Grand Rounds: Eating Disorders

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Outline

- Anorexia Nervosa
- Bulimia Nervosa
- Binge-Eating Disorder
- OB/Gyn Problems Associated with Eating Disorders
- Recommendations
- Local Resources
Anorexia Nervosa
Anorexia Nervosa

- Has the highest mortality rate of ANY mental disorder
  - Between 5-20% of patients will die
  - Starvation, substance abuse, suicide

- 0.5-1% of American women have anorexia nervosa

- Typically appears in early to mid-adolescence
Anorexia Nervosa

Diagnostic criteria:

1. Refusal to maintain body weight at or above a minimally normal weight for age and height
2. Intense fear of gaining weight or becoming fat, even though underweight
3. Disturbance in the way the body weight or shape is experienced, undue influence of body weight or shape on self-image, or denial of the seriousness of the current low body weight
4. Amenorrhea in postmenarchal females

2 Subtypes: Binge-eating and purging; Restrictive
Anorexia Nervosa

- History
  - Question pt about her weight – min, max, and ideal
  - Menstrual history
    - 20% will have amenorrhea *before* marked wt loss
  - Body image, Exercise regimen, eating habits
  - Current/past meds – especially laxatives or diet pills
- Sexual history
- Substance abuse
- Suicidal ideation and symptoms of depression
Anorexia Nervosa

- Physical Exam
  - Vitals, BMI or ideal body weight and determine appropriate percentile for age
    - Weigh in hospital gown only, after voiding
    - Low body temp, bradycardia, orthostatic hypotension

- Gyn Exam may show findings of reduced estrogen
  - Pubertal delay
  - Atrophic vaginitis
  - Breast atrophy
Anorexia Nervosa

Physical Exam – Other Typical Findings
- Skin: dry skin with lanugo, hair loss, acrocyanosis, brittle hair/nails
- CV: mitral valve prolapse
- Abd: scaphoid abdomen with retained stool
- Ext: ankle and leg edema
- Musculoskeletal: absence of fat pads over the scapulae, muscle wasting, thinning of bones
Anorexia Nervosa
Anorexia Nervosa

- Workup
  - CBC, BMP, TSH, Calcium, Phosphorus, Magnesium, ESR
    - May have low $K^+$, $Mg^{2+}$, and $Ca^{2+}$
    - May have normal TSH, sed rate, CBC, but if abnormal may point to a different diagnosis
  - UA – obtain urine specific gravity – patients often drink excessive amounts of water to alter weight readings
  - Majority will be amenorrheic – check LH, FSH, estradiol, Prolactin
    - Hypothalamic hypogonadism
  - EKG – may show bradycardia, prolonged QT, and ST changes
Anorexia Nervosa

- Health Consequences
  - Annual mortality rate: > 12x than the death rate in the general population of young women
  - Alcohol and other substance abuse disorders are 4x more common than the general population
  - Markedly elevated risk for OCD
Anorexia Nervosa

- Health Consequences
  - Amenorrhea -> osteopenia -> skeletal health problems
    - BMD is 25% lower than age-matched controls
    - Trabecular bone density may remain low even after recovery of normal weight
  - Amenorrhea of 1-yr duration may be tx with OCPs and they may slow the rate of bone loss
  - Normalizing menses appears to improve bone recovery
Anorexia Nervosa

- **Treatment**
  - Team approach – medical provider, mental health therapist, nutritionist, dietician
  - Family therapy for adolescents
  - Group therapy
Anorexia Nervosa

Treatment – Meds

SSRIs:
- some short term benefit (first 2 months) for decreasing number of binge-eating episodes and tx the depression and obsessive-compulsive ideation frequently seen in eating disorders.
- NOT the sole or primary treatment

Estrogen and progestin replacement is advocated after 1 yr of amenorrhea

Calcium and multivitamins for severely restricted patients

Stool softeners
Inpatient Criteria for Eating Disorder Tx

- Severe malnutrition (Wt < 75% of expected body weight)
- Dehydration
- Electrolyte disturbance
- Cardiac arrhythmia
- Physiologic instability (severe bradycardia, hypotension, hypothermia, orthostatic changes)
- Arrested growth and development
- Failed outpatient treatment
- Acute food refusal
- Uncontrollable binge-eating and purging
- Acute malnutrition complications: syncope, seizure, cardiac failure
- Psych emergencies – suicidal or acute psychosis
- Comorbidities that interfere with tx (depression, OCD, family dysfunction)
Bulimia Nervosa
Bulimia Nervosa

- **Diagnosis/Definition:**
  - Recurrent episodes of binge-eating with the consumption of large food quantities in a discrete time period that is associated with a sense of lack of control.
  - Recurrent inappropriate compensatory behavior in order to prevent weight gain occurring *at least two times a week for 3 months*.
  - Induced vomiting, fasting, excessive exercise, and misuse of laxatives, diuretics, enemas, or other medications.
Bulimia Nervosa

- Characteristics
  - Lack of control over the amount and type of food eaten and experience feelings of guilt over inability to stop the binge-eating and purging
  - These patients will ask for help whereas patients with anorexia nervosa identify with their eating disorder and resist treatment efforts
Bulimia Nervosa

- History
  - GI: Vomiting, diarrhea, or constipation
  - Pelvic pain – may be due to abnormal food intake and laxative use
  - Ask about meds (laxatives or diuretics to control weight)
  - Careful psych evaluation
  - Menstrual history: usually do have menses, but may have oligo- or amenorrhea
  - Sexual history – Pts often have impulsive, risk-taking behavior that can lead to STIs and unintended pregnancy
Bulimia Nervosa

- Physical exam – frequently normal
  - Weight typically normal or slightly overweight
  - Pelvic pain and constipation
  - Other findings: scalp hair loss, parotid swelling, abnormal dentition (gum disease/gum recession/enamel erosion), Scars on fingers (Russell sign) and perianal erythema
Bulimia Nervosa
Bulimia Nervosa

- Workup:
  - CBC with diff
  - BMP
  - Calcium, phosphorus, magnesium
  - Baseline ECG recommended (mandatory if electrolyte abnormalities noted)
    - Bradycardia, prolonged QT associated with torsade de pointe, and sinus tachycardia changes
Bulimia Nervosa

- Health Consequences
  - Electrolyte abnormalities:
    - Hypokalemia, hypophosphatemia potentially lethal
    - Hypomagnesemia: muscle cramps, weakness, restlessness
  - GI disorders: Pancreatitis, esophagitis, esophageal rupture, Mallory-Weiss lesions, paralytic ileus secondary to laxative abuse
  - Pulmonary: aspiration pneumonia, pneumomediastinum
  - Ipecac use can cause irreversible cardiomyopathy
Bulimia Nervosa

Treatment:
- Inpatient if indicated (same as anorexia)
- Medical supervision, psychologic therapy, nutritional counseling
- Group therapy often indicated
- Hormonal contraceptives for menstrual irregularities
Binge Eating Disorder
Binge-Eating Disorder

- Definition/Characteristics:
  - Pt consumes large quantities of food, but does *not* purge or engage in compensatory behaviors
  - Binge episodes typically associated with 3 of:
    - eating more rapidly than normal
    - eating until uncomfortably full
    - eating large amounts of food even when the person does not feel hungry
    - eating alone because of embarrassment or depression
    - feeling disgusted with oneself, depressed, or very guilty after overeating
Binge-Eating Disorder

- Definition/Characteristics:
  - *Binges typically occurs at least 2 day per week for 6 months*
  - May eat regular meals and snacks throughout the day
  - Possible triggers: dieting (fasting), chronic restrained eating, and excessive exercise
Binge-Eating Disorder

- History and Physical:
  - Consider this diagnosis in *every* obese patient with PCOS
  - Labwork profile of morbidly obese patient
  - Commonly have associated psych diagnosis (depression is most common)
  - Menstrual cycle irregularity

- Health Consequences:
  - Those associated with obesity – HTN, dyslipidemia, heart disease, DM2, gallbladder disease
Binge-Eating Disorder

- Treatment
  - Healthy weight-control techniques
  - Eliminating the “thin ideal of beauty”
  - Improving the self-esteem of adolescents
  - SSRIs – decrease the number of binges and may help prevent relapse in patients with remission
  - Combined hormonal contraception for menstrual irregularities
OB/Gyn Problems and Eating Disorders
Kimmel et al. study - 2015

- Unplanned Pregnancy
  - Anorexia = 2x risk
  - Bulimia = markedly elevated risk

- Eating behaviors during pregnancy
  - Anorexia = Remission, but as high as 60% with some disordered eating
  - Bulimia = highest rates of remission
  - Binge eating = vulnerable for onset and continuation

- Gestational weight gain
  - Anorexia = average weight gain
  - Bulimia and Binge eating = excessive weight gain
OB/Gyn Problems and Eating Disorders

- Nutrition during pregnancy
  - Anorexia = More likely to be vegetarians, no vitamin/mineral deficiencies
  - Binge eating = incr intake of total fat; lower intake folate, K+ and vit C

- Hyperemesis
  - Bulimia = incr risk of having hyperemesis. Worsening of disorder.

- Birth Outcomes
  - Anorexia = contradictory evidence for increased risks
  - Bulimia = increased odds of preterm ctx, resuscitation of newborn, and very low 1-min Apgars. Preterm birth associated.
  - Binge Eating = Maternal HTN, prolonged labor, LGA infant, higher weight pre-preg and higher gestational weight gain
OB/Gyn Problems and Eating Disorders

- Postpartum weight gain
  - Anorexia = more rapid wt loss, but WNL up to 36 months postpartum
  - Bulimia/Binge Eating = stable with small steady increase from 6mo-3yr

- Breastfeeding
  - No differences in initiating breastfeeding for any eating disorder.
  - Anorexia = increased risk of cessation before 6 months
OB/Gyn Problems and Eating Disorders

- Postpartum depression/anxiety
  - Anorexia = higher risk. If depression also present, more likely to report past history of sexual trauma
  - Bulimia = higher risk, more severe depression and higher rates past trauma
  - Binge eating = Higher risk. Psychological distress assoc with continuation and crossover to bulimia nervosa
Eating Disorders in Pregnancy

- Patients desiring pregnancy should resolve their eating disorder prior to pregnancy.

- Weight gain recommendations for BMI:
  - < 18.5: 28-40 lbs
  - 18.5-24.9: 25-35 lbs
  - 25.0-29.9: 15-25 lbs
  - 30+: 11-20 lbs
OB/Gyn Problems and Eating Disorders

- Anorexia
  - Amenorrhea – hypothalamic hypogonadism.
  - No difference in pregnancy rates, but may have increased miscarriage
  - Decreased libido, higher sexual anxiety, *increased sexual drive with wt restoration*
  - Higher mortality from gyn cancers

- Bulimia and Binge Eating
  - Oligo/amenorrhea – often associated with PCOS
  - Bulimia: possible higher rates of fertility treatment
  - Higher rates of miscarriage
  - Sexual dysfunction
  - Endometrial cancer is a risk of obesity
Recommendations

- Screening for patients annually – keep it in mind if co-existing psych diagnosis is present
- Get a thorough history to establish a diagnosis
- Treat menstrual abnormalities with hormonal contraceptives
- Consider starting SSRIs on patients, especially if co-morbid depression exists
Recommendations

- Promptly refer these patients to qualified mental health providers for long term management.

- Patients desiring pregnancy should resolve their eating disorder prior to pregnancy:
  - May have extreme depression associated with weight gain during pregnancy.
  - Maternal Increased risk of: dehydration, cardiac irreg, GDM, preterm delivery, difficulty nursing, postpartum depression.
  - Neonatal risks: poor development, preterm birth, SGA, respiratory distress, feeding difficulties.
Local Resources

- **PATH Clinic, LLC (Wichita)**
  - Psychotherapy services only - Dr. Hartman McGilley, PhD. (Fellow of the Academy of Eating Disorders and is a Certified Eating Disorder Specialist)

- **Eating Disorder Center of KS (KC)**
  - Partial inpatient (10h days), intensive outpatient services

- **McCallum Place (KC)**
  - Outpatient and partial inpatient (day treatment)

- **Renew Counseling Center (Olathe)**
  - Intensive outpatient and outpatient services

- **Children’s Mercy Kansas City**
References


- National Eating Disorders Association Web Site: http://www.nationaleatingdisorders.org/

Questions?