Eating Disorders and Primary Care

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Aims

- Introduce PEDS
- Eating disorders and statistics
- Focus on Anorexia and Bulimia due to mortality rates
- Role of the Professional in Primary Care
- Increase understanding of MARSIPAN and resources useful
- Share NICE Guidelines and highlight relevant points
- Share ideas
- WIFM ...What is in it for you...
“Eating disorders are characterised by an abnormal attitude towards food that causes someone to change their eating habits and behaviour” (NHS, 2015)

The most common types of eating disorder include

1. **Anorexia Nervosa** - characterized by distorted body image and excessive dieting that leads to severe weight loss with a fear of becoming fat
2. **Bulimia Nervosa** - characterized by frequent episodes of binge eating followed by purging behaviours to avoid weight gain
3. **Binge Eating Disorder** - recurring episodes of eating significantly more food in a short period of time with episodes marked by feelings of lack of control.

Assessment tools include **SCOFF, ESP Eating Disorder Screen for Primary Care**

One study found that the best individual screening questions are:

- Does your weight affect the way you feel about yourself
- Are you satisfied with your eating patterns

(Cotton, Bell & Robinson, 2003)
Effects on the Body

How bulimia affects your body

- **Brain**: depression, fear of gaining weight, anxiety, dizziness, shame, low self-esteem
- **Cheeks**: swelling, soreness
- **Mouth**: cavities, tooth enamel erosion, gum disease, teeth sensitive to hot and cold foods
- **Throat & Esophagus**: sore, irritated, can tear and rupture, blood in vomit
- **Muscles**: fatigue
- **Stomach**: ulcers, pain, can rupture, delayed emptying
- **Skin**: abrasion of knuckles, dry skin

Anorexia affects your whole body

- **Brain and Nerves**: can’t think right, fear of gaining weight, sad, moody, irritable, bad memory, fainting, changes in brain chemistry
- **Hair**: hair thins and gets brittle
- **Heart**: low blood pressure, slow heart rate, fluttering of the heart (palpitations), heart failure
- **Blood**: anemia and other blood problems
- **Muscles, Joints, and Bones**: weak muscles, swollen joints, bone loss, fractures, osteoporosis
- **Kidneys**: kidney stones, kidney failure
- **Body Fluids**: low potassium, magnesium, and sodium
- **Intestines**: constipation, bloating
- **Hormones**: periods stop, problems growing, trouble getting pregnant. If pregnant, higher risk for miscarriage, having a C-section, baby with low birthweight, and post partum depression.
- **Skin**: bruise easily, dry skin, growth of fine hair all over body, get cold easily, yellow skin, nails get brittle
Effects on the Mind

- Negative thoughts
- Poor sleep / Poor concentration / Distracted
- Obsessive / Anxious / Isolative
- Irritable / angry
- Low mood or depression (and sometimes highs)
- Unusual behaviours (eating in a certain way, at a certain time)
- Over interest in other peoples eating habits, TV programmes, magazines related to food,
- supermarkets
- Secretive / Shameful / Guilty
- Irrational
- Minnesota Keys Experiment
Diagnosis Update

- **New DSMV diagnosis – Binge Eating Disorder (BED)**
- Rewording criteria for Anorexia – used to be at or under 85% of ideal bodyweight now significantly low weight – more clinical judgement. In the old DSM- women had to have skipped 3 or more periods
- **Bulimia** – changes made – now binge eating and compensatory behaviours to occur for at least once a week for at least three months (previously had to be at least twice a week)
- **Avoidant / Restrictive Food Intake Disorder (also known as ARFID)**. Previously known as EDNOS. A type of problem with eating (or in very young children, a problem with feeding)
- **OSFED (Other Specified Feeding or Eating Disorder)** has subtypes and UFED (Unspecified Feeding or Eating Disorder) instead of EDNOS
Over 1.6 million people in the UK are estimated to be directly affected by eating disorders (joint Commissioning Panel For Mental Health) www.jcpmh.info/wp-content/uploads/10keymsgs-eatingdisorders.pdf

Prevalence for males is unreliable as many assessment tools are gender-biased, and it is widely known that men have difficulty coming forward as it is still often referred to as a “women’s slimming disease”.

The National Institute of Health and Clinical Excellence estimates around 11% of those affected by an eating disorder are male.

Various studies suggest that risk of mortality for males with ED is higher than it is for females (Raevuoni, 2014).

Men with eating disorders often suffer from comorbid conditions such as depression, excessive exercise, substance disorders, and anxiety (Weltzin, 2014).
Eating disorders have the highest mortality rates among psychiatric disorders (physical complications and increased suicide risk) (Arcelus J, Mitchell AJ, Wales J. et al, 2011)

The number of teenagers admitted to hospital with eating disorders across the UK has nearly doubled in three years (Independent Newspaper, June 2015)

In the year 2010/11 the 959 teenagers aged 13 – 19 were admitted to hospital with eating disorders. This number rose to 1,815 in 2013-14. Health and Social Care Information Centre (www.hscic.gov.uk/article/3880/Eating-disorders-Hospital-admissions-up-by-8-per-cent-in-a-year)

Anorexia –average length 8 years Bulimia – 5 years

An eating disorder admission for a YP costs on average £70k and for an adult £90k
Primary Care

- **Top Tips:**
  - Update guidance, literature in your area – NICE, BEAT
  - Share assessment tools – EDQ, SCOFF, EAT
  - CPD days – NICE, weighing a patient, reviewing a patient
  - Be aware of local procedures ie pathways and referral protocols for adult and children in your area – visit CAMHS, Adult ED CMHT – establish links
  - Forming relationships with surrounding area ie Health Visitors, school nurses, wellbeing centres, clinics – joint training, sharing best practice – ED Forums, ED SIGs!
  - MARSIPAN – a must read!
Weighing a Patient

- Same scales (discourage weighing at home) / avoiding the reception area
- Same time (where possible)
- Alert to water loading / adding weights
- Significant changes (re-feeding, fabricating weight)
- Same clothes (no shoes, belts, jackets, heavy jewellery)
- Avoid commenting on weight changes
- Communicating concerns
Considerations

- Being aware of secretive aspect, person may lie (fear, embarrassment)
- Your role
- Early Intervention (and referral) and Risk Management – follow ups, spot weights, engagement
- Impact on carers and family
- Keeping the boundaries / consistency
- Motivation and Consent – Gillick / Fraser Competent
- Criteria and funding
- Language and communications with the patient – “not enough weight lost to be Anorexic”, “bloods are fine”, “eat more doughnuts”
- Maintenance range as opposed to “target”
- Diabetes and pregnancy
Replacing 2004 version

Removal of “8yrs and over”

EDE Q Tool – monitoring treatment

Immediate referral

Screening tools - not just SCOFF

BMI issues – not using alone and caution re reliability

Adult Treatments (including length):

Individual eating-disorder-focused cognitive behavioural therapy (CBT-ED)

Maudsley Anorexia Nervosa Treatment for Adults (MANTRA)

Specialist supportive clinical management (SSCM)

YP Treatments – FT for AN or CBT if N/A
- Age appropriate multi vitamin and mineral supplement
- Diabetes Management in EDs – ie insulin
- ECGs – risks of medication, weight loss, exercise, vomiting, caffeine, bradycardia, laxatives, diuretics, hypotension, electrolyte imbalance, muscle weakness
- Referring for bone density scans – after 1 yr in underweight children and after 2yrs in underweight adults (unless bone pain / fractures)
- GP medical monitoring guidelines for those with long standing AN not receiving treatment
- Re-feeding
- One month inpatient review regardless of weight
Re-feeding Syndrome

- Patients especially at risk include:
- Severely underweight / Acute weight loss of 5-10% in past 1-2 months,
- Has gone without food for several days,
- Abnormal electrolytes prior to refeeding (phosphate, potassium, magnesium),
- Prolonged and severe vomiting, Prolonged QTc interval on ECG,
- Usually occurs within first few days of starting to feed but can be up to 2 weeks (signs include oedema, confusion, seizures, arrhythmia)
- Can cause fluid and electrolyte disturbance and be life threatening
- Neurological, pulmonary, cardiac, neuromuscular, and haematological complications possible
- Caution with meal plans (useful to prescribe Thiamine and Vitamin supplement) Monitoring of bloods daily

Registered Charity Number: 1156578
Useful Links


- [http://mengetedstoo.co.uk/](http://mengetedstoo.co.uk/)

Update professional and patient resources in surgeries
Have the option of joining Network-ED http://www.network-ed.org.uk/ for central professional resource/support
Check out the MARSIPAN checklist (RCPsych) http://www.rcpsych.ac.uk/pdf/CR189checklistXX.pdf
CDC Gov Teen BMI https://www.cdc.gov/healthyweight/assessing/bmi/childrens_bmi/about_childrens_bmi.html
NICE ED Guidance May 2017
Contact specialist interest GP based in Bristol www.drdominiquethompson.com
PEDS liaison / links www.pedsupport.co.uk