Eating Disorders and MEED

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Conflicts of Interests Declaration

- I have received fees for talks from:
  - Takeda
  - Bristol Myers Squib

Outline

- Quiz
- Prevalence & nomenclature
- Clinical features
- Detecting EDs
- Risk assessment
- Outline of psychiatric treatment
- How to ensure you are supported

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Quiz

1. Which patient group's frequency of p
   - Young males/males
2. What % of patients with anorexia ner
   - 5-10% at 10 years
   - 18-20% at 20 years
3. Which acronym aids you to detect a r
   - SCOFF
4. Give 3 risk factors that *may* prompt a

BBC News
June 2023

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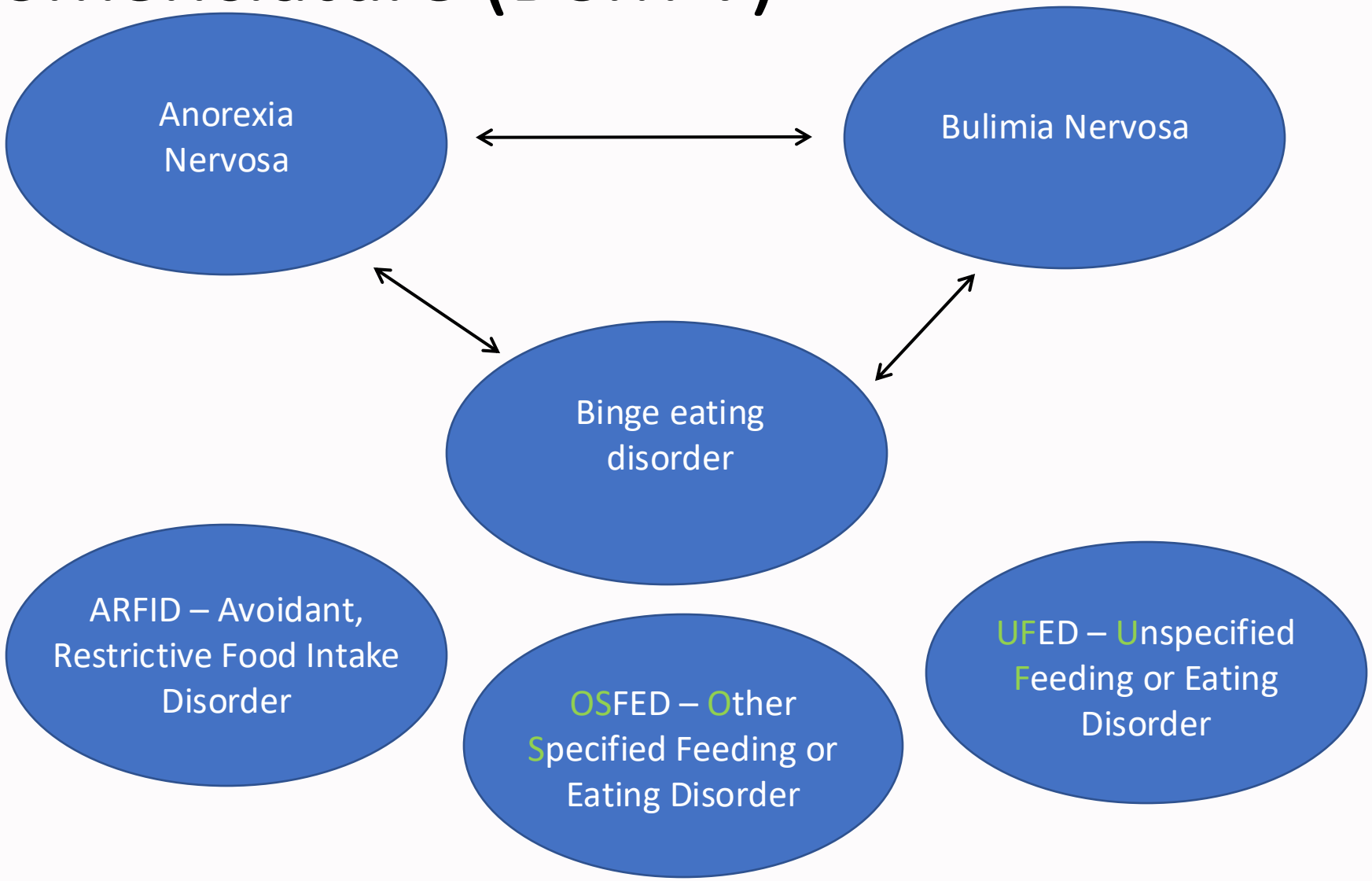
We are all seeing more patients

- Hospital admissions increased over 5 years
  - By 84% in all age groups
  - By 79% in adults
  - By 128% in males (all ages)

- High mortality
  - AN highest mortality of any psychiatric disorder
    - 20% AN deaths due to suicide
  - High rates of self-harm and depression

Nomenclature (DSM V)



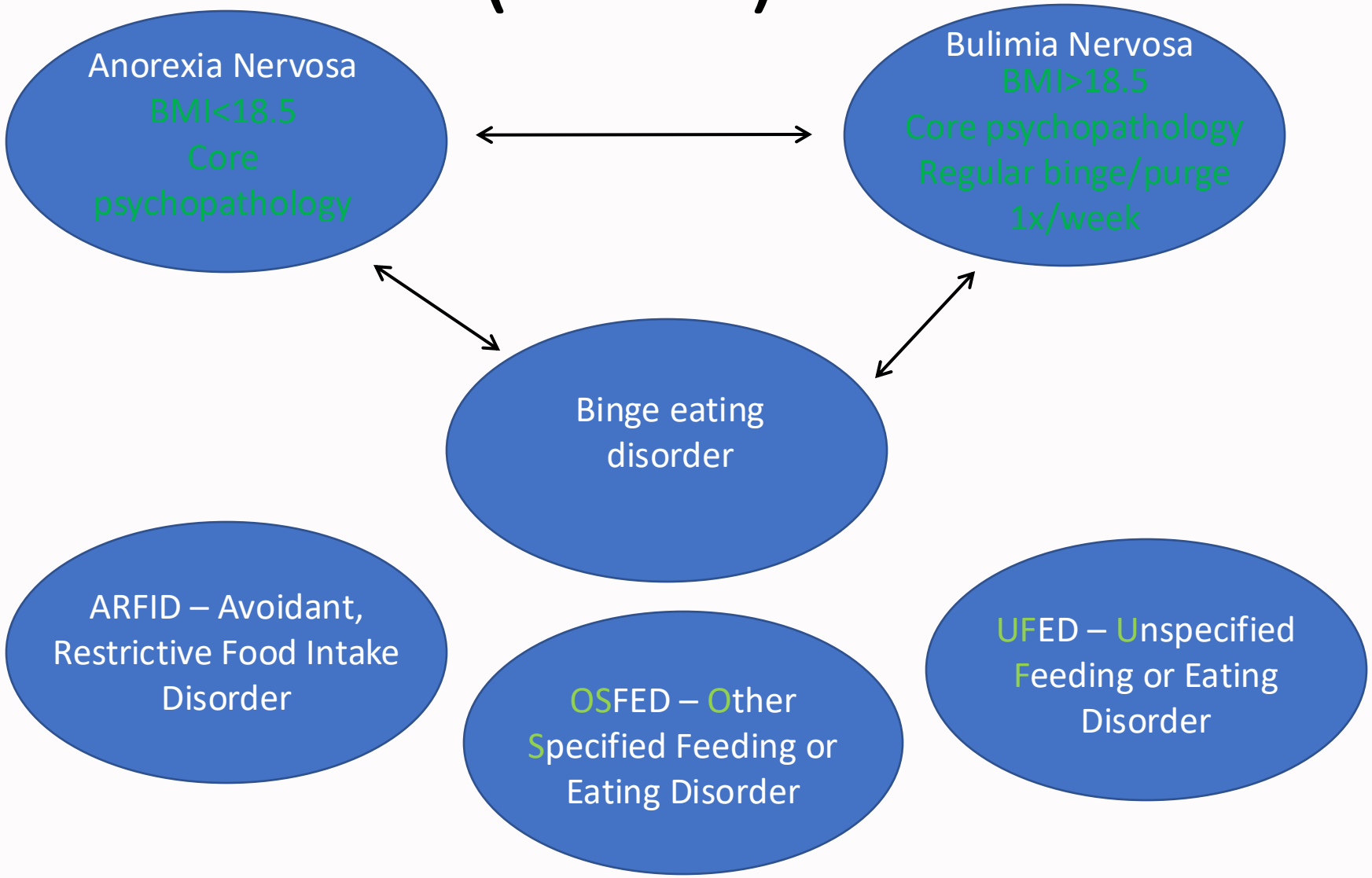
Nomenclature (DSM V)

Previously EDNOS – Eating Disorder Not Otherwise Specified

OSFED – Other Specified Feeding or Eating Disorder

UFED – Unspecified Feeding or Eating Disorder

Nomenclature (DSM V)



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Clinical Features

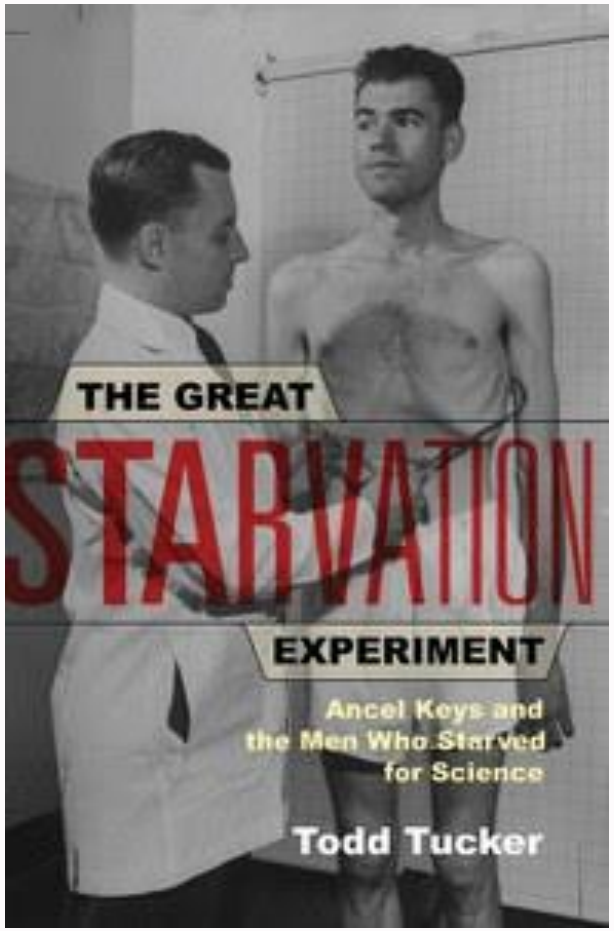
- Core psychopathology
- General psychopathology
- Behaviours
- Physical complications

Core Psychopathology

- Fear of fatness
- Pursuit of thinness
- Body dissatisfaction
- Body image distortion
- Self evaluation based on weight and shape

General psychopathology & Starvation Syndrome

- Minnesota experiment (Keys)
- Depression
- Anxiety, social phobia
- Suicidal ideation
- OCD symptoms



Common Behaviours

Anorexia nervosa

- Dieting
- Fasting
- Calorie counting
- Excessive exercise
- Water loading
- Diet pills, thyroxine, diuretics, appetite suppressants
- Excessive weighing
- Body checking
- Culinary behaviours
- Avoidance
- Isolation

Bulimia nervosa

- Bingeing
- Purging
- Starve-binge-purge cycle
- Misuse of insulin
- Laxatives
- DSH
- Substance misuse

Multiple complications

System	Starvation	Bingeing/purging
CVS	Bradycardia Hypotension Sudden death	Arrhythmias Cardiac failure Sudden death
Renal	Oedema Electrolyte abnormalities Renal calculi Renal failure	Severe oedema Electrolyte abnormalities Renal calculi Renal failure
GI	Parotid swelling **Delayed gastric emptying** Nutritional hepatitis Constipation	Parotid swelling Dental erosion Oesophageal erosion/perforation Constipation
Skeletal	Osteoporosis Pathological fractures Short stature	Osteoporosis Pathological fractures
Endocrine	Amenorrhoea Infertility Hypothyroidism	Oligomenorrhoea/amenorrhoea
Haem	Anaemia Leukopenia Thrombocytopenia	Leukopenia/lymphocytosis
Neuro	Generalised seizures Confusional states	Generalised seizures Confusional states
Metabolic	Impaired temperature regulation Hypoglycaemia	Impaired temperature regulation Hypoglycaemia
Derm	Lanugo, brittle hair and nails	Calluses on dorsum of hands (Russell's sign)

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Detecting an eating disorder

- Is this a new diagnosis??
  - SCOFF questionnaire ≥ 2 for anorexia/bulimia

  - 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 in a 3 month period?
  - Do you believe yourself to be FAT when others say you are too thin?
  - Would you say that FOOD dominates your life?

Morgan *et al.* BMJ 1999

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Assessing Risk

- MaRSiPAN 2010 and 2014
  - Management of Really Sick Patients with Anorexia Nervosa

- Now replaced by MEED, 2022
  - Medical Emergencies in Eating Disorders guidance on recognition and management

  - Not just anorexia
  - Combined management for adults/children
  - Diabetic-specific management

https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2022-college-reports/cr233

Assessing Risk

Factor	HIGH risk to life	High concern for impending risk to life	Low impending risk to life

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Wt loss	>1 kg/week for 2 weeks & low BMI	0.5-1 kg/week for 2 weeks & low BMI	Recent loss of <0.5 kg/week or fluctuating weight

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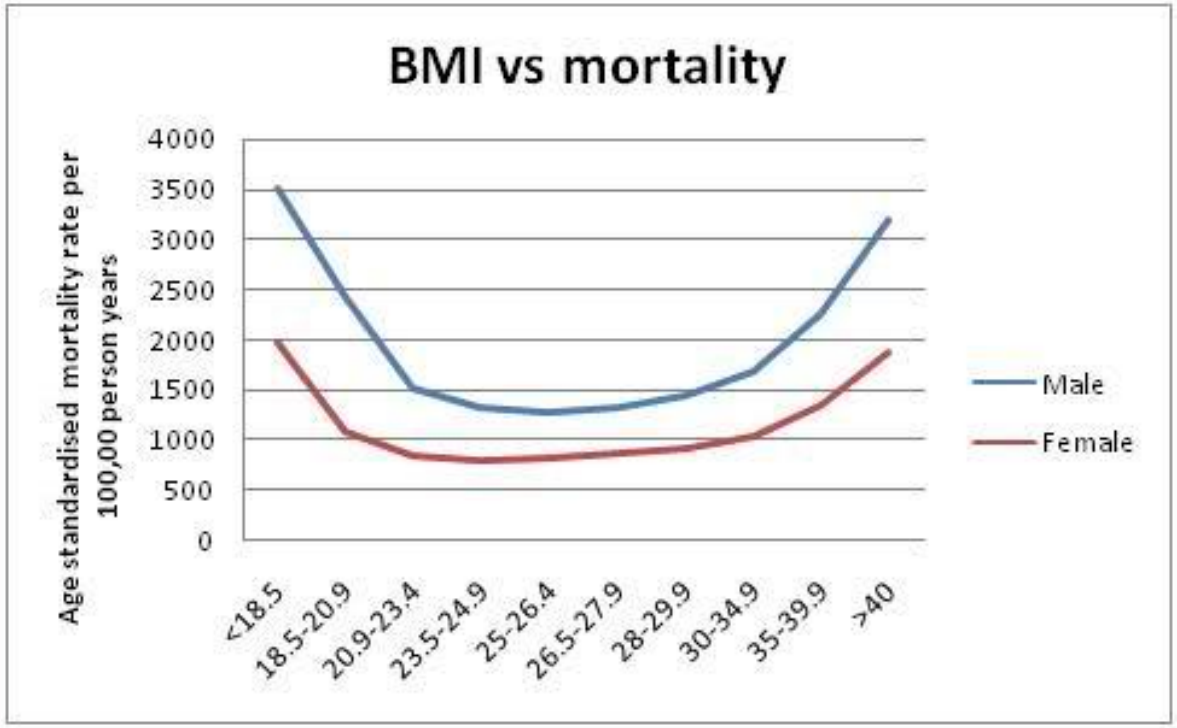
BMI	<13	13-14.9	>15

Body Mass Index

- BMI = wt(kg)/ht(m)^2
- <18.5 – AN
- <15 – moderate risk
- <13 – high risk
- Proxy measure of physical risk



Body Mass Index limitations

- Always interpret in context of clinical history & P/E
- Potential for manipulation
- Less reliable:
  - children; changes developmentally (www.cdc.gov/growthcharts)
  - rapid change in weight
  - extremes of height
  - men
  - bulimic features
  - fluid restriction/loading
  - physical comorbidity
  - pregnancy

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HR (awake)	<40	40-50	>50

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Systolic BP	<90 with recurrent syncope, postural BP drop >20 or HR increase >30	<90 with occ syncope, postural drop >15 or HR increase >30	Normal BP with no significant postural BP or HR changes

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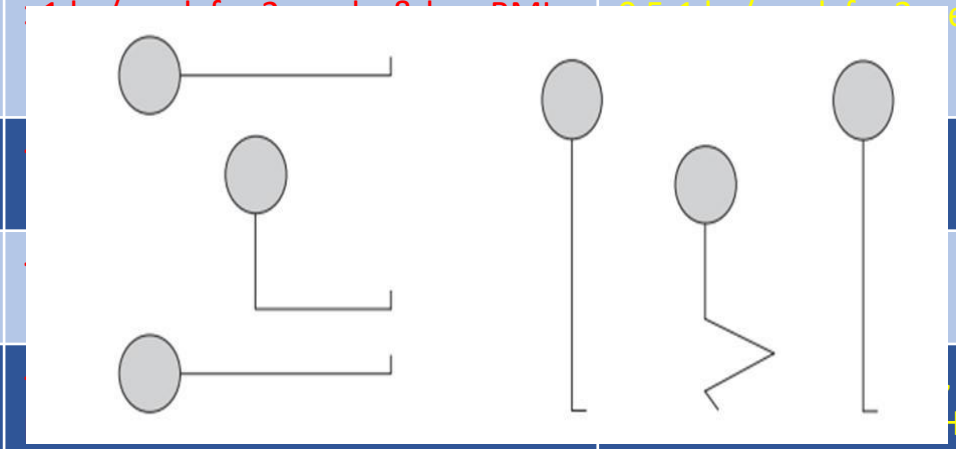
SUSS	Unable without using arms	Able with difficulty	Able with no difficulty



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SUSS	Unable without using arms	Able with difficulty	Able with no difficulty
ECG	QTc>450 (F) or >430 (M) and any other sig abnormality	QTc>450 (F) or 430 (M) but no other abnormality	Normal QTc

Assessing Risk

- Bloods
  - Guide admission if abnormal
  - Albumin usually normal
    - Not a nutrition marker

Don’t be falsely reassured if normal!

What to do next?

- Admit to dedicated area if high risk
  - Clear handover with plan
    - ? MH Section
    - ? NG feed
      - 20 kcal/kg/day

Physician
Dietitian
Lead Nurse

Mental Health Act, 1983

- Can we detain a patient with severe ED?
  - Yes
- Under what circumstances?
  - Significant risk to life
- Under what section?
  - Section 136 in A&E
  - Section 5 (2) from a ward
- Can we treat with NG feed?
  - Yes
- Under what section?
  - Section 2 (assessment, max 28 days, no extension)
  - Section 3 (treatment, max 6 months, can be extended)

What to do next?

- Admit to dedicated area if high risk
  - Clear handover with plan
    - ? MH Section
    - ? NG feed
      - 20 kcal/kg/day
  - Avoid ‘splitting’
  - Close liaison with psychiatrists
  - All should have pabrinex
  - Plus daily bloods (twice daily?) until normal

Physician
Dietitian
Lead Nurse

Ward environment

- Expect ‘anorexia-voice’ driven behaviours
  - Attempt to exercise ++
  - Desire to have hot baths/showers ++
  - Or be very cold (shivering)
  - ‘Fooling doctors’ when being weighed
    - Forums
  - Splitting teams
    - ‘He promised…/She said…
    - 16-18 year olds a particular risk

Language crucial

- Empathatic
- Distinguishing self vs. anorexia
- Understanding multiple drivers

Language crucial

- Empathatic
- Distinguishing self vs. anorexia
- Understanding multiple drivers
- Clear consistent messaging
  - Role of admission
  - How we are going to achieve this
- Expect pushback
  - Toddler training!

Nursing-specific guidance

- When under MHA Section
  - 1:1 supervision
  - NG visible at all times
  - Pump locked
  - No syringes left in room
  - Washes
    - Mainly bed baths
    - Shower x 1 weekly – with assistance

Nursing-specific guidance

- When under MHA Section
  - Strict bed rest
  - Wheel to bathroom on commode – supervision in bathroom at all times
  - No mobilising around bed
    - Walking
    - Standing
    - Fidgeting
    - Micro-exercising
  - Fluid balance chart (water loading)
    - May need fluid restriction (dietitian)
  - 4 hourly blood sugars
  - Weigh at random 3 x weekly

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Psychiatric treatments

- Usually done as an outpatient
- Most AN require specialist Rx
- BN & OSFED mainly treated in primary care or secondary services

- NG feeding last resort
- Treatment on a medical unit relatively rare

Psychiatric treatments

- Psychological intervention
  - MANTRA (Maudsley model for Anorexia Nervousa Treatment for Adults)
  - CBT (Cognitive Behavioural Therapy)
  - Guided self-help
  - CAT (Cognitive Analytic Therapy)
  - Psychodynamic psychotherapy
  - Family interventions
  - IPT (Interpersonal therapy)
  - DBT (Dialetic Behavioural Therapy)

- Medications
  - Fluoxetine 60mg daily in BN

- **Best services offer eclectic mix of therapies – not 'one size fits all'**
- **CBT is not the panacea**

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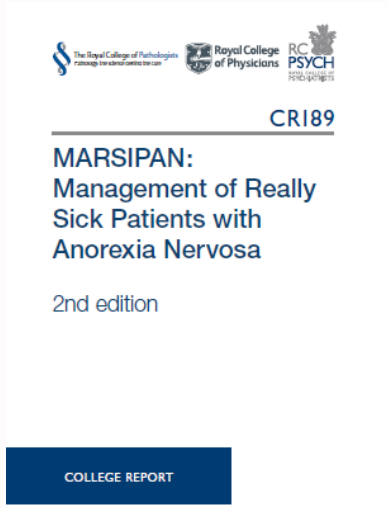
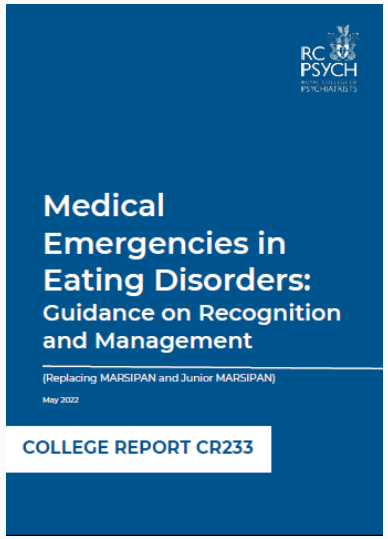
MARSIPAN and MEED reports





- Lack of coordinated care linked with ED deaths → MaRSiPAN (2010, 2014) → MEED (2022)

Recommendations:

- Develop local MEED care pathways for acute trusts which link in with community and inpatient ED services
- Coordinated care by MEED working group:
  - Physician with special interest in ED
  - ED/Liaison Psychiatrist +/- CMHT
  - Dietician and nutrition support team
  - Nursing team
- Regular MEED meetings

MEED care pathway

- Outlines local standards of care for ED patients in medical settings based on MEED report
- Should include:
  - Criteria for admission including referral process
  - Identified MEED ward
  - Medical monitoring
  - Dietetic support and NG feeding
  - Nursing care
  - **Management of challenging behaviours**
  - Transfer of care and discharge planning
  - MHA
  - Details of working group including ToR

MEED working group

- Essential
  - Physician with special interest in ED
  - ED Psychiatrist (inpatient and/or community)
  - Liaison Psychiatrist or CMHT representative
  - Gastro dietitian
  - Gastro nursing team
- If you can get them…..
  - Extended membership to core service MDTs
  - GP
  - Medical manager
  - AMU physician

MEED working group

- Meet at least quarterly
- Proactive approach to clinical care
- Monitor and review care pathway (clinical audit, tracker)
- Clear terms of reference
- Provide regular training
- Included in commissioning of services and job planning

Quiz

1. Which patient group's frequency of presentation is increasing fastest?
   - Young males/males
2. What % of patients with anorexia nervous are dead at 10 & 20 years?
   - 5-10% at 10 years
   - 18-20% at 20 years
3. Which acronym aids you to detect a new eating disorder?
   - SCOFF
4. Give 3 risk factors that *may* prompt admission?

Summary

- Be systematic
  - SCOFF to open up the conversation
  - MEED to guide admission/not
- Develop relationships with local ED team
- Ensure you are supported by MEED structure

Useful resources

- Royal College of Psychiatrists (2022) Medical Emergencies in Eating Disorders: Guidance on Recognition and Management (College Report CR233). Royal College of Psychiatrists.
- Royal College of Psychiatrists (2014) MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa (2nd edn) (College Report CR189). Royal College of Psychiatrists.
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