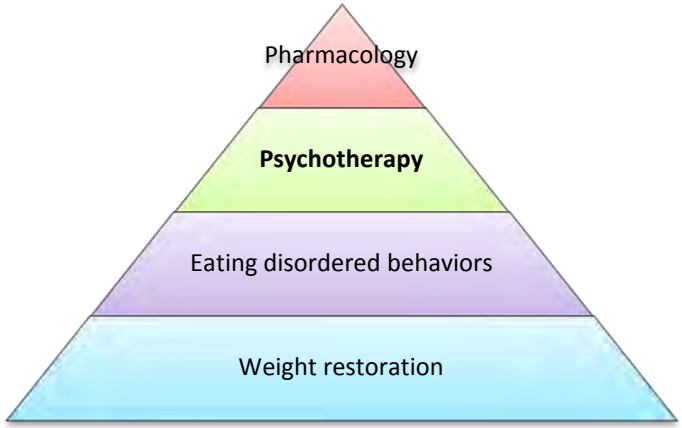
ANOREXIA NERVOSA: ADOLESCENTS



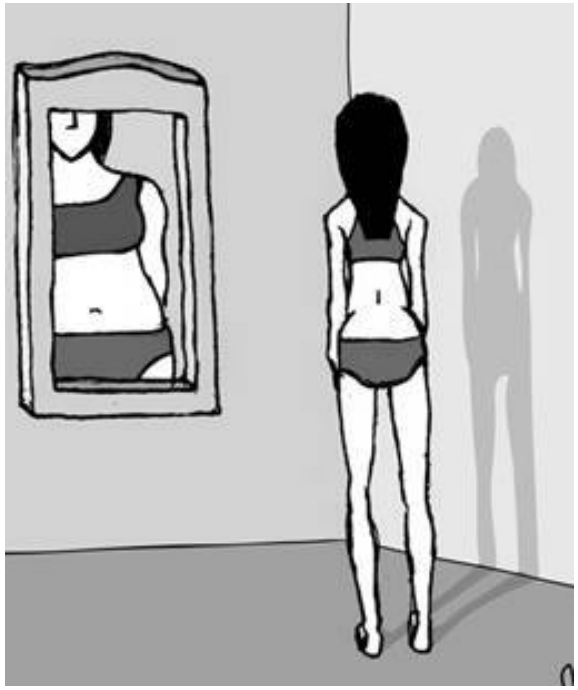
- Family Based Therapy has the most robust evidence
  - Caregivers take control of eating choices
  - Teaches the family how to support the child as food habits are normalized

http://images.clipartpanda.com/dinner-clipart-family-at-dinner-table-clipart-1.jpg

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



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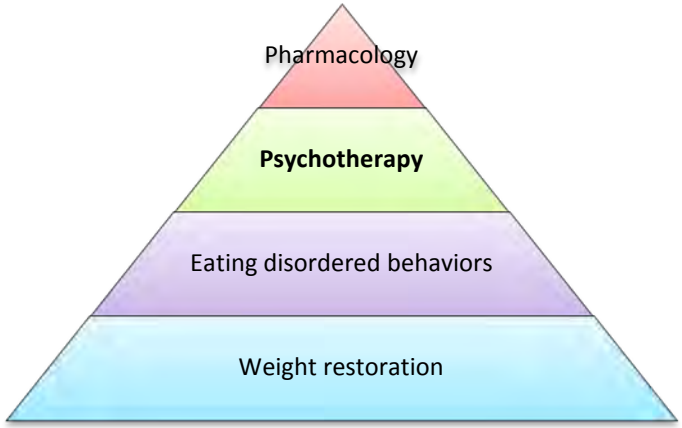
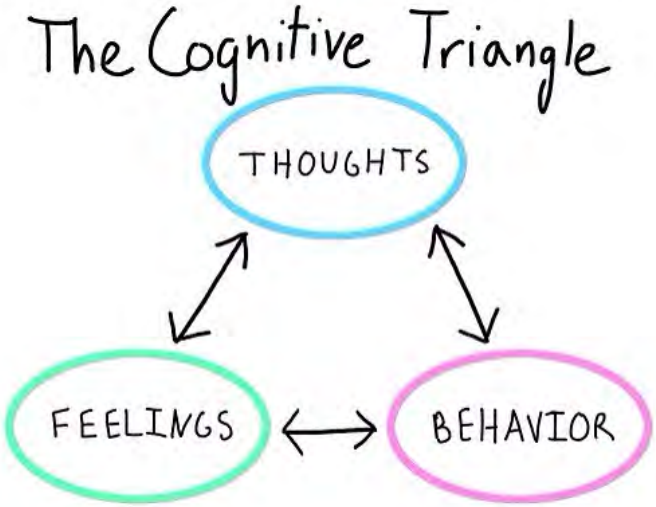
BULIMIA NERVOSA & BINGE EATING

- Good evidence that Cognitive Behavioral Therapy is the ***most effective intervention***





https://advocateglobalhealth.wordpress.com/eating-disorders/bulimia-nervosa/
http://prairie-care.com/blog/wp-content/uploads/2014/08/cognitive-triangle.jpg

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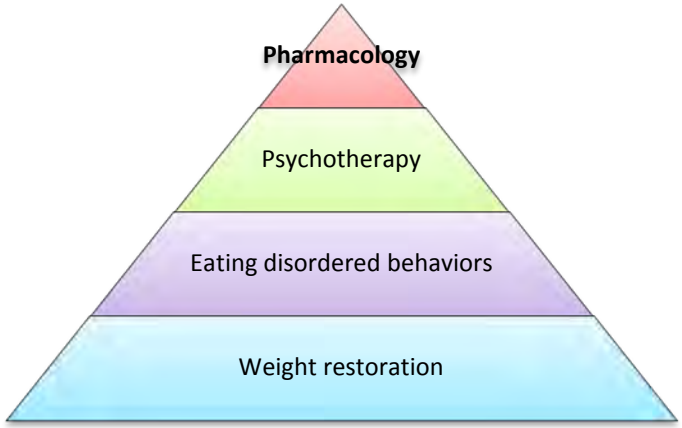
PHARMACOLOGY: ANOREXIA NERVOSA



- 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

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

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STEP AWAY FROM THE PRESCRIPTION PAD...

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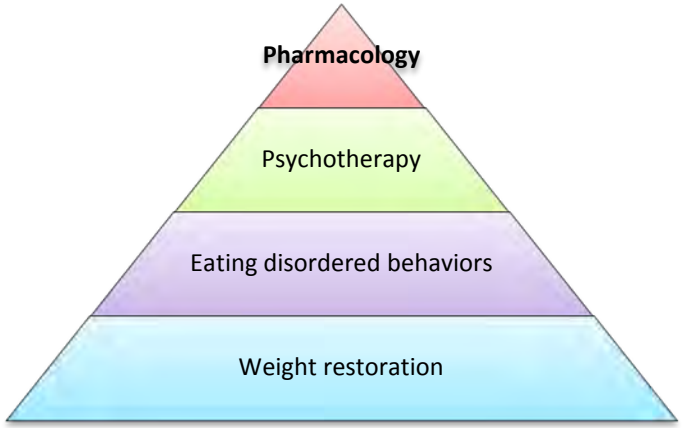
PHARMACOLOGY



- 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

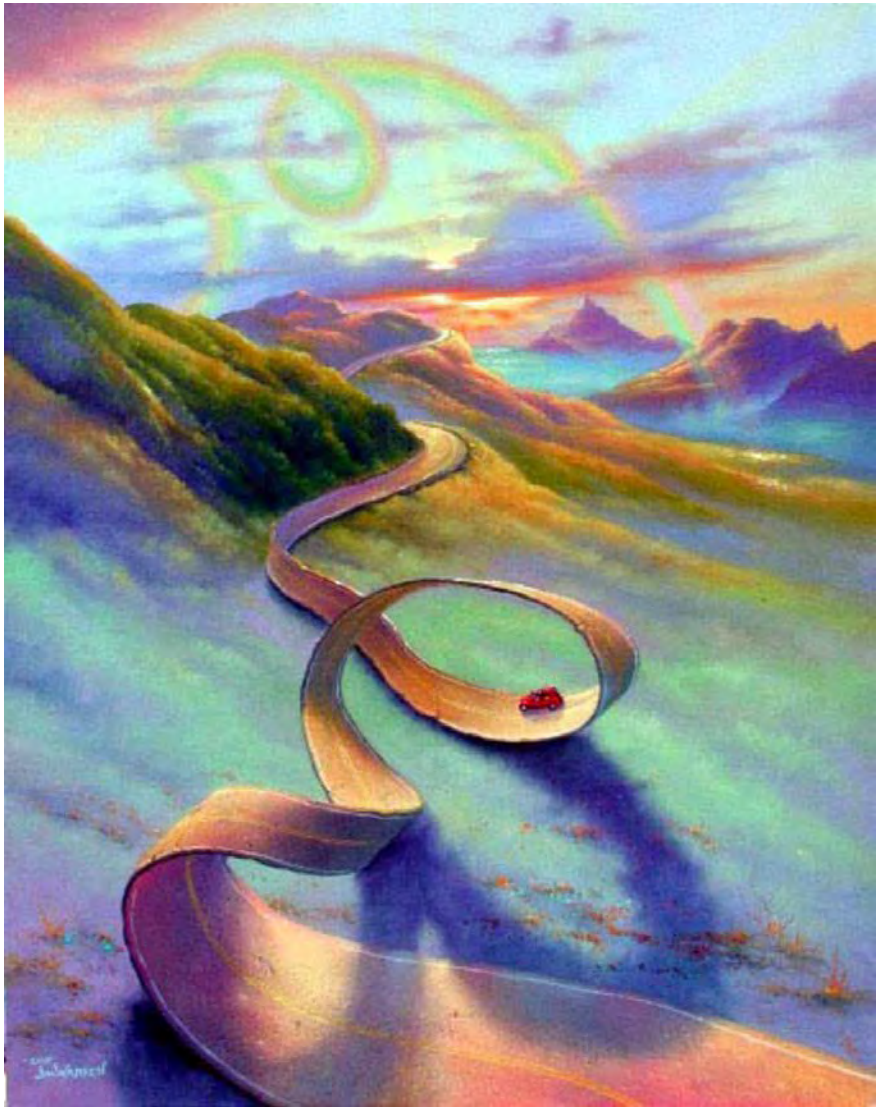
http://www.npr.org/sections/health-shots/2015/12/23/460719043/fda-approval-could-turn-a-free-drug-for-a-rare-disease-pricey

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)



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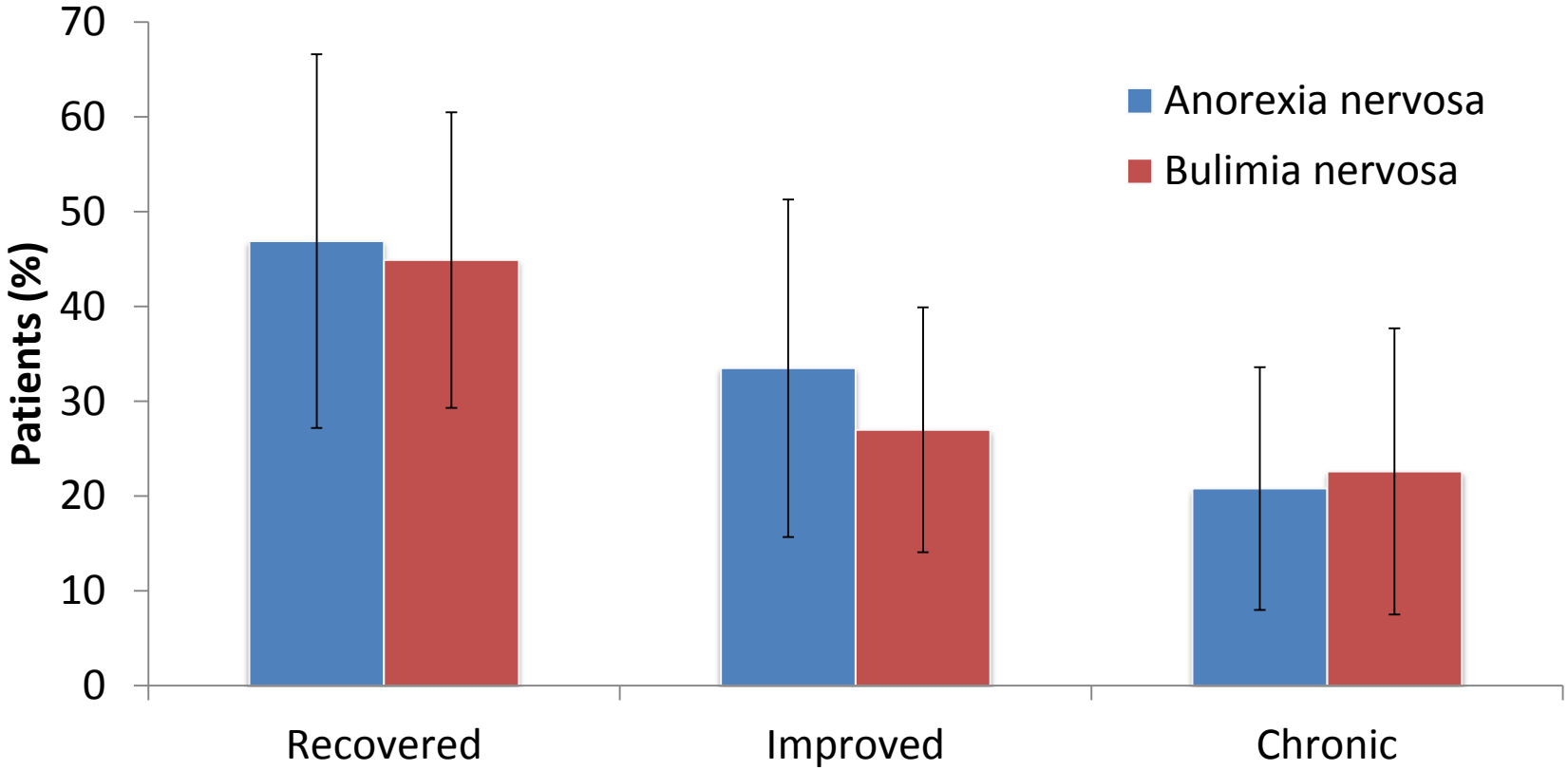
http://cp15.nevsepic.com.ua/242cp15/24173/1429086275-elusive-rainbow-331871976-1200x1520.jpg

RECOVERY

- Yes, these patients do get better



Based on reviews by
Steinhausen 2002 & 2009

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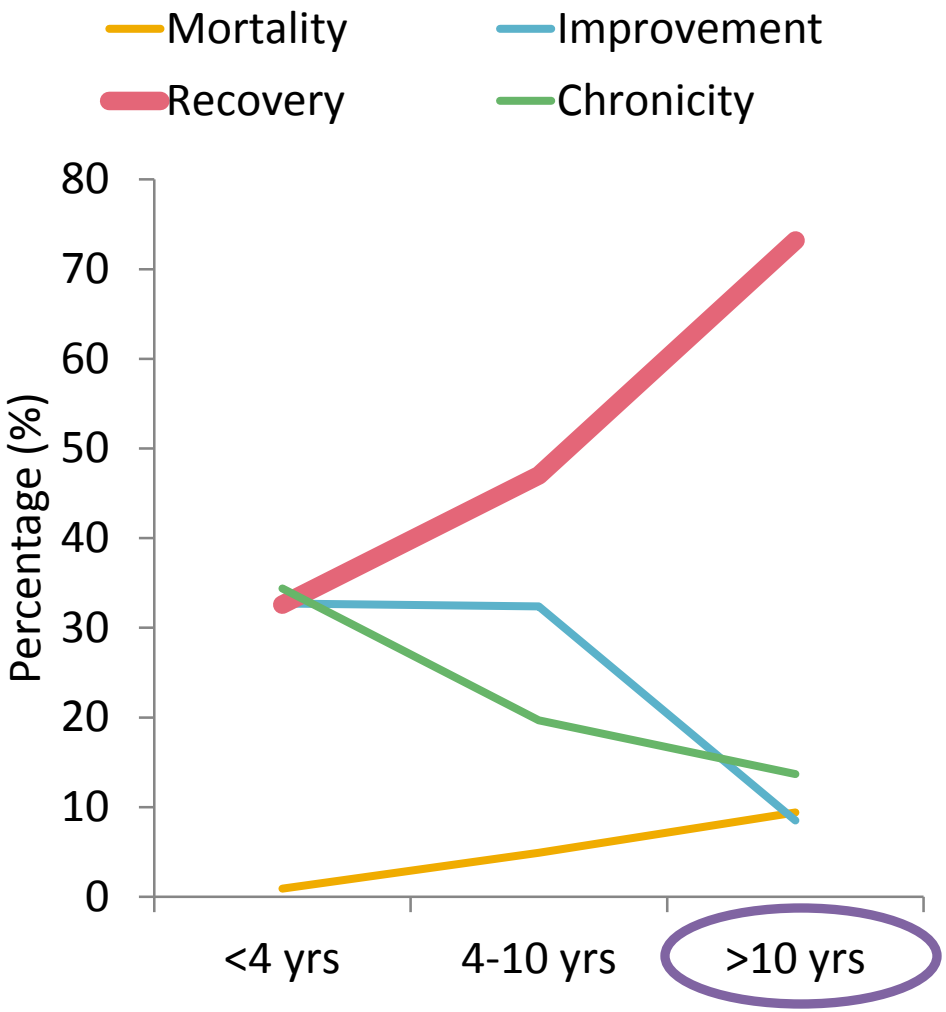
RECOVERY: ANOREXIA NERVOSA

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



(Steinhausen 2002)

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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/

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