UW PACC

Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

EATING DISORDERS:
An introduction for clinicians

Megan Riddle, MD PhD MS

UW Medicine
UW SCHOOL OF MEDICINE

Integrated Care Training Program
UW Psychiatry & Behavioral Sciences

project ECHO

SPEAKER DISCLOSURES

Nothing to disclose

UW PACC

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.

UW PACC

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

UW PACC

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

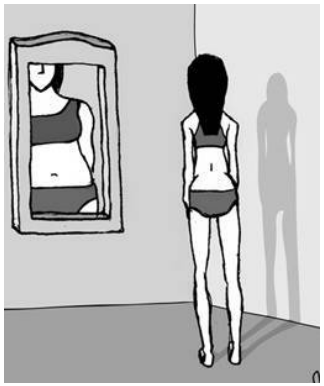
WHY TALK ABOUT EATING DISORDERS?

- Eating disorders have a high morbidity and mortality
- 30 million people in the US have eating disorders
- Often go unrecognize
  - Only 1 in 10 of bulimia patients are diagnosed

http://images.suite101.com/2553402_com_119900915_.jpg

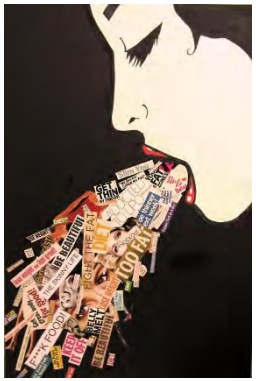
UW PACC

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/

UW PACC

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

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

UW PACC

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)

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

UW PACC

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"

UW PACC

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

UW PACC

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

UW PACC

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

UW PACC

MAKING A DIAGNOSIS

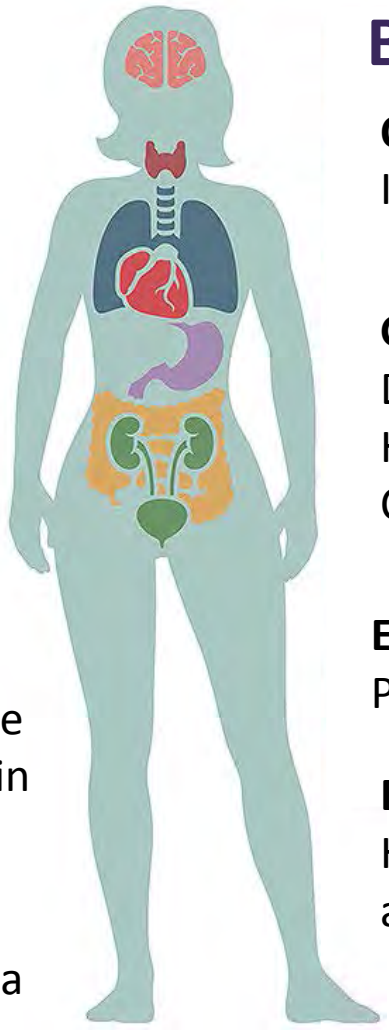
Anorexia nervosa

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

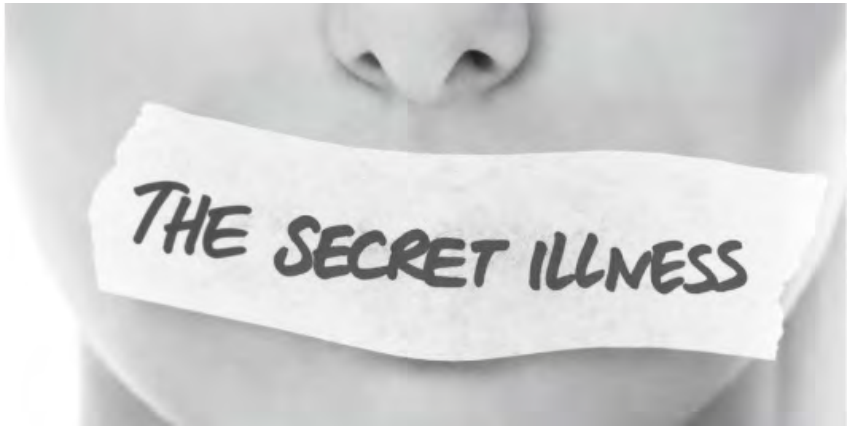
Electrolytes: Hypochloremia Hypokalemia, Metabolic alkalosis, Hyponatremia

UW PACC

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!



UW PACC

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

EATING DISORDERS: QUICK SCREEN

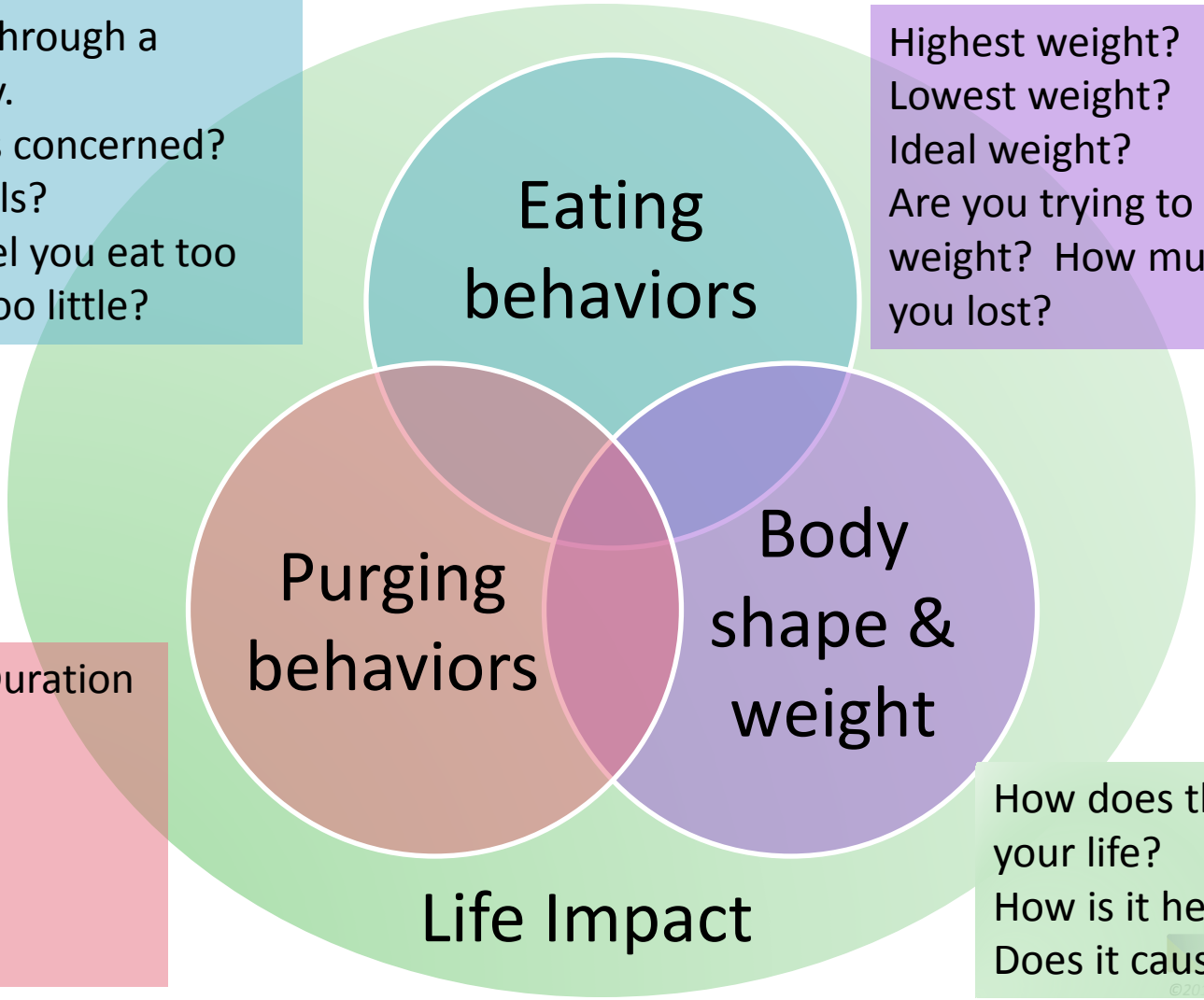
- Eating Disorder Screen for Primary Care
  - ✓ **Are you satisfied with your eating patterns?** (No is abnormal)
  - ✓ **Do you ever eat in secret?** (Yes is abnormal)
  - ✓ **Does your weight affect the way you feel about yourself?** (Yes is abnormal)
  - ✗ **Have any members of your family suffered 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

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

Highest weight?
Lowest weight?
Ideal weight?
Are you trying to lose weight? How much have you lost?



Frequency/Duration
Vomiting?
Diet pills?
Diuretics?
Laxatives?
Exercise?

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?

UW PACC

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

UW PACC

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

UW PACC

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

UW PACC

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

UW PACC

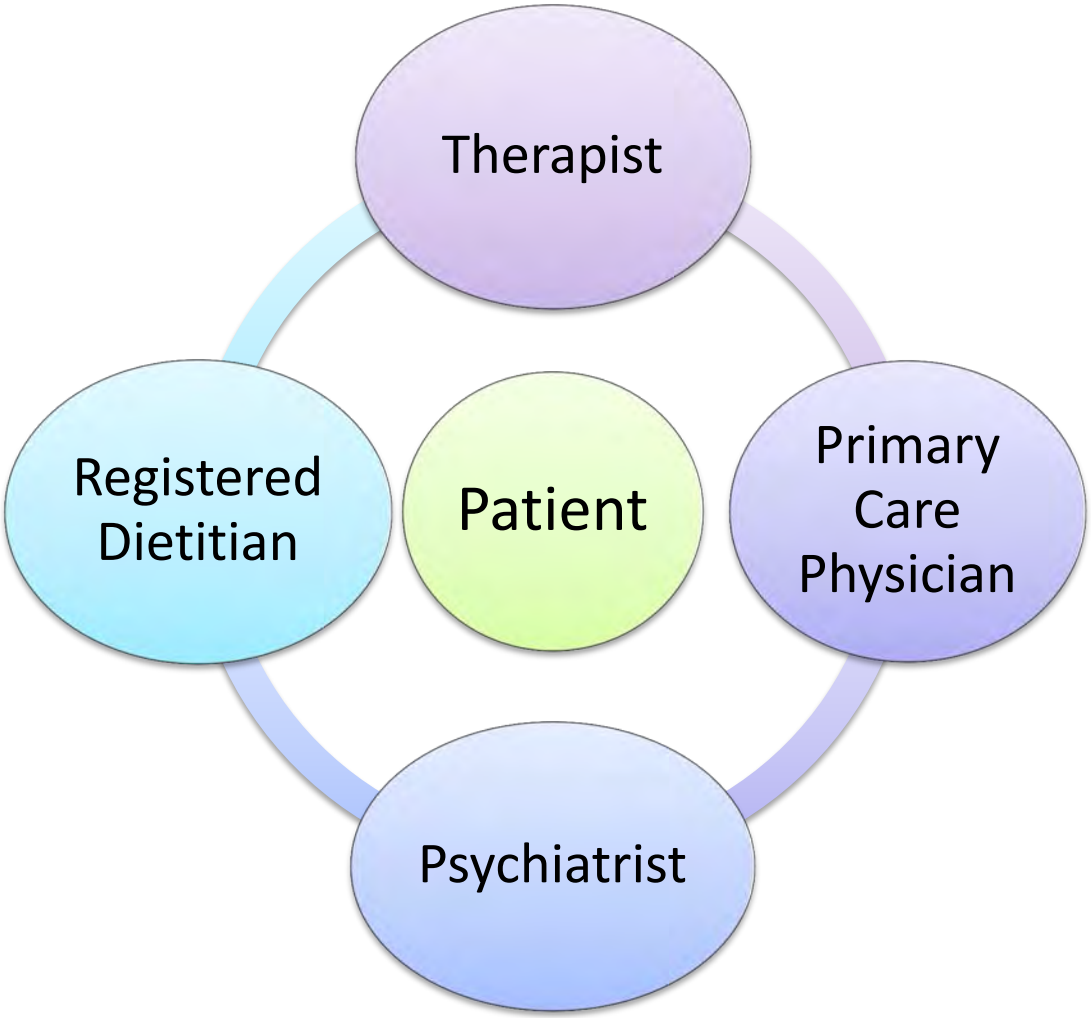
DIAGNOSE AND THEN?

- 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

UW PACC

https://s-media-cache-ak0.pinimg.com/736x/13/5f/d6/ 135fd6fcf7a7e 8b0de9b851b616e7b63.jpg

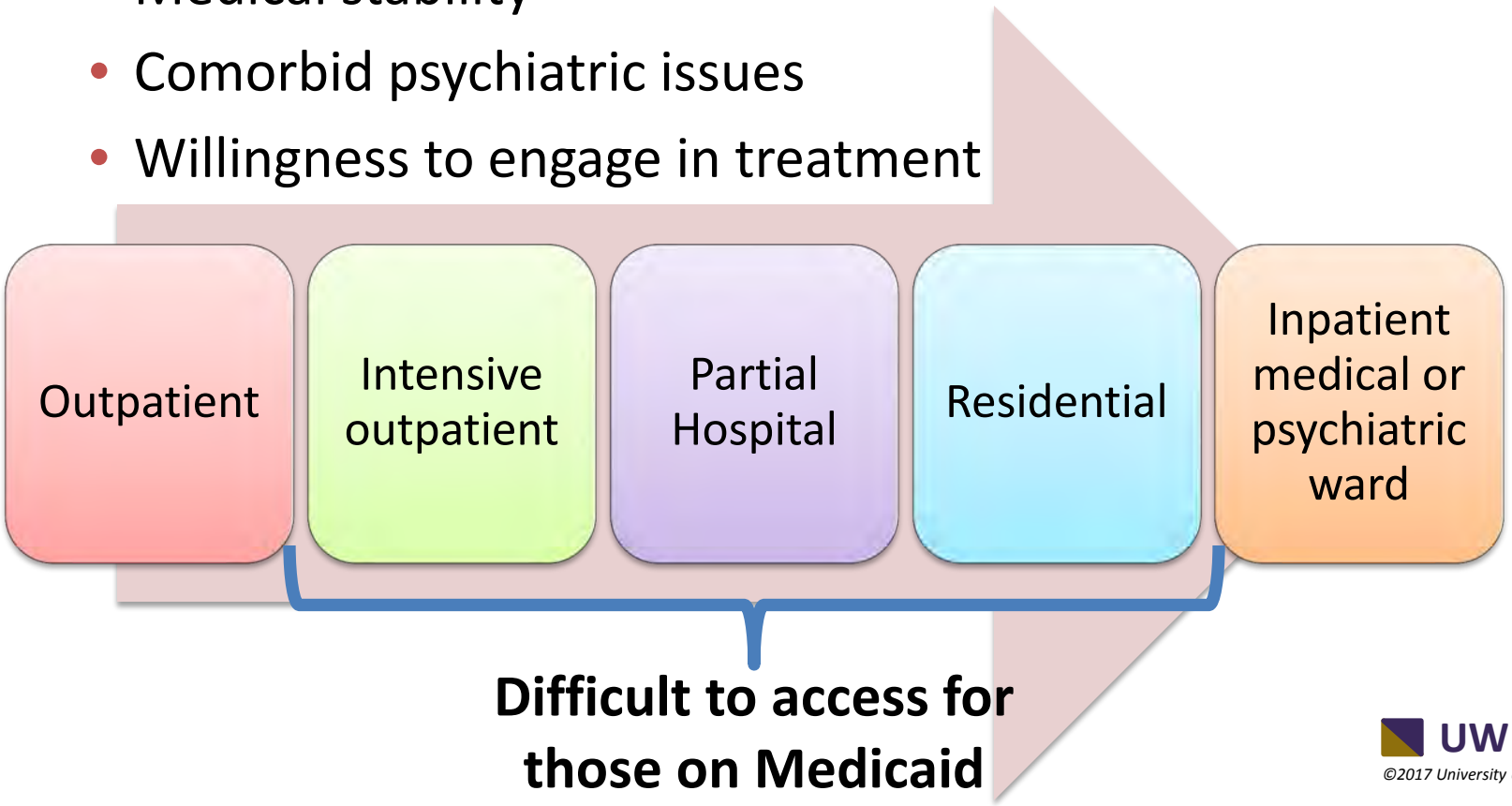
TREATMENT TEAM



UW PACC

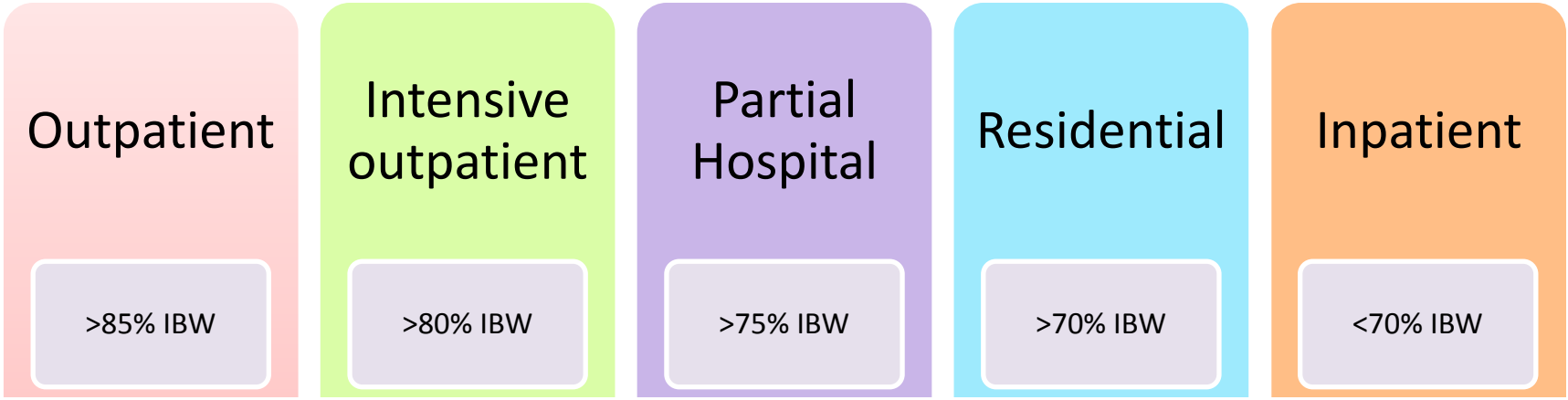
CARE CONTINUUM

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



UW PACC

CARE CONTINUUM



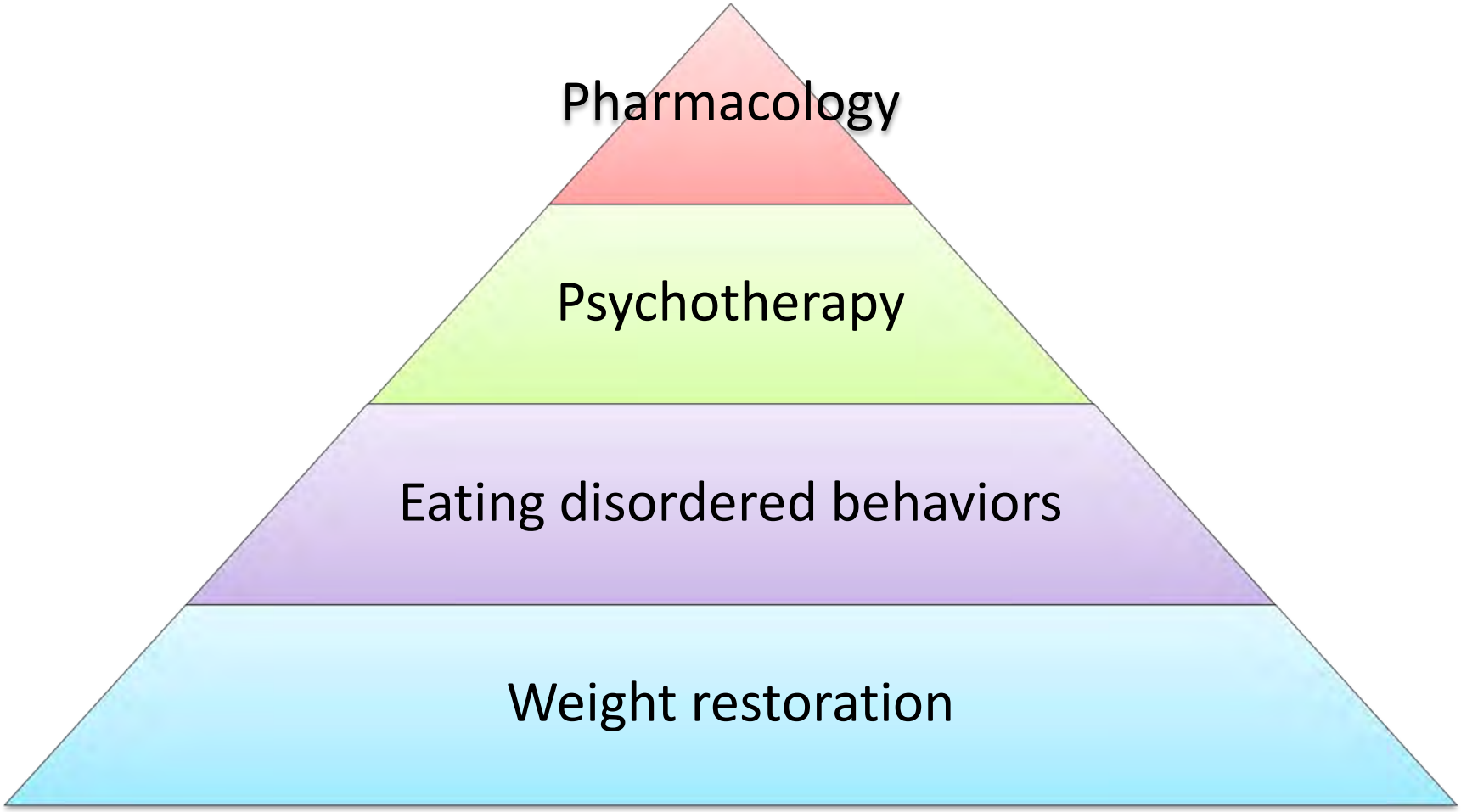
UW PACC

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

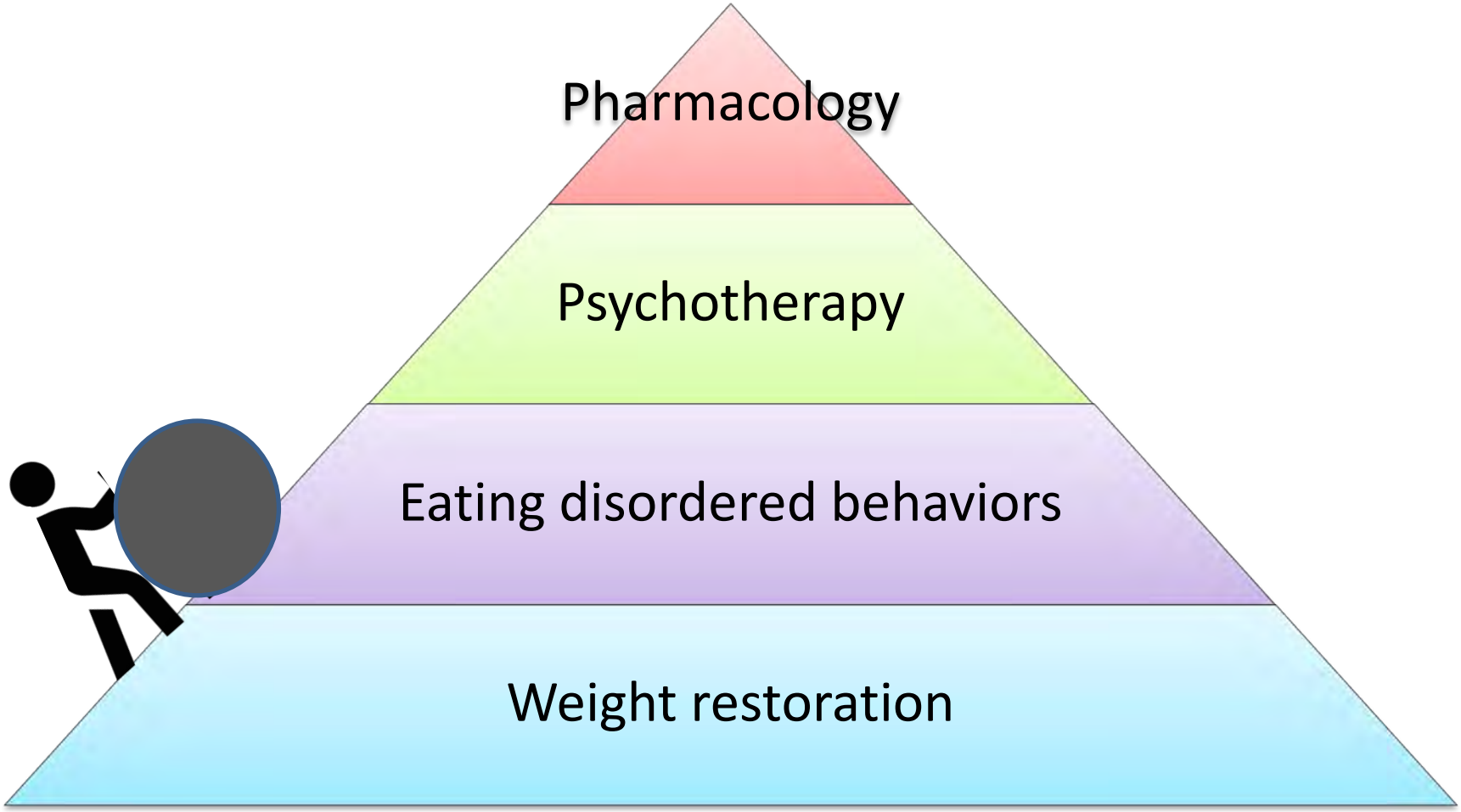
UW PACC

TREATMENT: AN UPHILL CLIMB



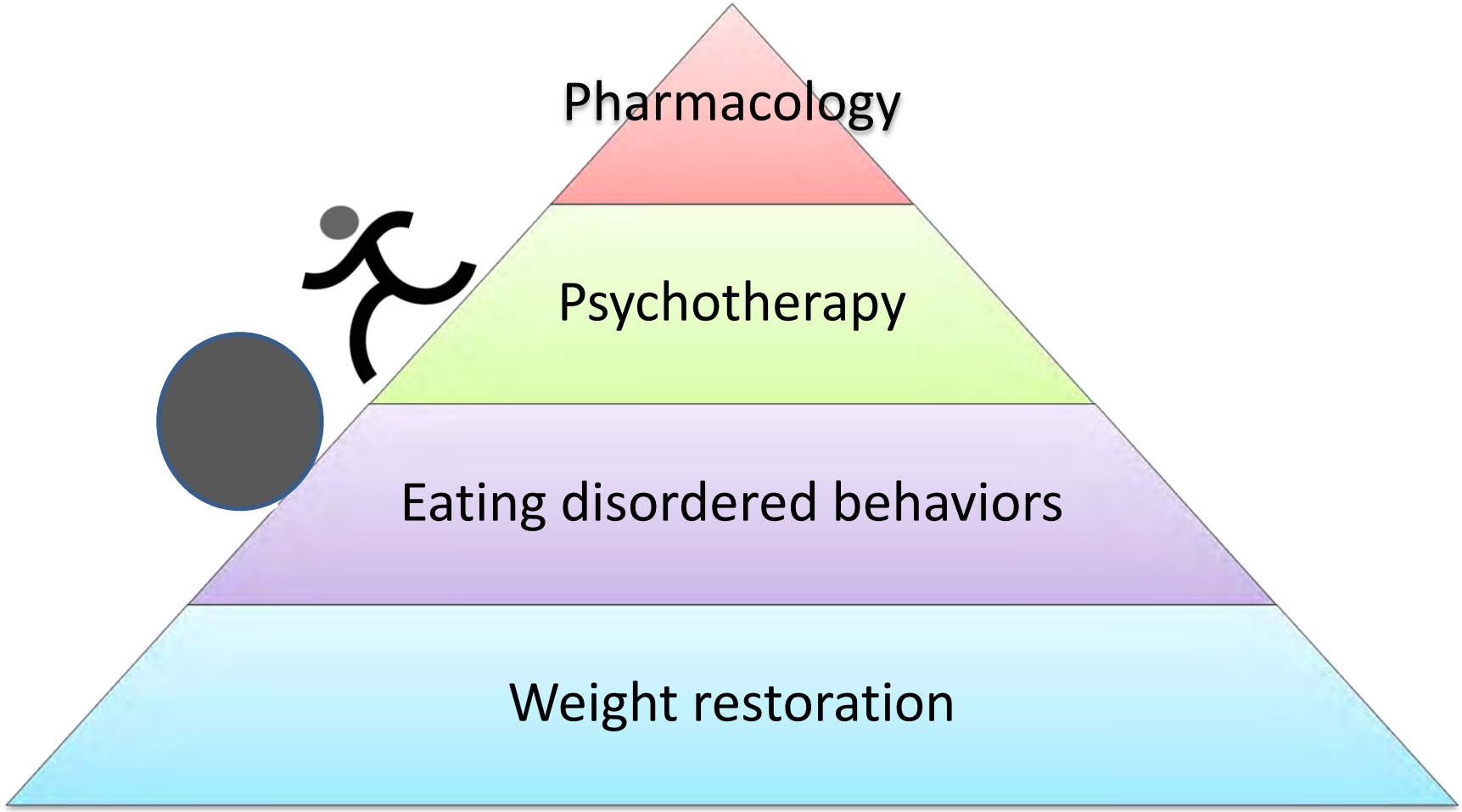
UW PACC

TREATMENT: AN UPHILL CLIMB



UW PACC

TREATMENT: AN UPHILL CLIMB



UW PACC

WEIGHT RESTORATION

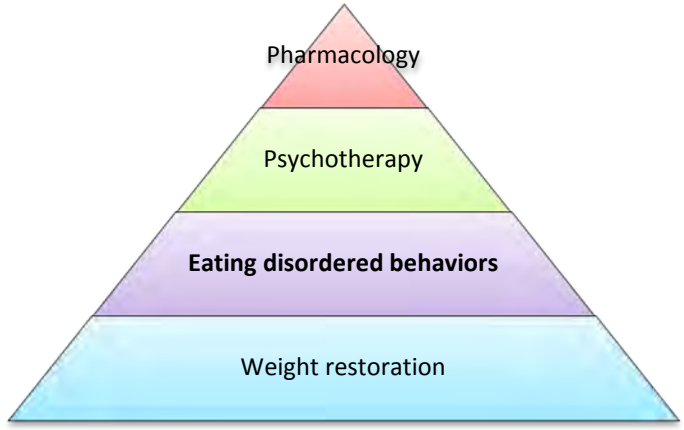
- Increase caloric intake
  - Starts at ~1200-1400kCal/day
  - Gradually increased to 3,000-4,000kCal/day depending on rate of weight gain
- Target weight gain:
  - 0.5-1lb/wk outpatient
  - 2-3lb/wk inpatient
- Working with a nutritionist is key

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

UW PACC

EATING DISORDERED BEHAVIORS

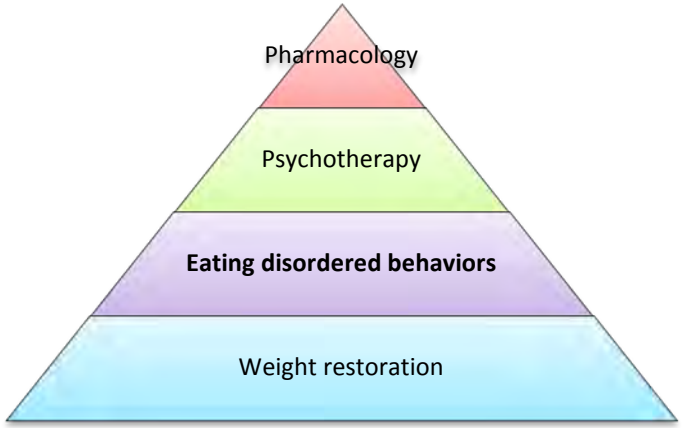
- Safe/unsafe foods
- “Allergies”
- Portioning
- Pacing
- Excess exercise
- Purging
- Timing of meals
- Fluid intake
- Rituals
- Hunger/satiety cues



UW PACC

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

EATING DISORDERED BEHAVIORS

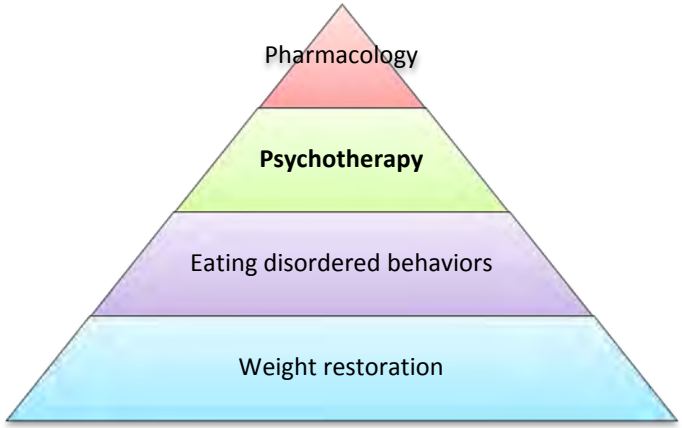


- Structured meal plans
  - Expand the quantity and variety of food
- Support and accountability around meals
  - Keeping a food record
  - Recruiting family members
  - Meal support at IOP, PHP, residential
  - Meals with outpatient therapy sessions
- Exposure to restaurants, grocery stores, cooking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

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

UW PACC

ANOREXIA NERVOSA: ADOLESCENTS

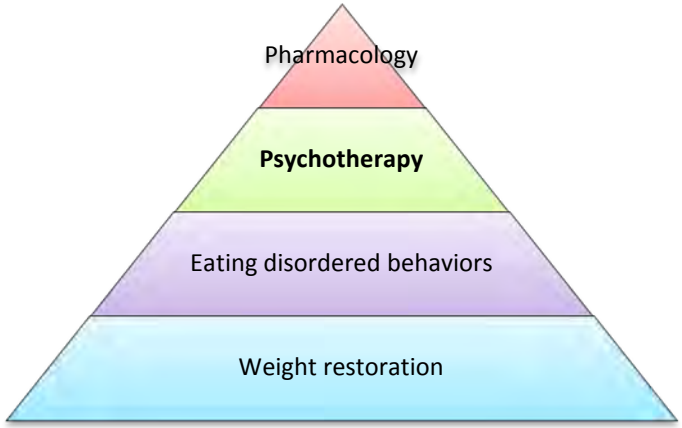


- Family Based Therapy has the most robust evidence
  - Caregivers take control of eating choices
  - Teaches the family how to support the child as food habits are normalized

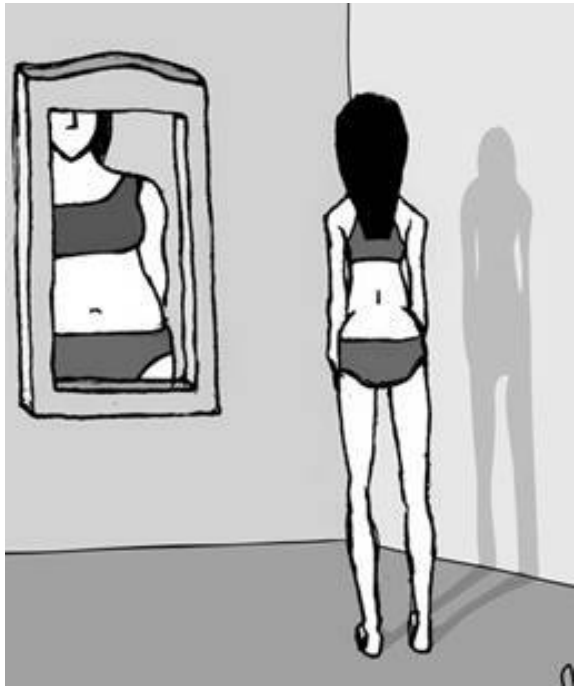
http://images.clipartpanda.com/dinner-clipart-family-at-dinner-table-clipart-1.jpg

UW PACC

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

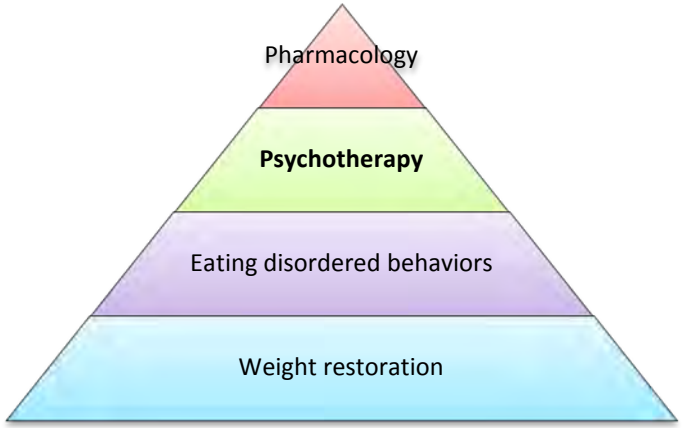


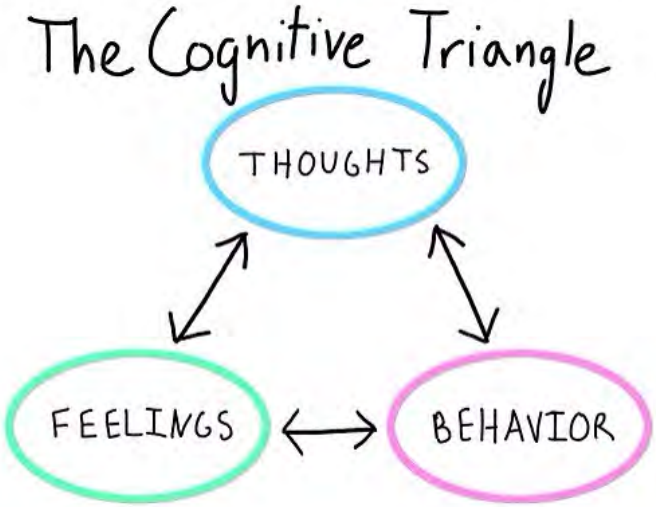
http://images.suite101.com/2553402_com_119900915_.jpg

UW PACC

BULIMIA NERVOSA & BINGE EATING

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

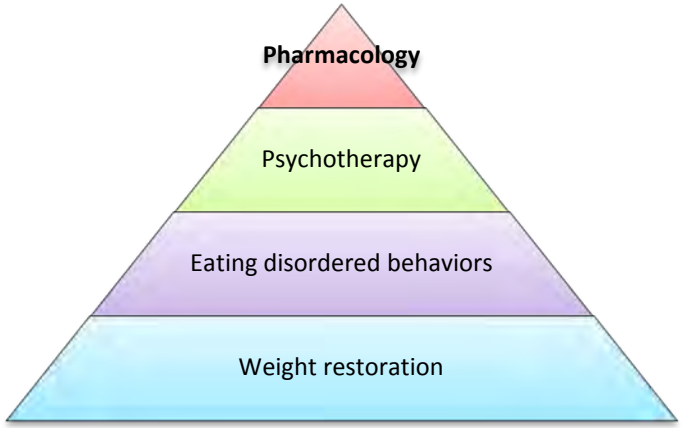




https://advocateglobalhealth.wordpress.com/eating-disorders/bulimia-nervosa/
http://prairie-care.com/blog/wp-content/uploads/2014/08/cognitive-triangle.jpg

UW PACC

PHARMACOLOGY



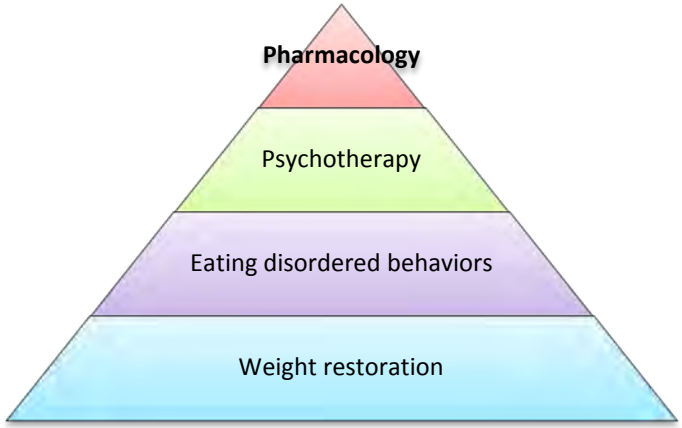
- Anorexia nervosa
  - Medications generally have limited efficacy
  - No FDA approved meds
  - Antidepressants
    - May help prevent relapse, but are ineffective at low weight
  - Antipsychotics
    - Have mixed evidence

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...

UW PACC

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

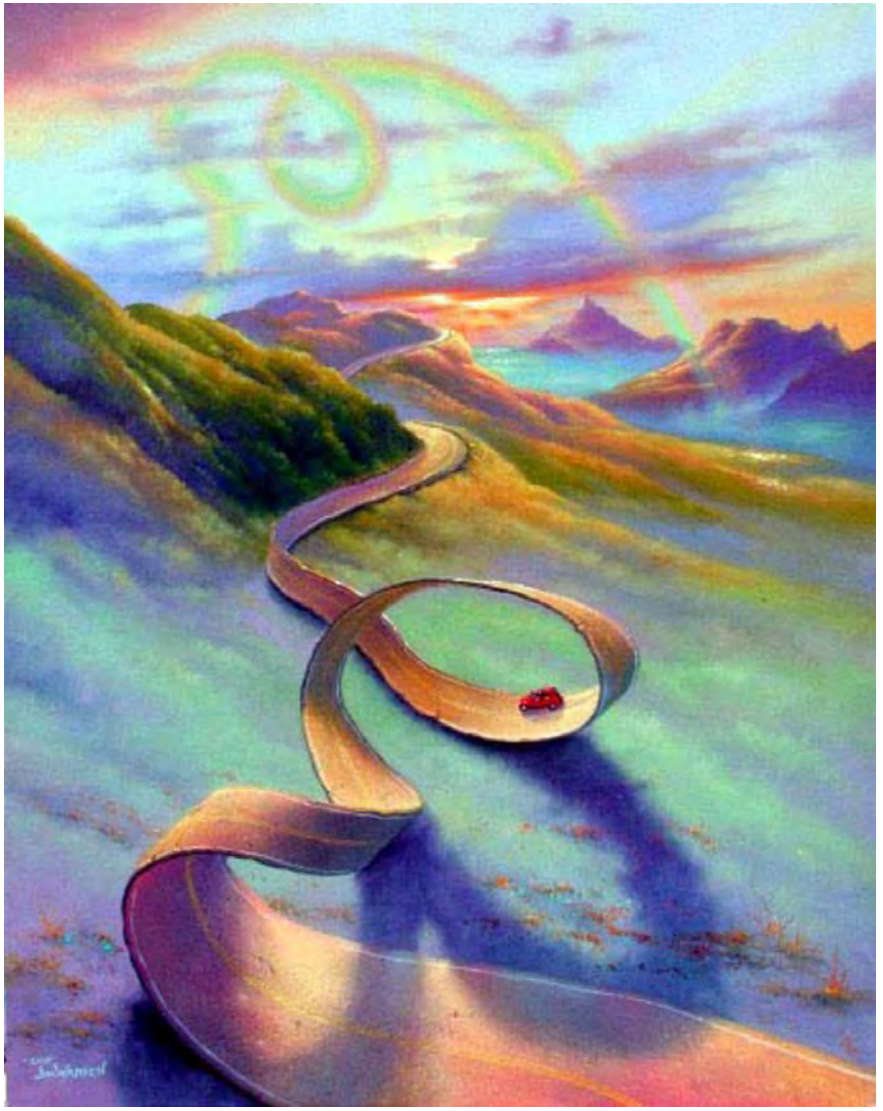
http://www.npr.org/sections/health-shots/2015/12/23/460719043/fda-approval-could-turn-a-free-drug-for-a-rare-disease-pricey

CASE: SARA

- Sara 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

Recovery has it's ups and down (literally)

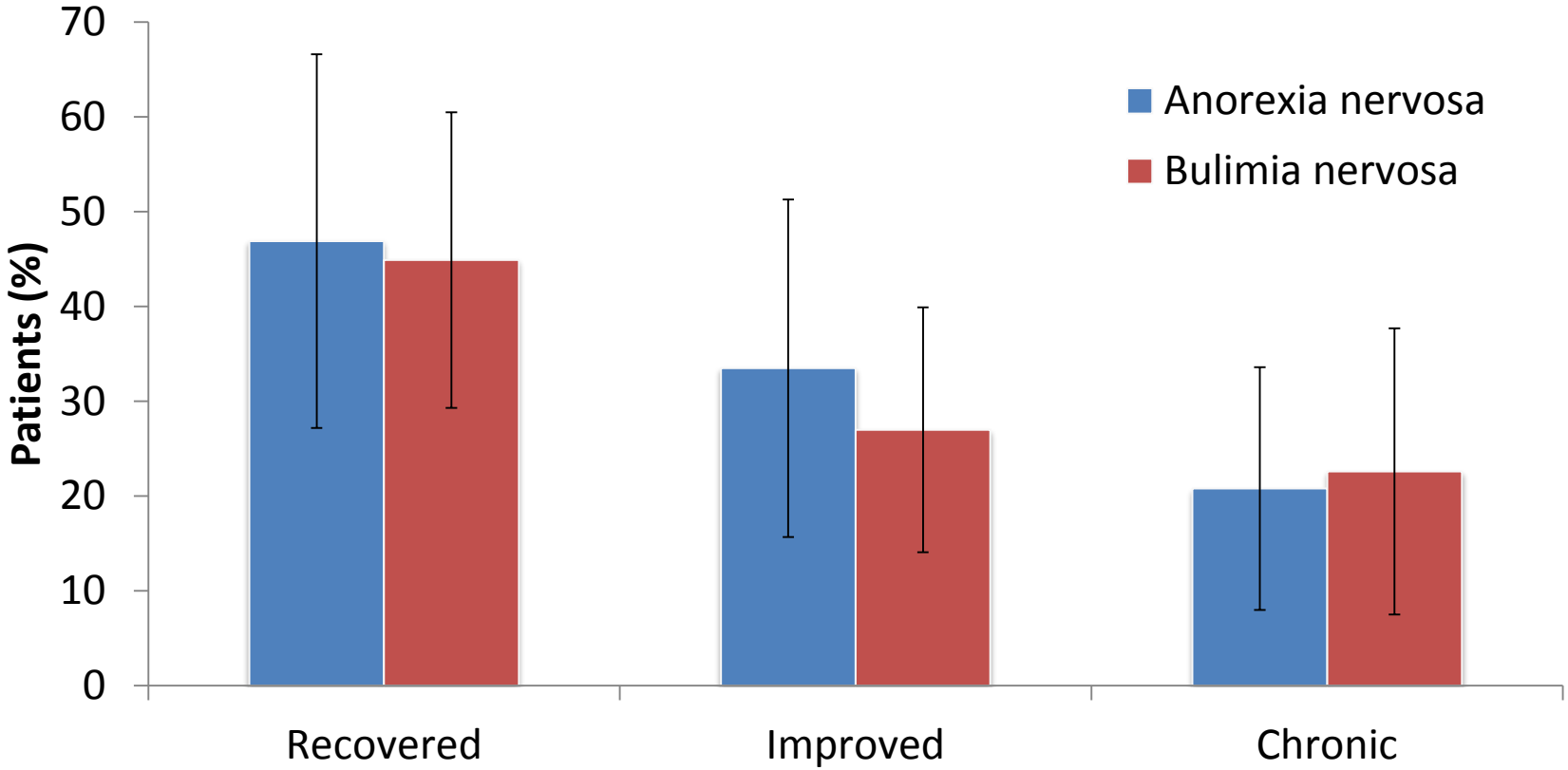


UW PACC

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

RECOVERY

- Yes, these patients do get better

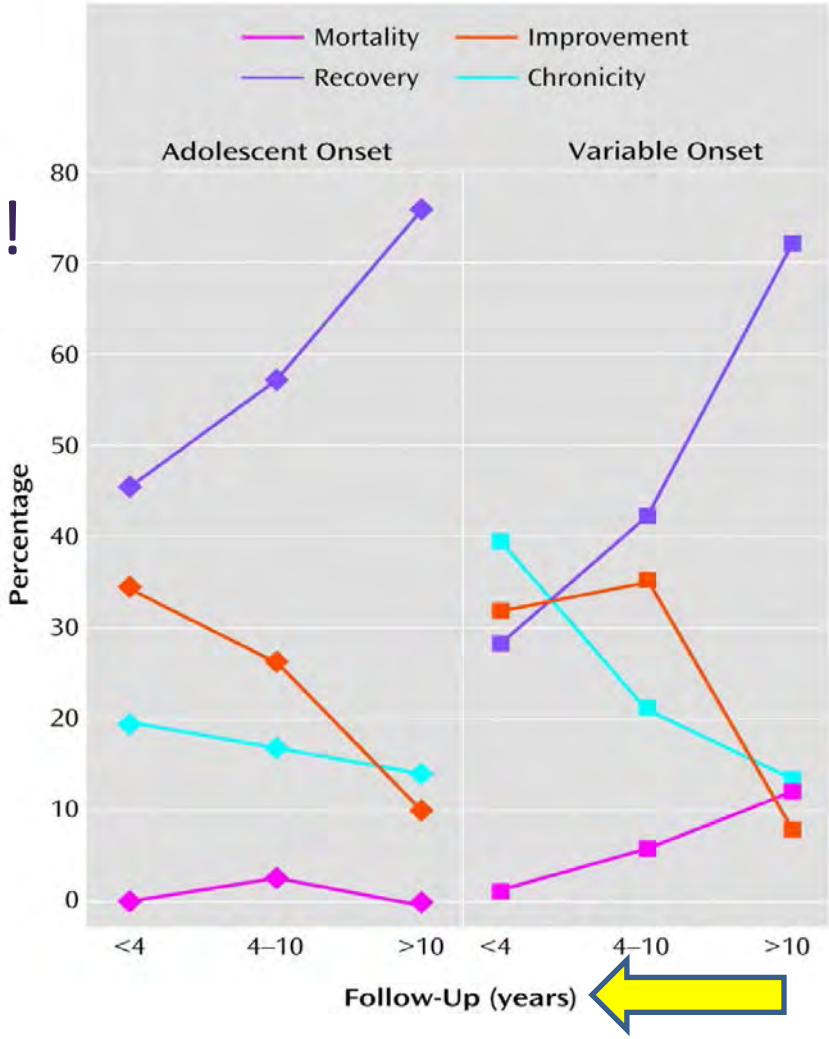


Based on reviews by
Steinhausen 2002 & 2009

UW PACC

RECOVERY: ANOREXIA NERVOSA

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



(Steinhausen 2002)

UW PACC

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!

UW PACC

https://s-media-cache-ak0.pinimg.com/736x/c5/90/c6/c590c680ce9a92b335fb42c44863a6e5.jpg

SELECTED REFERENCES

- Cotton MA, Ball C, Robinson P. Four simple questions can help screen for eating disorders. J Gen Intern Med. 2003 Jan;18(1):53-6.
- Jones WR, Saeidi S, Morgan JF. Knowledge and attitudes of psychiatrists towards eating disorders. Eur Eat Disord Rev. 2013 Jan;21(1):84-8.
- Mitchell KS, Mazzeo SE, Schlesinger MR, Brewerton TD, Smith BN. Comorbidity of partial and subthreshold ptsd among men and women with eating disorders in the national comorbidity survey-replication study. Int J Eat Disord. 2012 Apr;45(3):307-15.
- Smink FR, van Hoeken D, Hoek HW. Epidemiology of eating disorders: incidence, prevalence and mortality rates. Curr Psychiatry Rep. 2012 Aug;14(4):406-14.
- Steinhausen HC. Outcome of eating disorders. Child Adolesc Psychiatr Clin N Am. 2009 Jan;18(1):225-42.
- Steinhausen HC. The outcome of anorexia nervosa in the 20th century. Am J Psychiatry. 2002 Aug;159(8):1284-93.
- Watson HJ, Bulik CM. Update on the treatment of anorexia nervosa: review of clinical trials, practice guidelines and emerging interventions. Psychol Med. 2013 Dec;43(12):2477-500.
- Ulfvebrand S, Birgegård A, Norring C, Högdahl L, von Hausswolff-Juhlin Y. Psychiatric comorbidity in women and men with eating disorders results from a large clinical database. Psychiatry Res. 2015 Dec 15;230(2):294-9.
- Yager J et al. Guideline Watch (August 2012): Practice guidelines for the treatment of patients with eating disorders, 3rd ed. APA Practice Guidelines. 2012 Aug.
- Yager J et al. Practice guideline for the treatment of patients with eating disorders, 3rd ed. APA Practice Guidelines. 2006 June.

UW PACC