EATING DISORDERS

LAITH BAQAIN

EATING DISORDERS

Include 3 main disorders:
1. Anorexia nervosa
2. Bulimia nervosa
3. Binge-eating disorders

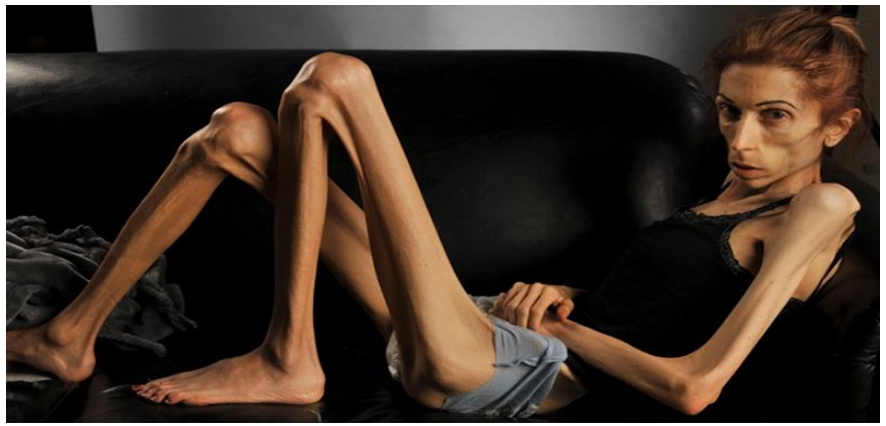
Most common in young females

ANOREXIA NERVOSA

- Intense fear of weight gain.
- Self-imposed dietary limitations, leading to severe weight loss resulting in inappropriately **low body weight** (BMI< 18.5 kg/m2).
- Body image distortion, 'feel fat' even when they are very thin.

If body weight cannot be described as significantly low, diagnosis = atypical anorexia nervosa.

- Mild: BMI > 17
- Moderate: BMI 16–17
- Severe: BMI 15–16
- Extreme: BMI < 15



ANOREXIA NERVOSA

The two main subtypes :

- **Binge-eating/Purging type:** Eating binges followed by purging behaviours (self-induced vomiting, laxative use, diuretic use). Some individuals purge after eating small amounts of food without binging. Over the last 3 months.
- **Restricting type:** Doesn't engage in purging behaviour. Weight loss is achieved through dieting, fasting, over-exercising. Repeatedly over the last 3 months.

PHYSICAL FINDINGS & COMPLICATIONS

Evidence of severe weight loss ; **Amenorrhea** , hypotension (especially orthostasis).

Constipation , **Lanugo** (fine , soft body hair typically found in newborns).

Peripheral Edema (from hypoproteinaemia), dry/brittle skin. Hypoglycemia

Vitamin deficiencies , muscle loss , weak bones(**osteoporosis**). Anemia & leukopenia.

Hypothyroidism. (Hormonal changes, multiple endocrine and metabolic abnormalities) . **Hypothermic**

Severe electrolyte abnormalities (sodium and potassium…) leading to **arrhythmias**.

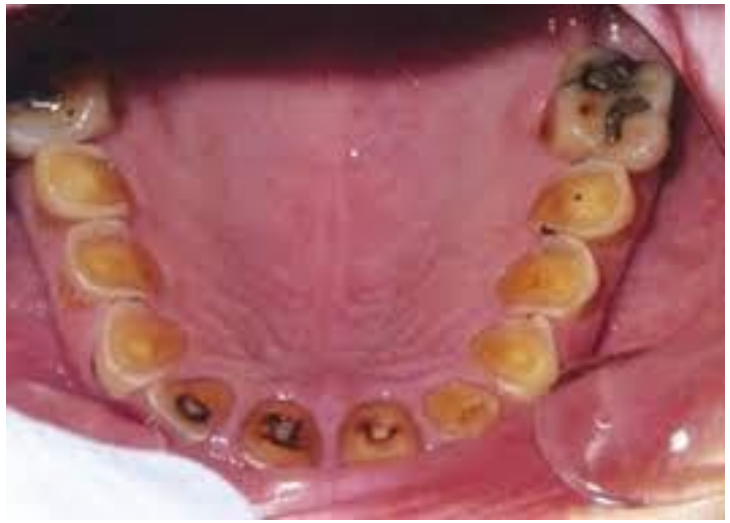
EKG findings as a result of potassium deficiency.

Most common cause of death is Cardiac arrhythmias.

ANOREXIA NERVOSA

Signs that distinguish **purging type** from **restricting type ;**

- bruised/calloused knuckles (Russell's sign). Can be seen in bulimia nervosa !
- Bad breath from vomiting
- Enamel erosion (stomach acid wears away the teeth)



LANUGO

ANOREXIA NERVOSA

Patients have a ***good appetite*** but starve themselves due to distorted body image.

Vs

Major depressive disorder: patients have a ***poor appetite*** which leads to weight loss .

EPIDEMIOLOGY

- **Ten to one** F:M ratio.
- More common in industrialized countries, where food is abundant and a thin body is idealized.
- Common in sports and professions which involve thinness and subjective judging (Ballet, cheerleading, figure skating, runway models…)

ANOREXIA NERVOSA

Course of disease : Chronic and relapsing. Most remit within 5 years.

Mortality rate is 5% per decade due to starvation, suicide, or cardiac failure.

Treatment : Food is the best medicine. Along with psychotherapy (CBT), some sources say OLANZAPINE (anti-psychotic) as it may promote weight gain.

When a patient with anorexia learns that weight gain is a common side effect he/she may refuse medication. Usually they are resistant to treatment.

BULIMIA NERVOSA

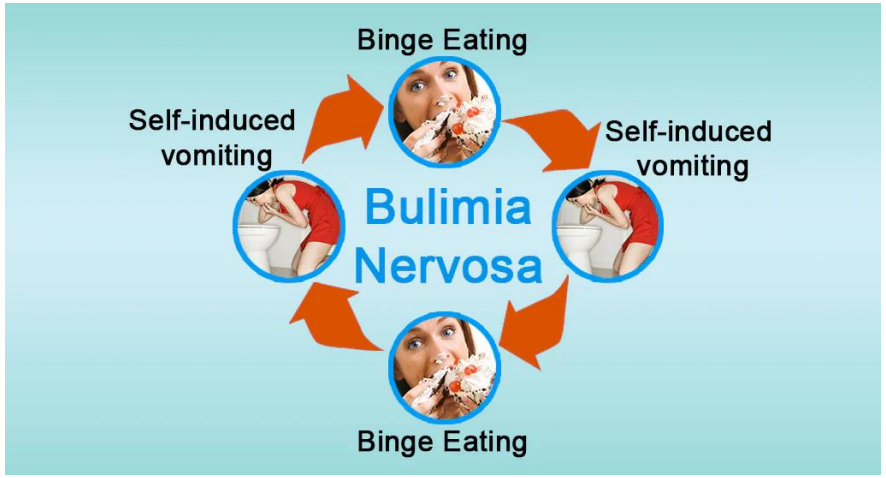
Similar to anorexia (purging type) : Recurring episodes of binge eating with compensatory purging behaviours at least weekly over the last 3 months.

If there is no compensatory behaviour the diagnosis is BINGE-EATING DISORDER.

Both bulimia and anorexia are characterized by a desire for thinness. But the distinguishing factor is the LOW BMI & RESTRICTION OF CALORIE INTAKE in anorexia.

Patients with anorexia and bulimia may have similar medical complications related to weight loss and vomiting.

10:1 F to M ratio



BULIMIA NERVOSA

- BMI is often Normal or even slightly overweight (18.5-24.9)
- Impulsive and emotional instability.
- Enlarged parotid gland (Because patients with bulimia typically induce vomiting multiple times a day, they are forced to produce excess amounts of saliva which causes their parotid salivary glands to become over-stimulated)
- Scars on the back of hand (Russell sign)
- Mallory-weiss syndrome
- Enamel erosion

TREATMENT : Psychotherapy, nutritional rehabilitation, anti-depresants (SSRI).

HOW TO DISTINGUISH

ANOREXIA NERVOSA

- Very thin, prefers to starve, v low BMI
- High self control
- Denies abnormal eating behaviour
- Turns away from food to cope

BULIMISA NERVOSA

- Normal BMI
- Impulsive & emotional instability
- Recognizes abnormal eating behaviour
- Turns to food to cope
- **More likely to have been overweight in the past.**

Question

- A 15-year-old girl is brought to the clinic by her mother, who found her vomiting in the bathroom. Her mother reports that the girl vomits daily after each meal. She is sometimes observed exercising excessively. She has numerous calluses on her hands as well as cavities and has not had her period in 3 months. She is 5’5’’ and weighs 90 pounds. What is her most likely diagnosis?
  - A. Bulimia nervosa
  - B. Anorexia nervosa
  - C. Eating disorder not otherwise specified
  - D. Obesity
  - E. Atypical depression

QUESTION

Classic case : A 20 year old college student is referred by her dentist because of multiple dental carries. She is normal in weight for her height, but feels that “she needs to lose 15 pounds” . She admits to eating large quantities of food in a short time and then inducing vomiting.

A. Bulimia nervosa

B. Anorexia Nervosa

C. Eating disorder

D. Obesity

E. Atypical depression

Anorexia vs Bulimia Nervosa

	Anorexia Nervosa	Bulimia Nervosa
Gender	W > M	W > M
Age	Mid-teenage years	Late adolescence/early adulthood
SES	Not specific to high	Not specific to high
Weight	>15% below ideal body weight	Varies, usually nl. or >nl.
Neurotransmitters	Serotonin/norepinephrine?	Serotonin/norepinephrine?
Binge/purge	Yes	Yes
Laxative/diuretics	Yes	Yes
Sexual adjustment	Poor	Good
Medical complications	• Amenorrhea • Lanugo • High mortality • Dental cavities • Electrolyte imbalances	• Electrolyte imbalances • Dental cavities • Callous on hands/fingers • Enlarged parotid and salivary glands • Cardiac abnormalities

BINGE-EATING DISORDER

Most common eating disorder in adults.

Patients with binge eating disorder suffer from emotional distress, but they do NOT try to control there weight by purging or restricting calories as anorexia and bulimia patients. Unlike anorexia and bulimia , patients with binge eating disorder **are not as fixated on their body shape and weight.**

They usually experience feelings of **shame, guilt and disgust.** They also eat well past the signs of fullness, frequently eat alone or in shame.

Patients are typically **OBESE,** and suffer from problems related to obesity (Metabolic syndrome, type 2 DM, CVS diseases.

Usually higher rates of psychiatric co-morbidities than in individuals without binge-eating disorder.

BINGE-EATING DISORDER

TREATMENT

- Psychotherapy ; CBT. With strict diet and exercise programs.
- Comorbid mood disorders or anxiety disorders should be treated.
- SSRI are first line treatment.
- Other pharmacotherapy drugs :

  LISADEXAMFETAMINE – Stimulant that suppresses appetite.

  Topiramate – Antiepileptic associated with weight loss.

  Orlistate – inhibits pancreatic lipase; which decreases amount of fat absorbed from the GI.