Eating disorders: summary of identification and management

January 2004

Identification, assessment and information

Identification in primary care and non-mental health settings

- Target groups for screening include:
  - young women with low BMI compared with age norms
  - women with menstrual disturbance or amenorrhoea
  - young people with type 1 diabetes
  - people with gastrointestinal problems, signs of starvation
  - people with repeated vomiting
  - children with poor growth
  - people consulting with weight concerns who are not overweight
- With specific target groups, consider using questions such as, "Do you think you have an eating problem?" and "Do you worry excessively about your weight?"
- When considering anorexia nervosa, note that:
  - low BMI alone is not a reliable indicator of an eating disorder
  - attention should be paid to the overall clinical assessment (repeated over time) including rate of weight loss, growth rates in children, objective physical signs and appropriate laboratory tests

Initial assessment

- Early assessment and intervention is important in reducing long-term risk
- Comprehensive assessment is important and should include physical, psychological and social components

Low/moderate risk

Outpatient treatment

High risk

- Severe emaciation
- Serious risk of self-harm
- Severe deterioration
- Poor response to treatment

Consider inpatient treatment/ urgent referral to specialist service

Care across all conditions

- Information should be available to patients, families and carers
- There should be access to self-help groups and support groups
- Patient ambivalence should be acknowledged

Laxatives

- Where laxative abuse is present, gradually reduce laxative use

Diabetes

- Active treatment of both sub-threshold and clinical cases of bulimia nervosa is essential in people with diabetes
- In people with type 1 diabetes, intensive regular medical monitoring is required to reduce the risk of retinopathy and other complications

Pregnancy

- Pregnant women require careful monitoring throughout pregnancy and in the post-partum period

Dental care

- All patients with an eating disorder where vomiting is a symptom are also at risk of poor dental health, so consider:
  - regular dental reviews
  - providing information on dental hygiene including avoiding brushing after vomiting, rinsing with a non-acid mouth wash after vomiting, and reducing an acid oral environment

Bulimia nervosa
See separate panels

Atypical eating disorders
See separate panel

Anorexia nervosa
See separate sheet

Bulimia nervosa

Following the initial assessment consider:

- as a possible first step, an evidence-based self-help programme – direct encouragement and support to patients undertaking such a programme may improve outcomes. This may be sufficient treatment for a limited subset of patients

Psychological treatment should form the key element of treatment, so consider:

- *for adults*: cognitive behaviour therapy for bulimia nervosa (CBT-BN), which should normally be 16 to 20 sessions over 4 to 5 months
- *for adolescents*: CBT-BN adapted as needed to suit their age, circumstances and level of development
- *where there has been no response to CBT or it has been declined*: other psychological treatments, particularly interpersonal psychotherapy (IPT). (Note: patients should be informed that IPT takes 8–12 months to achieve results comparable with CBT-BN)

Pharmacological interventions may have a role

- Consider a trial of an antidepressant drug as an alternative or additional first step to using an evidence-based self-help programme
- In terms of tolerability and reduction of symptoms, SSRIs (specifically fluoxetine) are the drugs of first choice for the treatment of bulimia nervosa
- The effective dose of fluoxetine is higher than for depression (60 mg daily)
- Beneficial effects will be rapidly apparent and are likely to reduce the frequency of binge eating and purging, but the long-term effects are unknown
- No drugs, other than antidepressants, are recommended for the treatment of bulimia nervosa

Remember that, for patients with poor impulse control, notably substance misuse, response to standard care may be limited. As a consequence, treatment regimes may need to be adapted.

Physical management

- Careful monitoring of risks should be a concern of all health professionals working with people with this disorder
- Assess fluid and electrolyte balance where vomiting is frequent or there is frequent use of laxatives
- If electrolyte balance is disturbed, consider behavioural management as first option
- If supplementation is required, use oral rather than intravenous preparations

Bulimia nervosa – inpatient or day care

- Consider inpatient treatment for patients with risk of suicide or severe self-harm
- Admit patients to setting with experience of managing this disorder

Primary care

- Patients with enduring anorexia nervosa not under the care of a secondary care service should be offered an annual physical and mental health review by their GP
- Where management is shared between primary and secondary care, there should be clear agreement between individual healthcare professionals on the responsibility for monitoring of patients with eating disorders. This agreement should be in writing (where appropriate using the care programme approach) and should be shared with the patient and, where appropriate, families and carers

Atypical eating disorders including binge eating disorder (BED)

General treatment

In the absence of evidence to guide the management of atypical eating disorders (eating disorders not otherwise specified) other than binge eating disorder, it is recommended that the guidance on the treatment of the eating problem that most closely resembles the individual patient's eating disorder is followed.

Psychological treatments for BED

- As a possible first step, consider an evidence-based self-help programme; direct encouragement and support from a healthcare professional may improve outcomes
- In adults, where self-help is not offered or is declined, consider cognitive behaviour therapy for binge eating disorder
- For persistent BED, consider other psychological treatments – interpersonal psychotherapy for binge eating disorder (IPT-BED), and modified dialectical behaviour therapy
- For adolescents with persistent binge eating disorder, consider suitably adapted psychological treatments
- Note that all psychological treatments for binge eating disorder have a limited effect on body weight
- Consider providing concurrent or consecutive interventions focusing on the management of comorbid obesity

Pharmacological interventions for BED

- As an alternative or additional first step to using an evidence-based self-help programme, consider a trial of an SSRI antidepressant

Eating disorders: summary of identification and management *continued*

Anorexia nervosa – outpatient care

Psychological interventions

Psychological interventions are the key element in the management of anorexia. The delivery of psychological interventions should be accompanied by regular monitoring of a patient's physical state including weight and specific indicators of increased medical risk.

- Treatment should be of at least 6 months' duration
- When delivering a psychological treatment consider, in conjunction with patient:
  - cognitive analytical therapy (CAT)
  - cognitive behaviour therapy (CBT)
  - interpersonal psychotherapy (IPT)
  - focal psychodynamic therapy
  - family interventions focused explicitly on eating disorders
- Focus of treatment should be on weight gain, healthy eating, and reducing other symptoms related to eating disorders
- Dietary counselling should not be provided as the sole treatment for anorexia nervosa

Pharmacological interventions

Pharmacological interventions have a very limited evidence base for the treatment of anorexia nervosa.

- Medication is not effective as sole or primary treatment; caution should be exercised in its use for comorbid conditions such as depression or obsessive–compulsive disorder, as these may resolve with weight gain alone
- Avoid using drugs that prolong the QTc interval in patients with borderline/prolonged QTc

Note: drugs that prolong the QTc interval include antipsychotics, tricyclic antidepressants, macrolide antibiotics, and some antihistamines

- If medication that may compromise cardiac functioning is essential, ECG monitoring should be undertaken
- Place alert in prescribing record concerning the risk of side effects

Anorexia nervosa – inpatient care

- Consider inpatient treatment for patients:
  - with high or moderate physical risk
  - who have not improved with appropriate outpatient treatment
  - have significant risk of suicide or severe self-harm
- Admit to setting that can provide the skilled implementation of refeeding with careful physical monitoring (particularly in the first few days of refeeding) and in combination with psychosocial interventions
- If uncertain about formal admission, consider seeking advice from an appropriate eating disorder specialist regardless of the age of the patient
- Consider increased risk of self-harm and suicide at times of transition for patients with anorexia nervosa, especially that of the binge–purging sub-type

Psychological treatment

- Psychological treatment is a key element of an inpatient stay but evidence for what kind of treatment or approach to treatment is effective is limited
- A structured symptom-focused treatment regimen with the expectation of weight gain should be provided with careful monitoring of the physical status during refeeding
- Provide psychological treatment with a focus both on eating behaviour and attitudes to weight and shape, and wider psychosocial issues with the expectation of weight gain
- Do not use rigid behaviour modification programmes

Feeding against the will of the patient

- Feeding against the will of the patient should be an intervention of last resort in care and should only be done in the context of the Mental Health Act 1983 or Children Act 1989
- Feeding against the will of the patient is a highly specialised procedure requiring expertise in the care and management of those with severe eating disorders and the physical complications associated with it
- When making the decision to feed against the will of the patient, the legal basis for any such action must be clear

Post-hospitalisation treatment in adults

- Following discharge, extend the duration of psychological treatment over that normally provided to those who have not been hospitalised – typically for at least 12 months
- Offer outpatient psychological treatment that focuses both on eating behaviour and attitudes to weight and shape, and on wider psychosocial issues, with regular monitoring of both physical and psychological risk

Anorexia nervosa – physical management

Anorexia nervosa carries considerable risk of serious physical morbidity. Awareness of the risk, careful monitoring and, where appropriate, close liaison with an experienced physician are important in the management of the physical complications of anorexia nervosa.

Managing weight gain

- Aim for an average weekly weight gain of 0.5–1 kg in inpatient settings and 0.5 kg in outpatient settings. This requires about 3500 to 7000 extra calories a week
- Provide regular physical monitoring and consider multivitamin/multimineral supplement in oral form for both inpatients and outpatients
- Total parenteral nutrition should not be used unless there is significant gastrointestinal dysfunction

Managing risk

- Inform patients and their carers if the risk to their physical health is high
- Involve a physician or paediatrician with expertise in the treatment of medically at-risk patients for all individuals who are at risk medically
- Consider more intensive prenatal care for pregnant women to ensure adequate prenatal nutrition and fetal development
- Oestrogen administration should not be used to treat bone-density problems in children and adolescents as this may lead to premature fusion of the epiphyses
- Healthcare professionals should advise people with eating disorders and osteoporosis or related bone disorders to refrain from physical activity that significantly increases the likelihood of falls.

Additional considerations for children and adolescents

Special considerations apply in the treatment of children and adolescents. The involvement of families and other carers is particularly important. The right to confidentiality of children and adolescents with eating disorders should be respected.

Family members, including siblings, should normally be included in the treatment of children and adolescents with eating disorders. Interventions may include sharing of information, advice on behavioural management and facilitating communication.

Anorexia nervosa

- Family interventions that directly address the eating disorders should be offered to children and adolescents with anorexia nervosa
- Offer children and adolescents individual appointments with a health professional separate from those with their family members or carers
- For children and adolescents, once a healthy weight is reached ensure increased energy and necessary nutrients are available in the diet to support growth and development
- Involve carers of children and adolescents in any dietary education or meal planning

Inpatient care of children and adolescents with anorexia nervosa

- Inpatient care of children and adolescents should:
  - be to age-appropriate facilities (with the potential for separate children and adolescent services), which have the capacity to provide appropriate educational and related activities
  - balance the need for treatment and urgent weight restoration with the educational and social needs of the young person
- Consider using the Mental Health Act 1983 or the right of those with parental responsibility to override the young person's refusal to receive treatment that is deemed essential
- Avoid relying indefinitely on parental consent
- Seek legal advice and consider proceedings under the Children Act 1989 if the patient and those with parental responsibility refuse treatment, where treatment is deemed essential
- Consider seeking a second opinion from an eating disorder specialist where issues of consent to treatment are highlighted