Eating Disorders in children and adolescents: what a GP needs to know

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Introduction and Plan

- What is an Eating Disorder
- Eating Disorders in General Practice; obtaining information & assessing risk
- How to refer .... assessing Urgent vs Routine
- Information about specialist CAMHS ED teams
- Case studies
What is an Eating Disorder

- Anorexia Nervosa (AN)
- Bulimia Nervosa (BN)
- Other specified feeding or eating disorder (OSFED)
- Avoidant/restrictive food intake disorder (ARFID)
Anorexia Nervosa (AN)

- >15% below expected weight for height or a BMI of less than 17.5kg/m²
- Self induced weight loss
- Morbid fear of fatness
- Widespread endocrine disorder (amenorrhoea)
- Delayed/arrested puberty if prepubertal
In men

- Diagnostic criteria same
- Hormonal dysfunction: reduced libido in men and low testosterone
- Alcohol misuse more likely
- Differences in the idealised body shape:
  - Muscular strength
  - Muscle definition
  - Physical fitness
  - Gender issues
Bulimia Nervosa (BN)

• Recurrent episodes of binge eating.

• An episode of binge eating is characterized by both of the following:
  • Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.
  • A sense of lack of control over eating during the episode.
- Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, fasting, or excessive exercise.

- Self-evaluation is unduly influenced by body shape and weight.
  - Above behaviour at least twice weekly for >3 months
Other specified feeding or eating disorder (OSFED)

- Formerly described at Eating Disorders Not Otherwise Specified (EDNOS) in the DSM-IV, Other Specified Feeding or Eating Disorder (OSFED), is a feeding or eating disorder that causes significant distress or impairment, but does not meet the criteria for another feeding or eating disorder.
Avoidant/restrictive food intake disorder (ARFID)

- An eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:
  - Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).
  - Significant nutritional deficiency.
  - Dependence on enteral feeding or oral nutritional supplements.
  - Marked interference with psychosocial functioning.
The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice.

The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence body image disturbance.
The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder. When the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.
<table>
<thead>
<tr>
<th>How might you come across it in General Practice?</th>
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<tbody>
<tr>
<td>● Weight loss</td>
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<td>● Gastro intestinal symptoms</td>
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<td>● Menstrual disturbance/ Amenorrhoea</td>
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<td>● Food refusal/ Dietary restriction</td>
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<td>● Vomiting</td>
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<td>● Excessive or driven exercise</td>
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<td>● Disturbed electrolytes</td>
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<td>● low energy</td>
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<td>● mood swings</td>
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<td>● irritability,</td>
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<td>● sleep disturbance</td>
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<td>● anxiety</td>
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<td>● Family concerns regarding eating patterns/ weight loss</td>
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<td>● Concerns regarding endocrine functions</td>
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<td>● Diabetics with uncontrollable blood sugars</td>
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Risk

- Highest mortality rate of psychiatric disorders
- Most common cause, death due to starvation, sudden or gradual
- Medical complications due to re-feeding syndrome
- Chronic problems, e.g. osteoporosis
- Complications from mis-management of diabetes
Areas of risk

- Physical risk
- Suicidality
- Self-harm
- Child protection issues
- Driving
Physical risk of low weight

- Cardiac arrhythmias
- Postural hypotension
- Hypothermia
- Bone marrow suppression
- Electrolyte imbalance
- Renal failure
- Liver failure
- Muscle wasting
- Pressure sores
- Osteoporosis
- Impaired fertility
- Impaired cognitive functioning
Physical risk of compensatory behaviours

Vomiting
- Electrolyte imbalance
- Hypokalaemia
- Gastric and oesophageal trauma
- Swollen parotids
- Dental caries

Laxatives
- Dehydration
- Electrolyte imbalance
- Rectal bleeding
- Abdominal cramps
- Constipation
How do you assess risk?

- Junior MARSIPAN risk assessment
Junior MARSIPAN helps decide whether a paediatric assessment and/or admission is required

Risk assessment framework

- Red (high risk)
- Amber (alert to high risk)
- Green (moderate risk)
- Blue (low risk)
• Parameters include % weight for height, physical health, disordered eating behaviours, engagement with management plan, activity and exercise, self-harm and suicide, comorbidity

• This may be needed for:
  • Management of physical health complications
  • Management of refeeding syndrome
Suicide and self-harm risk

• SUICIDE
• Death due to suicide, planned (e.g. overdose) or impulsive (e.g. driving car off road)
• Second commonest cause of death in AN

• SELF-HARM
• Common in AN and BN
• E.g. cutting; but also burning, patient who pulls own hair
• Self-neglect common in AN, poor nutrition, not sufficiently deserving to eat adequately
What do you need to glean in consult?

- Weight history
- Eating History
- Fluid intake
- Physical state
- Psychological symptoms
Recognition - Helpful questions

- How much would you like to weigh?
- How do you feel about your present weight?
- Do you or anyone else have concerns about your eating or exercise?

Lawrence, Perrin & Benjamin (2006)
ACT

- Ask gentle questions
- Calmly express concerns
- Talk of your observations

Treasure, Smith and Crane (2007)
What do you need to do?

- **Weight** (Kilograms) and **Height** (metres)

- **Physical observations** including; blood pressure (sitting & standing), heart rate, temperature, assess risk of oedema and pressure areas.

- **Baseline blood monitoring** including; Urea & Electrolytes, Liver Function test, Magnesium, Calcium, Phosphate, Creatine Kinase, Full Blood Count, Random Glucose, Thyroid Function & Free T4, Vitamin B12 & Folate, LH & FSH

- Consult / Refer to D&D CAMHS EDT

- Self referral follow up
Urgent or Routine

- Included in packs
  - Junior MARSIPAN risk assessment guide
  - EDT urgent and routine criteria

- If there are urgent physical concerns please refer to paediatric ward/ day unit for further assessment e.g.
  - Acute food/ fluid refusal
  - Physical parameters in RED or AMBER zone, especially cardiac related
  - Oedema
Any thoughts/ questions?
Referral routes

- A&E
- Paediatrics
- CAMHS: Tier 2, Tier 3 & Crisis
  - CAMHS ED team and EDT
  - Schools
  - GP
- Non – Health Care Worker
- Self

Family Consent
What can you expect from specialist CAMHS ED teams?

- Referral- Access and Waiting Times standards

**GP referral to CEDS-CYP**

This is an established referral route; however, a new requirement will be for the GP to contact the eating disorder service via telephone or electronically following discussion with the child or young person and their parents or carers, as soon as an eating disorder is first identified. The CEDS-CYP should log the date of referral and the CLOCK STARTS at this time.

This is important to ensure optimal management is in place from first presentation. Appropriate treatment may include delivery in a primary care setting, under the overall supervision of the CEDS-CYP team. With late presentation, where the child or young person is extremely physically compromised or where there is very high psychiatric risk (for example, suicidality), in a minority of cases, the GP should arrange immediate paediatric and/or psychiatric care to manage risk via local protocols and should inform the CEDS-CYP accordingly. Again, at this point, the date of contact from the GP should be logged and the CLOCK STARTS.

- Requests for blood monitoring, baseline ECG and advice regarding possible referrals to other health providers
Specialist Eating Disorder Assessment

- Family Assessment
- Dietetic Assessment
- Psychometric Assessment
- Physical Assessment
- Mental Health Assessment
- Team formulation
- Collaborative care plan devised
Intervention

- Extended assessment / initial 6 week assessment
- 6 week Care plan review
- Collaborative care plan including:
  - Physiological
  - Psychological
  - Dietetics
  - Pharmacological
  - Regular CPA reviews
**Case Study**

- Young girl, age 14 presents at GP with Mum. Mum concerned regarding weight loss and lack of energy, girl states she is ‘just doing more’, a little worried about school work. She presents as quiet, but is attending school and achieving well. Says everything is okay and Mum is over protective.

- She is thinking of becoming vegetarian

- Periods are irregular

What would you do?
Any thoughts/ questions?