Eating Disorders Spotting The Signs

Supporting young people with eating disorders

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Aims

- To help you **identify eating disorders in young people**
- To help you better **understand (a) what it feels like to have an eating disorder** and (b) **what can be helpful and unhelpful when talking to a young person**
- To help you **support young people and their families to access specialist treatment**
- To highlight the **important role of the gp during and after specialist care**

Overview

- What is an eating disorder?
- How do you spot an eating disorder?
- When should I be concerned?
- What can I do?
- How can I support access to specialist help?
- What does specialist treatment usually involve?

What is an eating disorder?

What is disordered eating?

- Can mean lots of different things
- Key consideration is the extent of impact on a young person's life
- Health professionals define eating disorders using a set of criteria
- Young people do not always fit all of these criteria

Defined eating disorders

- Anorexia nervosa
- Bulimia nervosa
- Binge eating disorder

- ARFID

Anorexia nervosa

- Persistent restriction of energy **leading** to significantly low body weight
- Fear of weight gain and behaviours to avoid this
- Abnormal perception of body weight and shape
- Self evaluation is overly dependent on weight or shape

Bulimia nervosa

- Usually normal body weight
- Recurrent binge eating
- Purging behaviour (self-induced vomiting, laxatives)
- Self evaluation is overly dependent on weight or shape

What is not covered

- Binge eating disorder
- Other eating problems that are not classified as eating disorders

Frequency in young people?

- Worries about weight, shape and appearance are very common
- 30-70% of adolescents have engaged in dieting
- 1-2% of adolescents are diagnosed with anorexia or bulimia
- Around 10% of those diagnosed are male

How to spot an eating disorder

Early intervention is key!

- Outcomes MUCH better if specialist treatment accessed early
- Primary care professionals have a crucial role in identifying and supporting access to specialist help
- On this basis guidelines and funding have been released (NHS England)

What might you notice?

- What are the things that you might notice if a young person has an eating disorder?
- What are the things the young person might notice themselves?
- Consider:
  - Physical
  - Psychological
  - Behavioural

Physical signs

Others

- Loss of weight
- Fainting/dizziness
- Loss of energy
- Poor sleeping
- Swollen glands under jaw
- Thin brittle hair

Young person

- Feeling cold
- Loss of periods (females)
- Muscle weakness
- Constipation
- Feeling quickly full/ bloating
- Dry Skin

Behavioural signs

Others

- Change in personality
- More withdrawn
- Change in eating habits
- Secretiveness/hiding food
- Wearing baggy/warm clothes
- Frequent visits to the toilet
- Over-exercising/activity
- Focussing more or less on school work

Young person

- Early morning waking (effect of starvation)
- Arguing more
- Going out less
- Becoming more obsessional
- Doing better/worse at school

Psychological signs

Others

- Increased preoccupation with body size, weight and shape
- Fear of weight gain and eating particular foods
- Low mood/irritability
- Preoccupation with food, recipes, cooking for others

Young person

- Feeling happier (initially)
- Feeling unhappy
- Feeling confused/ unsure Feeling detached/numb
- Thinking about food, weight and shape constantly
- Poor concentration
- Narrowing of interests

The SCOFF questionnaire

- A simple five question test devised for use by non-professionals to assess the possible presence of an eating disorder
- A score of 2 or more positive answers should raise concern and indicate need for specialist assessment

The SCOFF questionnaire

- Do you make yourself **S**ick because you feel uncomfortably full?
- Do you worry that you have lost **C**ontrol over how much you eat?
- Have you recently lost more than **O**ne stone in a 3 month period?
- Do you believe yourself to be **F**at when others say you are too thin?
- Would you say that **F**ood dominates your life?

- Score 1 point for every 'yes'. A score of 2 or more indicates a likely case of an eating disorder.

Assessing physical risk

Access and waiting times standard

- Published in July 2015
- Guidelines aimed at commissioners, referrers and providers
- Linked to national funding to support the development of dedicated community eating disorder teams for children and adolescents
- Aims to facilitate early access to specialist evidence-based treatment
- **Assessment of physical risk by GP can form a key part of referral pathway**

Physical risk indicators

- Low body weight
- Rate of weight loss
- Food and fluid intake
- Blood pressure and pulse
- Purging (vomiting, using laxatives, diet pills)
- Excessively exercising
- Loss of periods (females)/delayed puberty

What is a healthy weight?

- CAMHS use minimum healthy weight for height
- Weight deficit is calculated as a percentage (%) below a minimally healthy weight.
  - higher weight deficit = lower weight
  - excel file available to calculate this
- Similar to BMI centile charts although deviates more at extremes of height

When to be concerned?

- **Not just about weight**
- Features that indicate medical risk are:
  - very low weight
  - inadequate fluid and food intake
  - frequent vomiting (electrolyte disturbance)
  - excessive exercise with low weight
  - rapid weight loss (e.g. 1kg a week)
  - low pulse (<50bpm), orthostatic cardiovascular changes
- For more details consult Junior MARSIPAN guidelines (RCP, 2012)

REFEEDING SYNDROME

- Heart failure
- Peripheral oedema
- Neurological disorders

What to do if you suspect an eating disorder

When to be concerned?

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- Features that indicate medical risk are:
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Making a plan

- Explore views of the young person
- Explore the views of parent/carer(s)
- Address confidentiality issues
- Conduct physical risk assessment
- Review medical history
- Consult colleagues
- Refer to CAMHS with key information (height, weight, history, BP, pulse, bloods)

Making a referral – Information required

- Height and weight
- Weight history
- Baseline bloods
- Blood pressure (sitting and standing) and pulse
- Eating behaviour and habits
- What is driving the eating behaviour?
- Food and fluid intake
- Other behaviours intended to aid weight loss (exercising, vomiting, use of laxatives)
- What are your concerns?

REFERRAL PATHWAY

- CAMHS Single Point of Access (SPA)
- ED screening form completed by SPA Team
- Referral to Eating Disorder Team
- Screening by Eating Disorder clinician
- Referral accepted
  - Routine: 4 weeks
  - Urgent: 1 week
- GP continues to monitor physical observations on a weekly basis in the meantime
- Any physical health concerns: refer appropriately

G.P Care and Monitoring

- Prior to assessment
  - GPs hold medical responsibility
  - Early recognition
  - Clear and specific referral
  - Physical health monitoring
- During ED work
  - Physical health monitoring
  - Facilitation of regular bloods
  - Pelvic ultrasound where indicated
  - Bone density scan where indicated
  - ECG where indicated
- Post-discharge
  - Physical health monitoring
  - Re-referral if indicated

Speaking to the young person

Be curious rather than confrontational….

Speaking to the young person

Focus on feelings not food…….

Speaking to the young person

Listen…

Avoid appearance based comments

How to refer to CAMHS

- **If in doubt refer!**
- Include as much information as you have been able to gather
- All referrals are screened for urgency the day they are received
- Urgent cases are seen within a week
- Contact CAMHS to discuss referral if you have questions

What does specialist treatment involve?

Treatment for eating disorders:

- National Institute of Clinical Excellence (NICE) published guidelines for the treatment of eating disorders in 2017

- New guidelines recommending early access to specialist treatment services published 2015 (NHS England)

Anorexia nervosa

- Early intervention and immediate access to specialist treatment leads to better outcomes
- A family-based treatment focussing on factors maintaining the eating disorder has the best evidence
- Treatment is likely to last 9-12 months, requiring weekly family based sessions at the outset, regular physical monitoring, and supervised meals to help initial weight gain
- Individual therapy is sometimes offered in addition/ at a later stage

Bulimia nervosa

- Leading treatment is cognitive-behavioural therapy for bulimia
- Family-based treatment can also be helpful
- Around 20 sessions, starting weekly
- Sessions more likely to be individual with some family involvement
- Key features of treatment are to help regularise eating and target maintaining factors

Does treatment work?

- Family-based and cognitive behavioural treatment leads to recovery in between 30-50% patients at the end of treatment
- Follow-up studies indicate good maintenance of treatment benefits
- Treatment outcomes are poorer as the duration of illness increases

Summary

Seek advice and further information whenever appropriate

In Buckinghamshire call The Single Point of Access (SPA) Team in CAMHS. 01865 901951

In Oxfordshire call The Single Point of Access (SPA) Team in CAMHS. 01865 902515

Any questions?

Information you can share

- Royal College of Psychiatry leaflets for young people and parents/carers
- http://www.rcpsych.ac.uk/healthadvice/parentsandyouthinfo/youngpeople/worriesaboutweight.aspx
- http://www.rcpsych.ac.uk/healthadvice/parentsandyouthinfo/parentscarers/eatingdisorders.aspx

Further information/advice

- CAMHS Eating Disorder guidelines for schools
- National Eating Disorder Charity website http://www.b-eat.co.uk/Home
- The MindEd website, launched in 2014, is a free e-learning resource to help adults to identify and understand children and young people with mental health issues.
- Junior MARSIPAN (2012) from Royal College of Psychiatrists covers physical risk assessment in detail
- Morgan JF, Reid F, Lacey JH (2000). "The SCOFF questionnaire: a new screening tool for eating disorders.". *West J Med* **172** (3): 164–5.
- Access and Waiting Time Standard for Children and Young People with an Eating Disorder (2015) NHS England

Further info

The Minnesota Starvation Study

36 healthy young men (22 -33 yr)

3 months: 3200 calories, then 6 months of 1560 calories (losing 25% of weight), then 2000-3000 calories.

Findings:

Physical:

- Emaciated

- Reduced basal metabolic rate

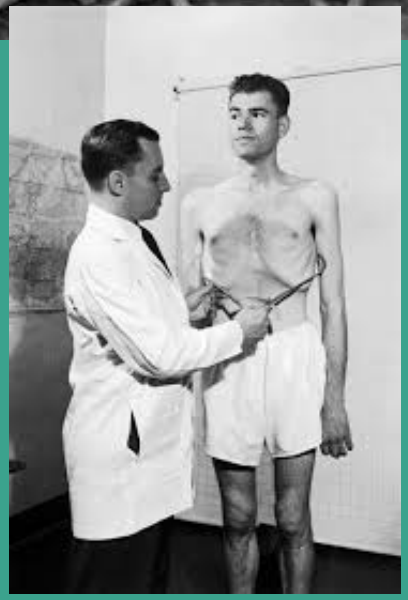
- Low muscle tone

- Low body temperature

- Decreased heart rate

- Reduced sex drive

- Poor concentration/comprehension/judgement



Psychological:

- Food obsession (Preoccupation with cooking/recipes)
- Depression
- Social withdrawal and isolation
- Hypochondriasis
- Apathy
- Irritability
- Fatigue

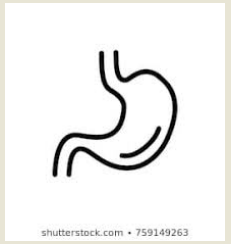
- ↑ GH, IgF-1 ↓
- ↑ cortisol
- Vasopressin dysregulation

↓ Leptin (satiety)

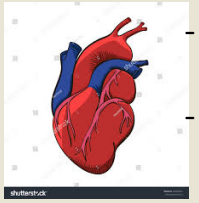
↓ serotonin and norepinephrine
Poor temperature regulation

Euthyroid sick syndrome
Low T3/T4
Normal TSH

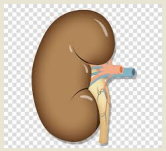
↑ Ghrelin (hunger)



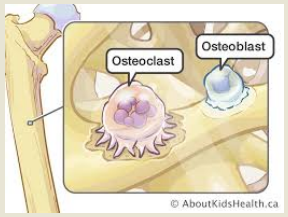
- Decreased gastric emptying
- Disuse atrophy
- Constipation/ diarrhoea



- bradycardia/hypotension/reactive tachycardia
- Prolonged QTc >450



- ↑ urea
- Dilute urine (vasopressin)
- Renal calculi



Osteoporosis – estrogen deficiency
Low Vitamin D

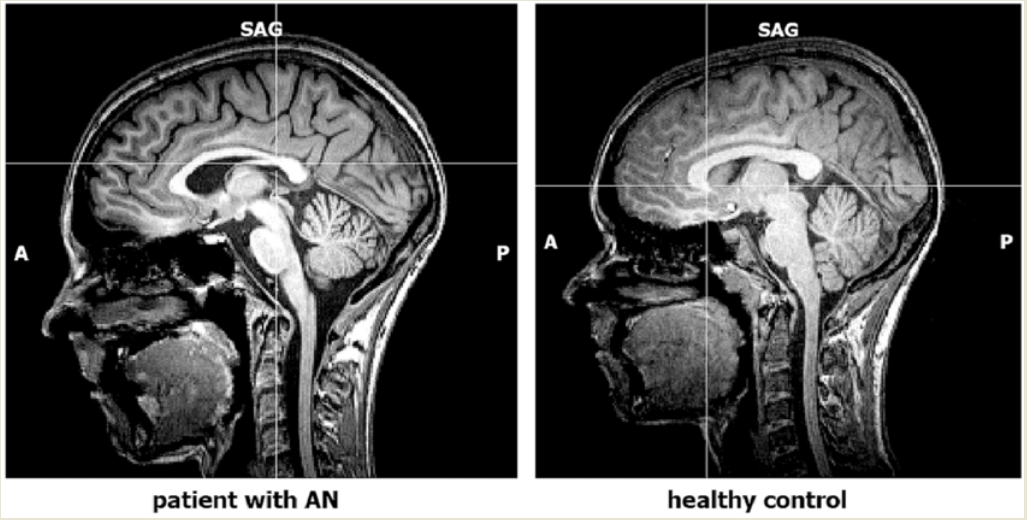
Amenorrhoea

Interesting lab values

- Normal prolactin, inspite of amenorrhoea
- Low WBC
- Low potassium
- Low phosphate
- Low T4 (not for treatment)
- Low glucose (Avoid treatment)

Brain Changes

- Roberto et al 2010
- Wagner et al 2005



- Significant deficits in brain grey matter volume
- Improved but did not normalize with weight restoration over 51 weeks
- All structural brain abnormalities recoverable in long-term weight restoration (29-40 months)