

EATING DISORDERS



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Striding for Quality

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Overview

- Introduction
- General characteristics
- Types of eating disorders
- DSM-5 diagnosis
- Etiology
- Comorbidity
- Treatment

General characteristic

- Marked disturbance in eating behavior, related thoughts and feelings.
- Including:
 - Anorexia nervosa.
 - Bulimia.
 - Binge Eating Disorder.
 - Obesity

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- Eating disorders are characterized by an overwhelming, consuming drive to be thin and a morbid fear of gaining weight and losing control over eating.
 - Mostly females are treated for eating disorders, although they can be experienced by males.
 - Onset is usually during adolescence, but can also be during early adulthood.

- Eating disorders can be overcome and it is important for the person to seek advice and treatment as early as possible, as eating disorders can have serious physical and psychological consequences.
- There is a commonly held view that eating disorders are lifestyle choice.
- Eating disorders are actually serious and often fatal illnesses, obsessions with food, body weight, and shape may also signal an eating disorders.

DSM-5 Types eating disorders

- Anorexia nervosa (often just called anorexia, which is the medical term for anyone who is off their food).
- Bulimia nervosa (often just called bulimia).
- Binge eating disorder.
- Other specified feeding or eating disorder (OSFED).
 - Avoidant/restrictive food intake disorder (ARFID).
 - Rumination disorder.
 - Pica.
- Unspecified feeding or eating disorder.

Anorexia nervosa

❖ serious, characterize By:

- Disturbed body image.
- Self-induced starvation.
- Morbid fear of fatness
- Serious malnutrition
- Mortality is 5-18%.

Diagnosis AN (DSM-V)

- Restriction of energy intake relative to requirements leading to a significantly low body weight in the context of age, sex.
- Intense fear of gaining weight or becoming fat, or persistent behavior that interferes with weight gain.
- Disturbance in one's body weight or shape , persistent lack of recognition of the seriousness of low body weight
- Specify:
 - Restricting type
 - Purging type/Binge Eating.

- **Restricting Type**: during last 3 months, the person has not engaged in recurrent episodes of binge eating or purging behavior
- **Binge-Eating/Purging Type**: during last 3 months, the person engaged in recurrent episodes of binge eating or purging behavior

Level of Severity

- Mild: BMI > 17 kg/m²
- Moderate: BMI 16-16.99 kg/m²
- Severe: BMI 15-15.99 kg/m²
- Extreme: BMI < 15 kg/m²

CLINICAL FEATURES

- PHYSICAL SIGNS:
 - Hypothermia.
 - Dependent odema.
 - Bradicardia.
 - Hypotension.
 - Lanugo Hair.
- ECG Changes:
 - ✓ Flat or invert T wave
 - ✓ Depressed ST Segment
 - ✓ Lengthening of QT Interval.

LABORATORY EXAMINATION

- Serum Electrolyte.
- Renal Tests.
- Thyroid Function.
- Glucose Level.
- Cholesterol Level.
- CBC.
- EEG.

Epidemiology:

- Life time prevalence 0.5- 3.7%
- Girls from 14- 18ys 0.5- 1%
- AN and BN 30 - 50%
- Death 3-8%
- Age: 10-30years.
- M:F ratio 1: 20
- In professions =modeling,ballet dancers.

Comorbidity of AN

- Depression ----- 65%
- Social phobia ----- 34%
- OCD ----- 26%

Biological Etiology :

- increased Concordance in MZ than DZ
- increased In familial with
 - depression
 - Eating disorders
 - Alcohol dependence.
- Decreased 3 Methoxy 4 hydroxy phenyl glycol(MHPG) in urine & CSF = norepinephrine turnover
- Decreased Endogenous opioid activity.
- Hypercortisolemia & non DST suppression.
- MRI= decreased volume of gray matter during illness.

PSYCHOLOGICAL ETIOLOGY:

- Reaction for independence.
- Lack of autonomy & selfhood.
- Over emphasis of thinness and exercise.
- Troubled parent relationship.
- Fear of pregnancy .

DIFERENTIAL DIAGNOSIS

- Medical illness[®] cancer, brain tumor.
- Depressive disorder.
- Somatization disorder .
- Bulimia (wt. loss less than 15%)

Prognosis

- 40% → recover.
- 30% → improve.
- 30% → chronic cases.

Treatment

- Outpatient.
- Inpatient : depend on degree of dehydration, starvation, & electrolyte imbalance and weight loss.
- Ensure weight gain
- Treatment of metabolic condition

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- HOSPITALIZATION: Recommended for patients who are 20 % below the expected.
 - Require hospitalization if patients are 30% less than expected→ two to six months .

PLAN OF TREATMENT

- Patient resists medication.
- Antidepressant
 - SSRI → Fluoxetine (Prozac)
 - Weight gain by cyproheptadine(periactin).
 - TCA → if nutritional status is ok .
- Group therapy:
 - Education
 - Supportive
 - Inspirational
- Individual psychodynamic (not effective)
- Family therapy
- Cognitive therapy

BULIMIA NERVOSA

BULIMIA NERVOSA

- Uncontrolled , rapid ingestion, Compulsive with in short time
- Followed by
 - Self-induced vomiting
 - Use of laxatives
 - Use of diuretics
 - Fasting
 - Exercise
- Specify type
 - Purging
 - Non purging

DSM-V Diagnostic Criteria

A. Recurrent episodes of binge eating:

1. Eating large amount in a discrete period of time
2. lack of control over eating

B. Recurrent compensatory behavior in order to prevent weight gain.

C. Binge eating and inappropriate compensatory behaviors is at least once a week for 3 months.

Level of Severity

- **Mild:** An average of 1-3 episodes of inappropriate compensatory behaviors per week
- **Moderate:** An average of 4 -7 episodes of inappropriate compensatory behaviors per week
- **Severe:** An average of 8 -13 episodes of inappropriate compensatory behaviors per week
- **Extreme:** An average of 14 or more episodes of inappropriate compensatory behaviors per week

Epidemiology

- Life time prevalence 1-4%
- Age 16-18 ys
- M:F 1:10.
- Occur in normal weight or obese.

Etiology

Biological

- decreased Norepinephrine and 5-HT
- increased Plasma endorphins after vomiting

psychological

- Patient have difficulties with adolescent demands.
- Bulimics are impulsive, angry, Self destructive sexual relation.
- Emotional Lability and suicide are at Risk.
- Binge Eating is Egodystonic so seeking more help.

Differential diagnosis

- Epileptic files.
- CNS tumors
- Borderline personality.
- MD.D

Course and Prognosis:

- Electrolyte imbalance (Hypomagnesaemia and Hyperamylasemia).
- Metabolic alkalosis.
- Esophagitis, Salivary Gland Enlargement.
- Dental caries.
- 60% recover within 5 years

Treatment

Hospitalization.

- Electrolyte imbalance.
- Metabolic alkalosis.
- For suicide

Pharmacological:

- Imipramine (Tofranil)
- Desipramine
- Trazadonce
- MAOI
- SSRI - Prozac

Psychological

- Increased Motivation - individual psychotherapy.
- Depression -cognitive therapy
- Group therapy

EATING DISORDER (NOS)

- AN but with regular menses.
- AN with weight within normal range.
- BN occur less than twice a week , or less than 3 months .
- Repeated chewing or spitting out large amount of food.
- Binge Eating Disorder in absence of compensatory behavior.

Binge eating disorder

- BED : recurrent binge eating but do not engage in the characteristic compensatory behaviors of bulimia nervosa.
- A common (30.1%) among subjects attending hospital-affiliated weight control programs.
- Rare in the community (2.0%).
- The disorder is more common in females than in males.
- Associated with severity of obesity and a history of marked weight fluctuations.

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- impairment in work and social functioning
 - Over concern with body/shape and weight
 - significant amount of time in adult life on diets
 - history of depression, alcohol/drug abuse, and treatment for emotional problems



❑ BE are associated WITH :

1. Eating much more rapidly than normal
2. Eating until feeling uncomfortably full
3. Eating large amounts of food when not feeling hungry
4. feeling disgusted with oneself, depressed, or very guilty afterwards

DSM-V Diagnostic Criteria for Binge Eating Disorder

- A. The binge-eating episodes are associated with three (or more) of the following:
 - 1. eating much more rapidly than normal
 - 2. eating until feeling uncomfortably full
 - 3. eating large amounts of food when not feeling physically hungry
 - 4. eating alone because of feeling embarrassed by how much one is eating
 - 5. feeling disgusted with oneself, depressed, or very guilty afterwards
- B. Marked distress regarding binge eating is present.
- C. The binge eating occurs, on average, at least once a week for three months.
- D. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior (for example, purging) and does not occur exclusive

Level of Severity

- Mild: 1-3 binge-eating episodes per week
- Moderate: 4-7 binge-eating episodes per week
- Severe: 8-13 binge-eating episodes per week
- Extreme: 14 or more binge-eating episodes per week

Association of binge eating disorder

- Major depression.
- Panic disorder.
- Bulimia nervosa.
- Borderline personality disorder.
- Avoidant personality disorder .

psychopathology binge eating disorder in obese

- history of frequent weight fluctuations.
- amount of time spent dieting.
- drive for thinness.
- feelings of ineffectiveness, stronger perfectionist attitudes
- impulsivity, less self-esteem.

Obesity

- Def: Characterized By excessive accumulation of fat in the body

Diagnosis: when the body wt. exceeds by 20% the standard wt. listed in ht-wt tables or according BMI, healthful BMI is range of 20 to 25.

Epidemiology:

- More in female by 6 times especially in lower social class
- More in female than male

Etiology:

Biological

- Impaired metabolic signal to the receptors in the hypothalamus after eating & remaining sense of hunger
- Leptin abnormality, act as a fat thermostat. While Patient level leptin is decreased more full in consumed.
- Baseline set patient (food in relation to energy to keep baseline fat store).

Genetic: 80% of patient have +ve family history.

Psychological:

- No Specific mental illness
- Stress produces hyperphagia
- Strong dependence needs produce overeating as compensation.

Differential diagnosis

- Metabolic: Cushing's disease
- Myxedema
- SRI[®] wt gain
- Anti-psychotic .

Treatment

- **Diet:** Balanced diet of 1.100 to 1.200 calories/day
- Supplemented iron, folic acid , Zn, vit B6.
- Side effect of modified fasting
 - Orthostatic hypotension
 - Impaired nitrogen balance.
- **Exercise.**
- **Drug:**
 - Orlistal (xenical) 260mg/d
 - Sibutramine (Meridia) 10-20mg/d
 - Mazindal (Anorex) 3-9mg/d

	Anorexia	Bulimia
	Disturbed body image	Binge eating
Ch.by	Weight loss ↓ 85% of expected.	Wt loss ↓ 15%
Specify type	Restricting Purging	Purging Non purging
Life time prevailing in female	0.5-3.7%	1-4%
Age of onset	10-30ys	16-18ys
M:F	1: 10 ↓MHPG in urine a CST	1:5 ↓ NE
Biological etiology	↓ endorphins	↓ 5-HT ↑ endorphins

	Anorexia	Bulimia
Treatment	Hospitalization	Hospitalization
	↑Weight	Metabolic alkalosis
	Metabolic balance	
Pharmacotherapy	SSRI	Tofranil
	Periactin	Norpromine
		MAOI
		SSRI
Psychological	Group therapy	Individual therapy
	Cognitive	Cognitive
	Family therapy	Group therapy

Other Specified Feeding and Eating Disorders (OSFED)

- Examples of presentations that can be specified using the “other specified” designation include the following:

Atypical anorexia nervosa:

- All of the criteria for anorexia nervosa are met, except that despite significant weight loss, the individual’s weight is within or above the normal range.

Bulimia nervosa (of low frequency and/or limited duration):

- All of the criteria for bulimia nervosa are met, except that the binge eating and inappropriate compensatory behaviours occur, on average, less than once a week and/or for less than 3 months.

Binge-eating disorder (of low frequency and/or limited duration):

- All of the criteria for binge-eating disorder are met, except that the binge eating occurs, on average, less than once a week and/or for less than 3 months.

Purging disorder:

- Recurrent purging behaviour to influence weight or shape (e.g., self-induced vomiting; misuse of laxatives, diuretics, or other medications) in the absence of binge eating.

Night eating syndrome:

- Recurrent episodes of night eating, as manifested by eating after awakening from sleep or by excessive food consumption after the evening meal.
- There is awareness and recall of the eating.
- The night eating is not better explained by external influences such as changes in the individual's sleep-wake cycle or by local social norms.
- The night eating causes significant distress and/or impairment in functioning.
- The disordered pattern of eating is not better explained by binge-eating disorder or another mental disorder, including substance use, and is not attributable to another medical disorder or to an effect of medication

Pica

- Persistent eating of nonnutritive, nonfood substances over a period of at least 1 month.
- The eating of nonnutritive, nonfood substances is inappropriate to the developmental level of the individual.
- The eating behavior is not part of a culturally supported or socially normative practice.
- If the eating behavior occurs in the context of another mental disorder (e.g., intellectual disability [intellectual developmental disorder], autism spectrum disorder, schizophrenia) or medical condition (including pregnancy), it is sufficiently severe to warrant additional clinical attention.

Rumination Disorder

- Repeated regurgitation of food over a period of at least 1 month. Regurgitated food may be re- chewed, re-swallowed, or spit out. The repeated regurgitation is not attributable to an associated gastrointestinal or other medical condition (e.g., gastro esophageal reflux, pyloric stenosis).
- The eating disturbance does not occur exclusively during the course of anorexia nervosa, bulimia nervosa, binge-eating disorder, or avoidant/restrictive food intake disorder.
- If the symptoms occur in the context of another mental disorder (e.g., intellectual disability [intellectual developmental disorder] or another neurodevelopmental disorder), they are sufficiently severe to warrant additional clinical attention.

Avoidant/Restrictive Food Intake Disorder

(ARFID)

- An eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating) as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:
- Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).
- Significant nutritional deficiency.
- Dependence on enteral feeding or oral nutritional supplements.
- Marked interference with psychosocial functioning.

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- The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice.
 - The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, and there is no evidence of a disturbance in the way in which one's body weight or shape is experienced.
 - • The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder.
 - When the eating disturbance occurs in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.

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- Unspecified Feeding or Eating Disorder (UFED)

