

# MEDICAL OFFICERS OF SCHOOLS ASSOCIATION

## GUIDELINE ON EATING DISORDERS

Eating Disorders – occurs mainly in Western World among female population in teens and twenties.

### Main Types

Anorexia Nervosa

Bulimia Nervosa

Obesity

Anorexia Athletica – Excess exercise for weight control and self-respect

Body Dysmorphic Disorder

Rumination Syndrome

Pica

### GP/School Doctor duty is to:

- a) Make initial assessment from physical psychological and social stand points. Determine if emergency, physical or psychiatric care needed
- b) Initial co-ordination of care
- c) Agree with Secondary Care Team who is responsible for which areas of treatment and monitoring
- d) Liaise with House Staff, parents and patient to decide whether patient is able to stay at school and/or boarding. Set rules/parameters for this to be achieved E.g. In anorexia nervosa improved eating and weight gain

### Anorexia Nervosa DSM11RICD 9

#### Characterised by:

- a) Food Avoidance causing a weight loss >15% of expected body weight
- b) Distorted body image
- c) Morbid fear of weight gain
- d) In girls – loss menstrual cycle for >3/12 after puberty or failure to establish regular periods if just prior to puberty

**Incidence:** About 1% Adolescent Population

Girls – 12 ~ 25 (average age of 15 to 17)

In Teen years girls to boy ratio of 10:1

Boys average age of 12. Can occur in childhood when girls to boys ratio of 3:1

Boys – are usually younger at presentation with more physical complaints, greater weight loss, less likely to have bulimia, or use laxatives.

Differential Diagnosis: Diabetes Mellitus, Thyrotoxicosis, Malabsorption Syndrome and Chronic Infection.

### Symptoms:

Sanatorium Nurses, Matron, teaching staff or fellow boarders often report these behavioural changes to the school doctor.

### Behavioural

- a) Unusual or extreme diet, avoidance of carbohydrates and fats, chaotic eating patterns, avoidance of public meals
- b) Excessive exercise often at inappropriate times.

- c) Unusual behaviour
- d) Laxative or diuretic use
- e) Vomiting after meals
- f) Change in academic performance
- g) Wearing of baggy, concealing clothes

### Psychological

- a) Mood swings, irritability – more extreme than usual for teenagers
- b) Depression (if severe with suicidal thoughts) & withdrawn from social life of school
- c) Poor self esteem
- d) Avoidance of conflict
- e) Distorted self image
- f) Obsessive thoughts based on food avoidance
- g) Compulsive behaviours/rituals

### Physical

- a) Cold sensitivity-fine downy hair growth on limbs
- b) Fatigues, faints and weakness
- c) Constipation
- d) Amenorrhoea
- e) Significant weight loss (>15%) after puberty or cessation of growth in height/weight in childhood
- f) Low BP, low K, low Hb, abnormal LFT's, in teenagers low gonadotrophins
- g) Loss of bone mass
- h) If severe, long QT interval-arrhythmias. In extreme cases, cardiac arrest

### Causes: Multifactorial

- a) Dietary problems early in life
- b) FH of weight problems. 10% have siblings with an eating disorder
- c) Poor family or group dynamics – sufferer has lack of identity/purpose. Food refusal and weight loss are means of controlling other family members and give a sense of achievement
- d) Uncontrolled dieting. Period of being overweight due to immobility of illness or trauma, 'puppy fat' or changing body requirements at puberty prompts a sensible diet, which overshoots target weight, & weight loss becomes central activity of life.
- e) Cultural demands for unrealistic thinness as portrayed on TV and in films and magazines

### Treatment

*NICE Clinical Guidelines, 9<sup>th</sup> January 2004, sets out current recommendations for ideal treatment of anorexia in detail.*

If there are extreme physical symptoms eg biochemical changes, extreme weight loss (> 15% and falling) or refusal of treatment, hospital admission may be needed, possibly under the Mental Health Act

Most sufferers can be cared for as out patients working on restoring a good eating pattern, a normal weight to match centile height. Improvement of psychological state with the help of a specialist team in adolescent/childhood eating disorders, exploring and resolving family and social issues. The aim is to return to full activities

### Prognosis

80% of patients treated recover or have significant progress but this may take 3 ~ 7 years  
Best results in cases with:

Short duration of illness  
Smaller percentage weight losses  
Good family relationships

However, 16% still have low BMI's at 4 years from diagnosis. Unfortunately 2% die

### **Bulimia Nervosa - Characterised by:**

- a) Recurrent episodes of eating large amounts of food in a short time
- b) Loss of control during these binge sessions
- c) Fear of obesity
- d) Regular mechanisms to counter fattening effects of binges

### **Incidence**

- a) 1% population though a mild variant occurs in 3 ~ 5% of younger women
- b) Rare before puberty with peak time in late adolescence to early twenties
- c) Female: male ration = 10:1

### **Cause**

- a) Multifactorial, low self esteem, poor impulse control, anxiety and depression
- b) Poor relationship with parents
- c) FH alcoholism, depression or eating disorders
- d) In males, higher incidences of mental illnesses, weight fixation triggered by demands of a sport, body building ideals, homosexuality
- e) Previous sexual abuse

### **Symptoms**

Once again these are often noted first by house staff and/or peers

- a) Preoccupation with food while trying to lose weight, food cravings occur which cannot be controlled. Secret eating of excess food, guilt follows, finally calorie shedding, vomiting, laxatives or diuretic
- b) Weight is usually normal – unless severe diet between binges when weight level varies.
- c) Russell's Sign – calluses or abrasions on back of hands from front teeth caused when making themselves sick
- d) Damaged teeth – enlarged salivary gland and tonsillar hyperplasia, sore throat, heartburn

In extreme cases:

- a) Low potassium with muscle wasting, tetany, fits, cardiac arrhythmias
- b) Gastric or oesophageal rupture with haematemesis
- c) Chronic laxative use can cause diarrhoea
- d) Chronic laxative use and/or diuretic use further worsens electrolyte levels

### **Treatment**

- a) NICE Guidelines 9<sup>th</sup> January 2004 gives details of best treatment
- b) Most are cared for on an outpatient basis with CBT (specially modified for adolescents), if necessary, or an evidence-based self-help programme, Eg, eating meals only, limiting cash, never shopping alone.

### **Prognosis**

A chronic disease – 50% recover, 25% improve, and 25% do not

## **Help groups**

[www.eatingdisorders.org.uk/](http://www.eatingdisorders.org.uk/)

[www.fmhsussex.co.uk/](http://www.fmhsussex.co.uk/)

[www.rcpsych.ac.uk/](http://www.rcpsych.ac.uk/) Link to several useful websites

[www.edauk.com/](http://www.edauk.com/)

[www.anred.com](http://www.anred.com) USA site for lay people. Very detailed and supportive. Best for parent information

[www.something-fishy.com](http://www.something-fishy.com) User friendly for a young lay audience and suitable for patient.

## **Sources**

Mentor

Barton Blunda. Eating Disorder Specialist - BUPA

NICE Guidelines, 9<sup>TH</sup> January 2004

Anred.com

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