Top tips for GPs on Eating Disorders (ED)

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Introduction
An ED is a term used to include a range of frequently complex conditions. EDs have the highest mortality rate of all psychiatric disorders. Generally an ED is characterised by a person’s overwhelming need to control their food intake to try to avoid gaining weight.

There are three main types of ED: anorexia nervosa; bulimia nervosa; and other related eating problems, usually called ‘atypical EDs’ otherwise known as EDs not otherwise specified (EDNOS). This last group includes ‘binge eating ED’. 1

EDs are common. The average age of onset is between 12-25 years, although children younger than this have been diagnosed. Whilst most sufferers are female, 1 in 10 are male. Three quarters of admissions are for Anorexia. EDs are increasingly common in adults although it is rare for people to first develop the condition in middle age. In this case, most people have either had it for decades but have concealed it well or they have had it previously, recovered and for various reasons, the ED resurfaced. An average GP may only see new presentations of Anorexia twice a year, but prevalence of bulimia and EDNOS is higher.2

1. Behaviours associated with EDs include people starving themselves, vomiting and using laxatives. Usually people hide these behaviours from others, and as their weight may be normal, others around them may not notice their behaviour. If suspicious of these behaviours, enquire sensitively and tactfully utilising a normalising approach.

2. Sufferers may be ambivalent to diagnosis, remain in denial and may also be secretive or ashamed. This means that for many individuals with an ED, there is a significant delay in seeking help, which may in turn impact their prognosis. Early diagnosis and referral is therefore important to prevent entrenched behaviours.

3. There may also be a delay between a patient being seen, identified and engaged in primary care and receiving specialist input, due to difficulties in accessing the appropriate secondary care services and also that the clinicians attitude does not facilitate disclosure. GPs may have little experience with EDs, and feel anxious about their management. It is important in such an instance, to offer regular review and risk assessment, signpost to self-help resources, and monitor physical health parameters.

4. There are a number of high risk groups GPs should be alert to
   - Children and young people (CYP) with a history of psychological difficulties or trauma,
   - CYP engaged in competitive sport of performance arts,
• CYP with low body mass index (BMI) compared with age norms;
• Patients consulting with weight concerns or about diets who are not overweight; women with menstrual disturbances or amenorrhea,
• Patients with physical signs of starvation or repeated vomiting.

GPs should retain a **high index of suspicion for potential EDs** in
• Women diagnosed with PCOS,
• Patients with ongoing gastrointestinal symptoms,
• Children with poor growth,
• Children of people who have had an ED,
• Women with a history of an ED and or depression (particularly during key life transitions),
• People with diabetes type I

and finally consider ED as a **differential diagnosis in non traditional groups**- including men and people from Black and Minority Ethnic groups

5. If an ED is suspected, A GP can screen with a few **sensitive questions**-
Do you think you have an eating problem?
Do you worry excessively about your weight?
Does your weight affect the way you feel about yourself?
Are you satisfied with your eating patterns?

A screening tool that has been validated for use in Primary care is SCOFF;\(^3\)

**The SCOFF questions**
Do you make yourself Sick because you feel uncomfortably full?
Do you worry you have lost Control over how much you eat?
Have you recently lost more than One stone in a 3 month period?
Do you believe yourself to be Fat when others say you are too thin?
Would you say that Food dominates your life?

*One point for every “yes”; a score of ≥2 indicates a likely case of anorexia nervosa or bulimia and necessitates referral for a specialist eating disorders assessment.

6. When an ED has been identified, **examination and further assessment can guide next steps** (See appendix 1). For people presenting with more 'mild' or sub-clinical presentations, the GP may take the lead in co-ordinating a care team for the individual, providing information about support groups and involving other practitioners including a psychologist and a dietitian. Where the patient wishes, it may be appropriate to share information with family or carers.\(^4\) A supportive family can be important for an individual’s recovery. More specialist treatment is often necessary in many presentations of EDs.

8. **BMI should not be the only factor in referral.** For patients with disturbances in blood tests or abnormal examination, rapid rate of weight loss, comorbidities or atypical presentations, an early referral to specialist services is important or admission to hospital for physical health complications indicated. Referral for assessment may be to the local CMHT or CAMHS or specialist ED service if available. A GP should know local referral pathways or how to seek advice for adults and children.

9. There can be **breakdowns in communication**, particularly when patients’ care is
being shared between primary and secondary care. When care is shared, there should be a clear agreement, preferably written, on how the patient should be monitored and who is responsible for each aspect of the care. 5 This can be particularly important in young people who move around frequently e.g. students.

10. Concerns about confidentiality can occur such as whether to disclose the patient’s information when the patient did not want their diagnosis divulged. Patients may also not want family involved or informed. Patients may also refuse treatment, and this can be a difficult dilemma for GPs to deal with. When assessing a patient’s capacity to reach a decision regarding treatment, remember that the patient’s capacity is time and decision specific. 6 Keep these matters under review, and consider whether the patient should be assessed under the Mental Health Act. Healthcare professionals assessing children and adolescents with EDs should be alert to indicators of abuse (emotional, physical and sexual) and should remain vigilant on safeguarding so throughout treatment. Respect the right to confidentiality of children and adolescents with EDs.

Appendix 1

A guide to assessment of an new ED for GPs

1. Blood tests- FBC/ U&Es/ CK/ Glucose/LFTs/Mg/PO4/Ca/(+TFT/ ESR first time), prolactin,

2. ECG if BMI<17.5 or taking medications affecting QT interval

3. Weight and height (calculate BMI)

4. Blood pressure and pulse (sitting and standing)

5. Body temperature

6. Gastrointestinal examination

7. Evidence of vomiting/laxative or diuretic abuse

8. Thyroid examination

Resources

B-eat (formerly the EDs Association): Helpline adults: 0845 634 1414; beat youth helpline (under 25): 0845 634 7650. B-eat is the UK's leading charity supporting anyone affected by EDs or issues with food, including families and friends.

Diabetics with EDs website
http://dwed.org.uk/

(Men get EDs too): A national charity dedicated to representing and supporting the needs of men with EDs.
http://mengetedstoo.co.uk/

A resource for people with an ED and their family
http://www.anorexiabulimiacare.org.uk/

Eating disorders in CYP
http://www.youngminds.org.uk/for_parents/worried_about_your_child/eating_problems?gclid=COGn_qjAgNICFYO77QodAU4Nag

Advice on Eating Disroder
http://www.mind.org.uk/information-support/types-of-mental-health-problems/eating-problems/#.WJsPsNKLTcs

Elefriends is a supportive non-specific mental health problem community
https://www.elefriends.org.uk/

2 EDs in over 8s: management
Clinical guideline [CG9] Published date: January 2004
3 The SCOFF questionnaire: assessment of a new screening tool for EDs
BMJ 1999; 319 doi: https://doi.org/10.1136/bmj.319.7223.1467 (Published 04 December 1999)
Cite this as: BMJ 1999;319:1467
4 Academy for EDs Position Paper: The Role of the Family in EDs. International Journal of EDs 00:0 000–000 2009
5 EDs Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa, and related EDs 2004, The British Psychological Society & The Royal College of Psychiatrists
Mental Capacity Act 2005