Information for Physicians and Other Health Care Professionals

As a health care professional you may see individuals with eating disorders during the course of your day-to-day practice. While prevention of an eating disorder is optimal, early identification and effective treatment are linked with positive outcomes.

Eating disorders are a range of illnesses characterized by psychological and behavioural disturbances associated with food and weight. Types of eating disorders include anorexia nervosa, bulimia nervosa, and binge eating disorder, as well as other specified feeding or eating disorders (OSFEDs). For definitions of these disorders, please go to: http://nedic.ca/clinical-definitions#Anorexia

Often, it is family members / caregivers who are the first to realize that there may be a problem. It is important to listen to parents / guardians / partners who express concerns about their family member's issues around food, body image and weight. In fact, it may be a family member who comes to see you first – often the individual with an eating disorder will not feel that there is a problem, or may feel embarrassed about seeking help.
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Prevention and Early Intervention

While prevention of an eating disorder is optimal, early identification and effective treatment is linked with positive outcomes.

Often, it is family members / caregivers who are the first to realize that there is a problem. It is important to listen to parents / guardians / partners who express concerns about their family member’s issues around food, body image and weight. It may be a family member who comes to see you first – often the individual with an eating disorder will not feel that there is a problem, or may feel embarrassed about seeking help.

Relationship between Dieting and Eating Disorders

- Body image dissatisfaction and subsequent dieting behaviour are the primary antecedents to disordered eating and eating disorders.
- As a practitioner, the most important action you can take is to never promote dieting behaviour – regardless of weight status. The emphasis should be on messages about healthy lifestyles and healthy choices.
- For the Canadian Paediatric Society’s position statement, Dieting in Adolescence please go to see http://www.cps.ca/en/documents/position/dieting-adolescence

How May a Person with an Eating Disorder Present

Individuals often present with apparently unrelated symptoms which are a result of disordered eating patterns or an undiagnosed eating disorder, including:

1. Physical
   - Low energy
   - Low iron
   - Menstrual disturbances or amenorrhea
   - Gastrointestinal symptoms
   - Type 1 diabetes and poor treatment adherence
   - Low body mass index (BMI) compared with age norms OR fluctuating weight.

2. Psychological
   - Depression, mood swings, anxiety
   - Substance abuse
   - Sleep disturbance
   - Lack of concentration
   - Obsessive symptoms, particularly related to food and weight
   - Self-harming behaviours
3. Social Difficulties

- Change in social pattern
- School or work problems
- Problems in the family and/or other relationships
- Involvement with the justice system

Key Screening Questions for an Eating Disorder

When an eating disorder is suspected, the issue can be explored through questions such as:

- Many people have concerns about food. Please tell me about your eating habits. Do you worry about your eating or do you think that others do?
- Some people have concerns about their weight. Please tell me how you feel about your body and weight?
- Some people have trouble with eating to the point of discomfort or until they are uncomfortable. Please tell me when this has been a problem for you?

If the person indicates having concerns, then ask more detailed questions in an empathetic and non-judgmental manner:

The SCOFF questionnaire has been determined to be a reliable five-question screening tool for individuals who may have anorexia nervosa or bulimia nervosa. (It will not identify binge eaters who are not thin).

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) or 14 pounds in a three month period?
- Do you believe yourself to be Fat when others say you are too thin?
- Would you say Food dominates your life?

* One point for every ‘yes’; a score of greater than 2 indicates further question is warranted.

http://ebm.bmj.com/content/8/1/390.full?sid=9e205ce3-e56c-4c24-8bd7-c2485779a0e2
What Should I Look for in Children and Adolescents?

Adolescents need to be considered separately and differentiated from adults with eating disorders (Society for Adolescent Medicine, 1995). Diagnostic criteria, such as the DSM-5 may not be reliable indicators for the following reasons:

• There is a wide variability in height and weight gain during normal puberty
• For girls, there may be an absence or unpredictability of menstrual periods in early puberty
• Lack of psychological awareness regarding abstract concepts (such as self-concept, motivation to lose weight or affective states)
• Clinical features such as pubertal delay, growth retardation or impairment of bone mineral acquisition may occur at sub-clinical levels of eating disorders.

Reliance on strict criteria may delay or preclude the early identification of eating disorders. Sub-clinical levels of disordered eating and significantly abnormal eating attitudes may result in significant long-term impairments to health. Therefore, for children and adolescents, assessment for the possibility of an eating disorder should occur if there is:

• Any evidence of excessive dieting (ex: omitting food groups, skipping meals, fasting, rigid rules around foods, rituals)
• Excessive concern with weight / body image;
• Weight fluctuations
• Failure to achieve appropriate increases in weight or height

If the assessment provides reason for concern, close monitoring and referral for further assessment is appropriate (Pediatrics, Committee on Adolescence, 2003). For more information please go to http://pediatrics.aappublications.org/content/126/6/1240.full.pdf+html

Obtaining an Eating History

1. Screen for important physical symptoms

- When was your last period?
- Have you noticed any weakness in your muscles? What about climbing stairs or brushing your hair?
- Are you more sensitive to the cold than other people?
- What is your sleep like?
- Have you fainted or had dizzy spells?
- Do you have any problems with your teeth (hot/cold sensitivity, etc.)?
- Have you had any problems with your digestive system?
2. Eliciting psychopathology
- What do you think of your current weight?
- Do you think you would feel different if your weight was lower?
- How do you think your life would be different if you lost weight?
- Do you ever get depressed or feel guilty?
- Do you ever feel suicidal?
- Do you have any special rules about exercise or food (e.g., eating only low calorie or fat-free foods, skipping meals or making yourself exercise before eating)?
- Do you have compulsions to do things (e.g., binge or over-exercise)?

3. Establishing eating behaviours
- Do you avoid eating with others?
- Which foods feel 'safe' and which do you avoid?
- Do you ever vomit, exercise, use laxatives and/or diuretics? If so, how often and when?

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**Checklist - Signs and Symptoms of Extreme Weight Loss**

**Reproductive function:**
- Loss of menstruation
- Fertility and pregnancy difficulties

**Musculoskeletal:**
- Myopathy particularly of the limb girdle muscles
- Pathological fractures
- Periodontal disease
- Osteopenia

**Cardiovascular:**
- Palpitations
- Syncope
- Postural & resting hypotension
- Bradycardia

**Renal:**
- Nocturia (night time urination)
- Renal stones
- Acute failure

**Skin and hair:**
- Loss of head hair
- Increase in body hair (lanugo hair)
- Raynaud’s (discoloration of fingers and/or toes)
- Self-mutilation
- Abrasions on knuckles
Metabolic:
- Hypoglycemia
- Liver dysfunction
- Hypercholesterolemia
- Hypothermia

Gastrointestinal:
- Delayed gastric emptying
- Constipation
- Barrett’s esophagus
- Tears on the esophagus

Central nervous system:
- Poor concentration
- Difficulty in undertaking complex thought

Checklist - Signs of Binging and Compensatory Behaviours (ex: Vomiting, Laxative Abuse, Over-Exercise)

Gastrointestinal tract:
- Teeth, loss of enamel, abrasions
- Salivary gland hypertrophy
- Upper and lower intestinal tract bleeding
- Abdominal distension
- Constipation

Renal:
- Edema
- Dehydration
- Kidney stones
- Kidney failure

Cardiovascular:
- Dysrhythmias (abnormal rhythms)
- Postural hypotension
- Electrolyte imbalance

Central nervous system:
- Hyperreflexia
- Carpopedal spasm
- Cramps
- Laryngospasm
For Diabetics:
- Insulin manipulation for weight loss

Physical Injury:
- Stress fractures

Checklist - Investigations/Tests that Physicians May Consider

Physical Exam
- A review of skin for lanugo hair, Raynaud's, abrasions on knuckles, self mutilation.
- An examination of teeth for loss of enamel, abrasions.
- Check lying and standing blood pressure for dehydration and reduced autonomic nervous system function.
- Check ability to rise from a squat for proximal myopathy.

Standard
- Complete Blood Count (CBC) with differential
- Urinalysis
- Complete Metabolic Profile: Sodium, Chloride, Potassium, Glucose, Blood Urea Nitrogen, Creatinine, Total Protein, Albumin, Globulin, Calcium, Carbon Dioxide, AST, Alkaline Phosphates, Total Bilirubin
- Serum magnesium
- Thyroid Screen (T3, T4, TSH)
- Electrocardiogram (ECG)

Special Circumstances
- 15% or more below healthy body weight (HBW)
- Chest X-Ray
- Complement 3 (C3)
- 24 Creatinine Clearance
- Uric Acid

20% or more below HBW or any neurological sign:
- Brain Scan

20% or more below HBW or sign of mitral valve prolapse:
- Echocardiogram

30% or more below HBW
- Skin Testing for Immune Functioning

Weight loss 15% or more below HBW lasting 6 months or longer at any time during course of eating disorder:
- Dual Energy X-Ray Absorptiometry (DEXA) to assess bone mineral density
- Estadiol Level (or testosterone in males)
• Medical tests often fall short of revealing problems until the more advanced stages of the illness. Patients engaging in dangerous behaviors may have normal test results.
• As a physician it is important to not only check for any medical complications that need attention, but also to establish a baseline for future comparisons.
• In cases where laboratory tests come back normal, it could be explained to the patient that this may not be an indicator of healthy functioning - but rather that the body finds ways to compensate for starvation; for example, decreasing the metabolic rate to conserve energy.

Evidence-Based Multi-Disciplinary Treatment

Unless otherwise noted, the following guidelines have been drawn from the National Institute of Clinical Excellence (NICE), Eating Disorders Treatment Guidelines that was published in January 2004. http://www.nice.org.uk/guidance/CG009

There are a number of broad areas of agreement regarding what makes treatment most effective for eating disorders. These are:
• Intervention at the earliest possible opportunity
• Family involvement / therapy is key to the success of treatment, particularly with children and adolescents and often beneficial when working with adults
• Treatment should begin with the least intrusive and then move to more intensive interventions only as warranted by the clinical situation
• In more complex cases, the involvement of clinicians from various disciplines including psychologists, social workers, general practitioners, occupational therapists, dietitians and nurses is warranted
• After weight restoration, follow-up care should be provided for at least 12 months.

No single professional or professional discipline is able to provide the necessary broad medical, nutritional, and psychiatric care necessary for recovery. A team of professionals who communicate regularly must provide this care. This teamwork is necessary whether the individual is undergoing inpatient or outpatient treatment.
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<th>Type</th>
<th>Treatment Goals</th>
<th>Treatment Components</th>
<th>Cautions</th>
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<tr>
<td><strong>Anorexia Nervosa (AN)</strong></td>
<td>• Reducing risk • Encouraging weight gain and healthy eating • Reducing other symptoms related to an eating disorder • Facilitating psychological and physical recovery.</td>
<td>Multi-disciplinary treatment with any combination of: • Medical monitoring • Treatment of any physical / medical conditions associated with the eating disorder • Psychological treatment: cognitive behavioural, interpersonal, focal dynamic (individual and group) • Motivational interviewing • Nutritional rehabilitation; individualized guidance and meal plans, trials of 'safe' and 'unsafe' foods • Dietary counselling • Family interventions, family counselling</td>
<td>• Rigid inpatient behaviour modification programs are not effective for AN. • Dietary counselling should not be used as the sole treatment for AN. • Pharmacological options should be de-emphasized prior to weight stabilization. • Cardiac side effects of any medications used should be considered due to compromised cardiovascular function</td>
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<td><strong>Bulimia Nervosa (BN)</strong></td>
<td>• Reducing harm • Establishing regular meals to reduce the urge to binge (King’s College, 2005) • Reducing other symptoms related to BN • Facilitating psychological and physical recovery</td>
<td>In less complex cases: • Evidence-based self-help program for BN Cognitive Behaviour Therapy (CBT-BN) along with medical monitoring and encouragement provided by general practitioner More complex cases: • Individualized combination of medical monitoring and psychological treatment – For example, CBT-BN nutritional counselling, family counselling and pharmacology. • As an alternative or additional first step to using an evidence-based self-help program, adults with bulimia may be provided with a trial of an anti-depressant drug. Selective serotonin reuptake inhibitors (SSRIs), especially fluoxetine, are the drugs of first choice in terms of acceptability, tolerability and reduction of symptoms. For individuals with BN the effective dose is higher than for depression (60 mg daily). Family involvement: • It is helpful to include the family in any plan of treatment, especially with children and adolescents. • However, the involvement of family and/ or friends can be beneficial to both the individual and family for older individuals also (King’s College, 2005). • Individuals with BN who have poor impulse control, particularly with substance use, may be less likely to respond to a standard program of treatment. In order to be effective, treatment should be adapted to the problems presented.</td>
<td>• Pharmacological options should not be the sole treatment response. • In situations where individuals do not respond to CBT-BN, or do not want CBT-BN, interpersonal psychotherapy (IPT) should be considered. However, people should be informed that it takes 8-12 months to achieve the same results as 4-5 months with CBT-BN. • Adolescents with BN may be treated with CBT-BN, adapted to be age appropriate, and including family, as appropriate.</td>
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| Binge Eating Disorder (BED) | • Reducing harm  
• Establishing regular meals to reduce the urge to binge (King’s College, 2005)  
• Reducing other symptoms related to BED  
• Facilitating psychological and physical recovery | In less complex cases:  
• Evidence-based self-help program for BED (ex: CBT-BED) along with medical monitoring and encouragement provided by general practitioner  
More complex cases:  
• Individualized combination of medical monitoring and psychological treatment – For example, CBT-BED  
• As an alternative or additional first step to using an evidence-based self-help program, adults with BED may be provided with a trial of an anti-depressant drug. Selective serotonin reuptake inhibitors (SSRIs) especially fluoxetine, are the drugs of first choice in terms of acceptability, tolerability and reduction of symptoms. For individuals with BED, the effective dose is higher than for depression (60 mg daily).  
Family involvement:  
• It is helpful to include the family in any plan of treatment, especially with children and adolescents.  
• However; the involvement of family and/or friends can be beneficial to both the individual and family for older individuals also (King’s College, 2005). | • Pharmacological options should not be the sole treatment response.  
In situations where individuals do not respond to CBT-BED, or do not want CBT-BED, interpersonal psychotherapy (IPT) should be considered. However; people should be informed that it takes 8-12 months to achieve the same results as 4-5 months with CBT-BED.  
• Adolescents with BED may be treated with CBT-BED, adapted to be age appropriate, and including family, as appropriate. |
| Other Specified Feeding and Eating Disorders (OSFED) | • Reducing harm  
• Establishing regular meals  
• Reducing other symptoms related to OSFED  
• Facilitating psychological and physical recovery | Follow the guidance on treatment of the eating disorder that most closely resembles the individuals’ eating disorder. | Pharmacological options should not be the sole treatment response. |

**Should I Prescribe a Specific Diet if an Individual is Overweight?**

As a practitioner, the most important action you can take is to never promote dieting behaviour – regardless of weight status. Rather, the emphasis should be on messages about healthy lifestyles and healthy choices. Body image dissatisfaction and subsequent dieting behaviour are the primary antecedents to disordered eating and eating disorders.

For the Canadian Paediatric Society’s position statement, Dieting in Adolescence please go to http://www.cps.ca/en/documents/position/dieting-adolescence
When to Refer for Further Psychiatric Assessment

Indications for referral for assessment include:

- Psychological complications: Co-morbid disorders (moderate to severe depression, obsessive-compulsive disorder, suicidal ideation, substance abuse including laxatives, steroids and nutritional supplements)
- Difficulties with treatment compliance and failure to progress
- Diagnostic uncertainty

When to Consider Hospitalization

Nearly all individuals with eating disorders can be treated on an outpatient basis. Hospitalization is a last resort and should only be considered when an individual is severely medically compromised or at risk of serious self-harm.

**Adults**
- Heart rate < 40 bpm
- Blood pressure <90/60 mm Hg
- Symptomatic hypoglycemia
- Potassium <3 mmol per liter
- Temperature < 36.1 c (97.0 F)
- Dehydration
- Cardiovascular abnormalities other than bradycardia
- Weight <75 per cent of the expected weight
- Any rapid weight loss of several kilograms within a short period of time
- Lack of improvement or rapid worsening while in outpatient treatment

**Children and Adolescents**
- Heart rate <50 bpm
- Orthostatic blood pressure resulting in increase in heart rate of >20 bpm or resulting in drop in blood pressure of >10 to 20 mm Hg
- Blood pressure <80/50 mm Hg
- Hypokalemia or hypophosphatemia
- Rapid weight loss within a short period of time
- Symptomatic hypoglycemia or fasting glucose <3.0 mmol per litre
- Lack of improvement or worsening despite outpatient treatment

**Psychological Indications**
- Poor motivation or insight (inability to recognize the seriousness of severe weight loss), lack of cooperation with outpatient treatment.
- Inability to eat independently or need for nasogastric feeding
- Suicidal plan, marked suicidal ideation
- Severe coexisting psychiatric disease
- Anti-therapeutic family environment, especially if abuse present

Publicly Funded Treatment Services

For information on treatment in hospital and community, see: eatingdisordersmanitoba.ca, or contact:

**Women’s Health Clinic – Provincial Eating Disorder Prevention & Recovery Program**
Phone: 204-947-2422, ext. 137 in Winnipeg
Phone: 866-947-1517, ext. 137 toll-free
Email: edprogram@womenshealthclinic.org
Website: [www.womenshealthclinic.org](http://www.womenshealthclinic.org)
Address: 419 Graham Ave, Winnipeg, MB

**Health Sciences Centre – Adult Eating Disorders Service Program**
Phone: 204-787-3482
Address: 771 Bannatyne Ave, Winnipeg, MB

**Health Sciences Centre – Child & Adolescent Eating Disorders Service Program**
Phone: 204-958-9660 Centralized Intake Service – Child & Adolescent Mental Health
Address: 771 Bannatyne Ave, Winnipeg, MB

For further information or educational resources, see:

**Eating Disorders Manitoba**
[www.eatingdisordersmanitoba.ca](http://www.eatingdisordersmanitoba.ca)

**Women’s Health Clinic – Eating Disorder Resources**

**Mental Health Education Resource Centre (MHERC)**
4 Fort Street – Suite 100, Winnipeg, MB R3C 1C4
Phone: 204-953-2355 Toll Free: 1-866-997-9918
Email: info@mherc.mb.ca Website: [www.mherc.mb.ca](http://www.mherc.mb.ca)
Resources

The following are links to clinical guidelines, position papers, frequently asked questions for practitioners, and research on various aspects of eating disorders.

**Academy for Eating Disorders** is an international transdisciplinary professional organization that promotes excellence in research, treatment and prevention of eating disorders.
   Website: www.aedweb.org

**Canadian Paediatric Society** re-affirmed its position statement on identifying and treating eating disorders in adolescents.
   Website: http://www.cps.ca/en/documents/position/dieting-adolescence

**Geneva Foundation for Medical Education and Research** is a non-profit organisation established in 2002 and supported by the Department of Health of the Canton of Geneva, the Faculty of Medicine, Geneva University and the Geneva Medical Association. The GFMER works in close collaboration with the World Health Organization (WHO). The Foundation’s website includes links to a range of guidelines and journal articles on eating disorder prevention, identification and treatment.
   GFMER Obesity, eating disorders: Guidelines, reviews, statements, recommendations, and standards.
   Website: http://www.gfmer.ch/Guidelines/Obesity_eating_disorders/Obesity_eating_disorders_mt.htm

**King’s College London Institute of Psychiatry at Maudsley’s** General Practitioners Guide to Eating Disorders is comprised of “Frequently Asked Questions for GPs” and contains many links including one to a comprehensive guide to the management and treatment of eating disorders in Primary Care produced by the Royal College of Psychiatrists.
   Website: http://www.kcl.ac.uk/iop/depts/pm/research/eatingdisorders/resources/GPsGUID20TOEATINGDISORDERS.pdf

**American Psychiatric Association** published guidelines Treating Eating Disorders in Primary Care in 2008.
   Website: http://www.aafp.org/afp/2008/0115/p187.html

**Ellyn Satter Institute** resources on developing healthy eating and healthy relationships to food for children/young adults
   Website: http://www.ellynsatterinstitute.org/