Eating Disorders

More than Meets the Eye

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Marie's case

- Marie, 20, presents with a 12-month history of progressive weight loss, associated with amenorrhea, very high activity level and restricted food intake.
- Physical exam shows a thin woman in little distress.

For Marie's test results, go to page 72.

Table 1

Core diagnostic features of anorexia nervosa

- Low weight (body mass index < 17.5)
- A drive for "thinness" or fear of "fatness"
- A distortion in the way the body is viewed
- Amenorrhea

Roughly half of individuals with anroexia nervosa have the restricting form of the illness; the oher half either purge, binge-eat or both, in addition to having the the restricting form.

Most individuals with an eating disorder will not admit to bingeing or purging; they need to be asked. Table 1 lists the core diagnostic features of anorexia nervosa.

Those presenting with bingeing at a normal weight have bulimia nervosa. About half of those individuals also have purging behaviours.

People with bulimia nervosa share weight and shape concerns with those suffering from anorexia nervosa and have undoing behaviours, such as strict fasting, exercise or purging to counteract the binge-eating. The presence of these undoing behaviours, along with concern about weight and shape distinguish bulimia nervosa from binge-eating disorder, a condition characterized by binge-eating alone and typically accompanied by massive weight gain.

Who is at risk and what is the prevalence of eating disorders?

Women are the primary population at risk for the development of an eating disorder, with peak incidence between the ages of 15 and 25. While men account for about one of every five cases in community surveys,

Marie's test results

Vitals & physical signs

- Weight: 40 kg
- Height: 160 cm
- Blood pressure: 85/60 mmHg sitting
- Pulse: 40 beats per minute
- Thinning hair on head, but a growth of fine downy hair on back
- Mild pedal edema just above the ankles
- Deep tendon reflexes are difficult to elicit; spleen is palpable
- Bilateral, symmetrical, non-tender swelling of her parotid and submandibular glands.

Lab results

- Hemoglobin: 93 g/dL
- Wct 1.2
- Potassium: 2.8 mmol/L
- Bicarbonate: 30 mmol/L
- Electrocardiogram: Pulse rate 38 beats per minute; QTc 0.50
- Dietary history: Intake limited to 1,000 kcal/day, with 1-2 hours of physical activity daily.

Marie is complaining only of fatigue and thinks everything else is fine.

What's your diagnosis? Go to page 73 for the answer?

they are less well represented in treatment settings, likely because they do not identify themselves at risk for the illnesses.

Common initiating factors include:

- activities that focus attention on weight and shape (such as dance or gymnastics),
- family difficulties,
- comorbid psychiatric illnesses and
- physical/sexual abuse.

Many individuals with eating disorders have affected relatives. It is thought there are genes conferring risk of developing the illness that interact with specific environmental factors to produce the illnesses.

How is it treated?

Bulimia nervosa and binge-eating

Most individuals with bulimia nervosa and binge-eating disorder can be treated as outpatients. The gold standard outpatient treatment for these conditions is cognitive-behavioural therapy, which has been demonstrated to be particularly effective in bulimia.

There is a role for antidepressant treatment as an adjunct to cognitive behavioural therapy.

It is rare for a patient with bulimia nervosa or binge-eating disorder to require hospital-based treatment, although some may require partial hospitalization or emergency medical interventions.

Anorexia nervosa

The majority of adults with anorexia nervosa of any severity will eventually require hospital or partial hospital-based treatment. There are no outpatient interventions that have been shown to be effective for anorexia.

However, adolescents with younger onset and shorter duration of illness may have a good response to a specific type of family therapy, the Maudsley method,

Marie's diagnosis and treatment

Marie presents with the classical symptoms of the purging type of anorexia nervosa. All her physical and lab findings are related to her state of starvation and dehydration.

The patient is reluctant to consider a diagnosis of anorexia nervosa, as she has heard most treatments are involuntary and involve long periods of bedrest.

You reassure her that information is out of date, provide your opinion that outpatient treatment is not likely to be helpful and offer to refer her to the nearest tertiary care centre with an expert program. She is offered a place in the program, but declines.

You continue to monitor her medically and a year later, when she has lost an additional 5 kg, she somewhat reluctantly agrees to enter the treatment centre.

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which is rapidly becoming the initial treatment of choice in this population.

What is the role of the family physician?

Because early identification and treatment tend to result in better outcomes, the family physician has a key role to play in diagnosis and access to specialized care. Treatment is often successful immediately if initiated in the first year of the illness, while treatment initiated later often takes five to seven years to produce good results. Sadly, as many as 20% of those diagnosed with anorexia nervosa may eventually die from their illness.

The medical management of these conditions is another important role for family physicians. For those with the restricting form of anorexia nervosa, monitoring cardiac function is essential. Pulse rates slower than 40 beats per minute, cardiac chest pain or palpitations, electrocaridogram (ECG) abnormalities and symptomatic orthostasis are indications for a visit to the emergency department (ED).

For bulimia nervosa, the monitoring of potassium levels in purgers is very important, with potassium levels < 2.5 mmol/L associated with ECG changes of cardiac symptoms warranting a referral to the ED. Dx