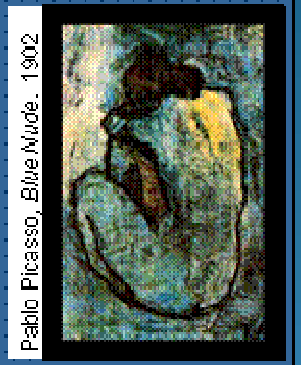
The South Island Eating Disorders Service



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South Island Eating Disorders Service

What are we dealing with?

Eating disorders are the 3rd most common disease of young women

High mortality

High morbidity

High co-morbidity

Eating Disorders consist of a wide spectrum of harmful and often ineffective eating behaviours used in an attempt to lose weight or achieve a lean appearance.

Am. College of Sports Medicine

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Classification

- Anorexia Nervosa
- Bulimia nervosa
- Eating Disorder NOS (EDNOS)
- Binge Eating Disorder

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Classification

- Anorexia Nervosa

  Refusal to maintain body weight

  Intense fear of gaining weight

  Body image disturbance

  Amenorrhea

  Restricting, Binge-eating/Purging subtypes

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Classification

- Anorexia Nervosa

  Lifetime prevalence for women 0.5%

  Point prevalence 15-19 years 0.5%

  Incidence 20/100,000 females/yr

  Increase in recent decades but now stable

  Younger onset

  20% mortality

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Classification

- Bulimia Nervosa

  Recurrent episodes of binge eating

  Recurrent compensatory behaviour

  Frequency 2/week for 3 months

  Self-evaluation influenced by shape/weight

  AN excluded

  Purging/non-purging subtypes

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Classification

- Bulimia Nervosa

  Lifetime for women 1-3%

  Point prevalence 1% young women

  Incidence 30/100,000 females/yr

  Rapid increase in diagnosis since described in 1979

  Now stable or declining

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Classification

- Eating Disorder NOS

Meets criteria for AN and/or BN BUT

Females have menses

May have significant weight loss but weight is in the normal range

Binging and purging occur less frequently than in BN

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Classification

- Eating Disorder NOS

  Point prevalence young women 3-5%

  More than half of clinical samples

  Virtually unstudied

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Prognostic Factors

Good

young age/first episode/short duration

relatively preserved body weight

intact family

established other roles

absence of co-morbidity

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Prognostic Factors

Bad

- purging anorexia
- chronicity > 6 years
- alcohol and drug use
- psychiatric co-morbidity esp personality disorder
- Unrelenting lack of insight

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Detecting an Eating Disorder

Cues to Anorexia nervosa

- Unexplained weight loss
- Failure to gain weight in proportion to height
- Secondary amenorrhea
- Bradycardia
- Hypotension

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Detecting an Eating Disorder

Cues to Anorexia nervosa

- Hypothermia
- Peripheral cyanosis
- Lanugo hair, brittle hair, hair loss
- Hypercarotenemia
- Preoccupation with additional weight loss despite thinness

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Detecting an Eating Disorder

Cues to Binge-Purge behaviour

- Swollen or tender parotid glands
- Dental enamel erosion / many new caries
- Calloused scarred area on back of hand
- Yo-yo weight pattern
- Hypokalemia

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Detecting an Eating Disorder

Screening questions

Are you worried about your weight?
Are you dieting?
Have you lost weight?
Have other people expressed concern about your weight?
Do you experience binge eating?
Do you purge after meals?
Do you use laxatives / diet pills?
Do you spend a lot of time thinking about food?
Do you feel compelled to do exercise?

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Physical complications and management

Metabolic abnormalities

- Metabolic alkalosis
- Hypokalemia
- Hypochloremia
- Hyponatremia
- Hypomagnesimia

Monitor -> HCO_3, K^+, Na^+, Cl^-, Mg^{++}

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Physical complications and management

Hypokalemia (muscle weakness, fatigue, constipation)

Regular monitoring of K+ if purging > 3 times per day. More so if combined with laxative abuse.

If K+ < 3.0 mmol/l -> daily monitoring initially with ECG

Treatment -> Oral K+, Slow K 1-2 tabs tds with fluids

If K+ < 2.5 mmol/l or there has been a rapid drop in levels, or progression of ECG changes -> ED dept / hospitalise

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Physical complications and management

Constipation and laxative abuse

Constipation is due to low calorie intake, chronic laxative abuse, hypokalemia

Constipation is aggravated by chronic use of stimulant laxatives (Bisacodyl, Senna, etc)

Treatment -> Education
Switch from stimulant laxatives to non-stimulant varieties (Metamucil, fibre, fluids)
Then no laxatives

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Physical complications and management

Cardiovascular complications

- Small heart, hypotrophic muscle
- Fatigue, decreased exercise tolerance
  Hypotension
- Bradycardia
- Cardiac arrhythmia
- Hypothermia
- Hypokalemia

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Physical complications and management

Cardiovascular complications

Cardiac risk increased by ->

- Severe and or rapid weight loss
- High purge frequency
- Drastic re-feeding and rehydration
- Excessive exercise

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Physical complications and management

Cardiovascular complications

Treatment ->

- Normalise electrolyte imbalances
- Weight restoration
- Refer severe cases to Cardiologist
- Avoid drugs causing QTc prolongation
  - tricyclic antidepressants
  - antipsychotics
  - cisapride
- Restrict activities

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Physical complications and management

Osteoporosis

Due to low oestrogen, high hydrocortisone

When early onset of amenorrhea, peak bone mass won't be achieved

Diagnosis -> DEXA bone scan

Treatment -> Weight restoration
Calcium supplement 1g daily
Cholecalciferol 1.25mg monthly
? Oestrogen / Progesterone replacement

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Medical indications to consider hospitalisation

Severe malnutrition (BMI < 13)

Rapid weight loss (> 4kg in 6 weeks)

Severe dehydration

K+ below 2.5 – 3.0 mmol/l

Prolonged QTc interval (>450 msec)

Dysrhythmias

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Medical indications to consider hospitalisation

Hypothermia (< 35.5 C)

Bradycardia (< 40 b/m)

Pulse differential (> 30 b/m)

Rapidly diminishing exercise tolerance

Frequent exercise induced chest pain

Oligouria (< 400 ml/day)

Low phosphate during initial re-feeding

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In Summary :

Patients with eating disorders present complex challenges

Treatment involves careful monitoring of physical parameters

Psychological support is needed

Weight gain must always be a priority