PE CHECKLIST

Eating disorders

Key points to look out for

by Allan S. Kaplan, MD

The diagnosis of an eating disorder requires both disordered eating behaviour and characteristic psychopathology. Obesity per se isn't considered an eating disorder because most obese individuals don't engage in disordered eating behaviour or have characteristic psychopathology (although about 40% do). There are two commonly recognized eating disorders; anorexia nervosa (AN) and bulimia nervosa (BN). Each is subtyped; for anorexia nervosa, there are binge/purge and restricting subtypes depending on whether the patient engages in binge eating and/or purging or simply caloric restriction. For bulimia nervosa, the subtypes are purging or non-purging depending on whether the patient engages in purging behaviours such vomiting or laxative use or compensates for binging by exercise or restriction.

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Characteristics of AN

- Patients pursue thinness and fall below a statistically normal weight for their height
- Psychopathology includes extreme body image distortion, obsessionality, perfectionism and anxiety

Characteristics of BN

- Patients binge eat regularly, may lose weight but don't fall below statistical norms
- Psychopathology includes impulsivity, unstable mood, anxiety, and body dissatisfaction

Differential diagnosis

Common psychiatric causes of weight loss that aren't eating disorders (ED):

- schizophrenia — delusions about food, being poisoned; not present in ED
- depression — anhedonic and disinterested in food; disturbed by weight loss. Patients with AN are not disturbed by weight loss and are obsessed with food
- conversion disorder (psychogenic vomiting) — patient doesn't know why she vomits and is disturbed by weight loss. There's no body image disturbance. Patients with ED vomit to rid themselves of calories, aren't disturbed by weight loss, and have a distorted body image
- substance abuse — cocaine, amphetamines induce true anorexia (loss of appetite). Patients with ED do not actually lose their appetite

COMMON MEDICAL CAUSES OF WEIGHT LOSS ON YOUNG ADULTS:

- inflammatory bowel disease, i.e. Crohn's disease. Presence of pain, evidence of malabsorption, lab findings of inflammation (elevated ESR) absent in AN
- malabsorption syndrome, i.e. celiac disease. Presence of steatorrhea and hypoalbuminemia, which are absent in AN
- malignancy — hypothalamic tumours; associated with other signs/symptoms
- infection — signs of inflammation are present
- endocrine disorders — hyperthyroidism, diabetes, Addison's disease. All accompanied by other signs/symptoms

Recognizing an eating disorder

Key questions to ask of any adolescent/young adult woman presenting with vague physical symptoms or weight loss:

BEHAVIOURAL SIGNS/SYMPTOMS:

- Have you lost weight recently? If so, how much?
- Do you eat any regular meals? If so, what do you eat?
- Are you restricting calories to below 1,500 a day?
- Do you have episodes of binge eating — eating huge amounts of food (over 2,000 calories) in a short period of time (under one hour)?
- Do you make yourself vomit? If so, how often?
- Do you take laxatives to lose weight? If so, how much and how often?
- Do you take diet pills? If so, how many and how often?
- Do you take diuretics? If so, how many and how often?
- Do you exercise excessively and compulsively for the purpose of weight control (more than 1-2 hours per day 3-4 times per week)?
- Do you use other medications to try and lose weight — thyroid, ipecac, or psychostimulants such as methylphenidate?
- Do you use street drugs to lose weight — cocaine, amphetamines?
- How much caffeine do you drink?
- Do you menstruate regularly?

COMMON PSYCHOLOGICAL SIGNS/SYMPTOMS:

- Do you have an unhealthy preoccupation with your weight and shape?
- Are you moody/irritable?
- Do you have difficulty sleeping?
- Have you withdrawn socially?
- Do you have trouble concentrating?
- Have you become more obsessional/perfectionist?
- Are you overly anxious?

COMMON PHYSICAL SIGNS/ SYMPTOMS:

Evidence of down regulation of autonomic nervous system as a result of deficient calories/weight loss:

- hypotension
- bradycardia
- hypothermia
- constipation
- amenorrhea
- hair loss
- osteopenia/osteoporosis
- lanugo (AN patients may grow downy white body hair to insulate them after fat loss)
- anemia
- electrolyte disturbance — hypokalemia, hyponatremia
- elevated liver function tests
- carotenemia causing yellowing of skin
- elevated creatinine secondary to dehydration
- enlarged salivary glands
- evidence of cortical and grey matter wasting in neuroimaging
- ECG changes (QT prolongation, U waves, other nonspecific changes)

Treating AN

- nutritional rehabilitation and weight gain; either in inpatient (severe) or day hospital program
- individual psychotherapy, with cognitive-behavioural and motivational components
- family therapy for patients under 18
- pharmacotherapy for co-morbidity — depression and anxiety
- currently no “anti-anorexia” drugs available; SSRIs are generally ineffective in underweight starved patients, who lack serotonin production
- for chronic treatment-resistance, focus on medical stability, psychosocial support, quality of life

Treating BN

- nutritional rehabilitation with structured meal planning, usually can be accomplished as an outpatient with input from a dietician
- structured day hospital treatment in more intractable cases
- individual therapy — cognitive behaviour therapy is very effective
- group therapy
- pharmacotherapy — selective serotonergic reuptake inhibitors have antibulimic properties at high doses. Fluoxetine, up to 60 mg/day

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