How to recognise and manage Anorexia Nervosa - Crib Sheet for General Practice

*To be used conjunction with Hampshire CAMHS Eating Disorder Pathway Appendix 3

Warning signs

- Preoccupation with body image, dieting, exercise
- Intense fear of gaining weight
- Significant weight loss or failure to gain weight during a period of growth
- Increased interest in preparation of food and calorific value of different foods, avoiding foods, eg chocolate, cake, meat, bread.
- Increased exercise
- Vomiting, misuse of laxatives or appetite suppressants
- Secondary amenorrhoea
- Mood, personality, social functioning change or other mental health difficulties e.g. obsessional behaviours

ICD - 11 Diagnostic Criteria for anorexia nervosa

- Weight loss, or in children lack of weight gain, leading to body weight at least 15% below normal or expected weight for age and height OR rapid weight loss (e.g. more than 20% of total body weight within 6 months) if other criteria met, even if current weight is normal or overweight.
- Weight loss is self-induced by avoidance of fattening foods, purging, excessive exercise.
- Self-perception of being too fat, intrusive dread of fatness, leading to self-imposed low weight threshold.
- Widespread endocrine disorder manifest in females as amenorrhoea (unless taking OCP) and males as a loss of sexual interest and potency may be seen but no longer required for diagnosis.

Always be suspicious if there is medically unexplained weight loss! Young person is likely to minimise or deny symptoms and not recognise the seriousness of low weight. Concern may only come from parent/carer/school.
Anorexia is much more common in females, but males can also be affected.

Questions to ask?

- Are you concerned about your weight?
- Have you been trying to lose weight? What is your ideal weight?
- Have you cut down on the amount you are eating?
- Are there foods you avoid?
- How much exercise do you do?
- Have you tried anything else to lose weight (vomiting, laxatives, diuretics, appetite suppressants)?
- Check for indicators of physical compromise (e.g. feeling cold, lightheaded, fainting, chest pain, palpitations)

Management

- Rapid exclusion of other conditions
  Differential diagnosis includes:
  - Endocrine – diabetes mellitus, hyperthyroidism, glucocorticoid insufficiency
  - Gastrointestinal – coeliac disease, inflammatory bowel disease, peptic ulcer
  - Oncological – lymphoma, leukaemia, intra-cerebral tumour
  - Chronic infection – tuberculosis, HIV, viral
  - Psychiatric – depression, autistic spectrum condition, obsessive compulsive disorder

- Risk assessment
  - Height, weight and Body Mass Index BMI (wt kg/ht m^2) and BMI centile if possible
  - Blood pressure (sitting and standing)
  - Heart rate (sitting and standing)
  - Temperature
  - Blood tests: FBC U&E LFTs TFTs ESR Ca Mg Phos Glucose Iron status Coeliac antibody screen *If vomiting suspected very important to check U&E for hypokalaemia and check bicarbonate
  - Self harm
  - ECG if underweight (<80% weight for height), pulse <50, frequent vomiting or any cardiac symptoms.

- Refer promptly to CAMHS every young person with probable anorexia nervosa. Please complete **online referral to SPA on Hampshire CAMHS website**. Please ensure that your referral includes **ALL** observations highlighted above on the Hampshire CAMHS referral form (or the referral will be delayed while we request you provide this information). This is in accordance with MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa (Available online P.16 Management in Primary Care)

- Refer to paediatrics any child with one or more criterion of red risk (see table below) with simultaneous referral to CAMHS.

- Medication
  - Have a low threshold for prescribing a Multivitamin od (eg Sanatogen Gold), Vitamin B co Strong tds (eg Berocca) and Thiamine 50mg tds to reduce the risk of re-feeding syndrome.
  - Prescription of the Oral Contraceptive or Hormone Replacement Therapy is **not** recommended.

Key points to consider

Young person may not be underweight yet be very unwell. Speed of weight loss is important to establish. A young person that is overweight may begin to diet, lose control and develop an eating disorder and be physically compromised at a 'normal weight'.

Children and adolescents become physically compromised more quickly than adults with the same weight loss. Therefore, they can move from low risk to high risk in a short space of time and need regular monitoring. Continued monitoring by primary care at least weekly is paramount while assessment at CAMHS is sought. After assessment we will offer physical monitoring as required. Refer early a 'wait and see' attitude is contraindicated.

If Anorexia Nervosa suspected always refer to CAMHS or seek advice from local CAMHS Consultation Line.

Further information is available in Hampshire CAMHS Eating Disorder Care Pathway including contact details for all Hampshire CAMHS teams.

Risk assessment Framework for Young People with Eating Disorders (from JUNIOR MARSIPAN)

	Red (high risk)	Amber (alert to high concern)	Green (moderate risk)	Blue (low risk)
BMI and weight	Percentage median BMI <70% (approx. below 0.4th BMI centile)	Percentage median BMI 70-80% (approx. between 2nd and 0.4th BMI centile)	Percentage median BMI 80-85% approx.. 9th-2nd BMI centile)	Percentage median BMI >85% (approx.. above 9th BMI centile)
Rate of weight loss	Recent loss of weight of 1kg or more/week for 2 consecutive weeks	Recent loss of weight of 500-999g/week for 2 consecutive weeks	Recent weight loss of up to 500g/week for 2 consecutive weeks	No weight loss over past 2 weeks
Heart rate	Heart rate (awake) <40bpm	Heart rate (awake) 40-50 bpm	Heart rate (awake)50-60 bpm	Heart rate (awake) >60bpm
Sitting blood pressure		Sitting BP systolic <0.4th centile (84-98 mmHg depending on age and gender); diastolic <0.4th centile (35-40mmHg depending on age and gender)	Sitting BP systolic <2nd centile (98-105 mmHg depending on age and gender); diastolic <2nd centile (40-45mmHg depending on age and gender)	Normal sitting blood pressure for age and gender with reference to centile charts
History of syncope/orthostatic cardiovascular change	History of recurrent syncope; marked orthostatic cardiovascular changes (fall in systolic BP of 20mmHg or more, or below 0.4th-2nd centile for age or increase in heart rate of >30bpm)	Occasional syncope: moderate orthostatic cardiovascular changes (fall in systolic BP of 15mmHg or more or diastolic BP fall of 10mmHg or more within 3 min standing or increase heart rate of up to 30bpm	Pre-syncopal symptoms but normal orthostatic cardiovascular changes	Normal orthostatic cardiovascular changes
Heart rhythm	Irregular heart rhythm (does not include sinus arrhythmia)			Normal heart rhythm
Peripheries			Cool peripheries, prolonged peripheral capillary refill time (normal central capillary refill time)	
ECG	QTc>460ms (girls) or 400 ms (boys) with evidence of bradycardia or tachyarrhymia (excludes sinus bradycardia and sinus arrhythmia) ECG evidence of biochemical abnormality	QTc>460ms (girls) or 400 ms (boys)	QTc<460ms (girls) or 400 ms (boys) and taking medication known to prolong QTc interval family history of prolonged QTc or sensorineural deafness	QTc<460ms (girls) or 400 ms (boys)
Hydration status	Fluid refusal Severe dehydration (10%): reduced urine output, dry mouth, decreased skin turgor, sunken eyes, tachypnoea, tachycardia	Severe fluid restriction Moderate dehydration (5-10%): reduced urine output, dry mouth, normal skin turgor, some tachypnoea, some tachycardia, peripheral oedema	Fluid restriction Mild dehydration (<5%): may have dry mouth or not clinically dehydrated but with concerns about risk of dehydration with negative fluid balance.	Not clinically dehydrated
Temperature	<35.5ºC tympanic or 35 ºC axillary	<36 ºC		
Blood abnormalities	Hypophosphataemia (<0.5) , **hypokalaemia** (<3 mmol/l –admit consider an HDU, PICU or ICU if <2–2.5 mmol/l) hypoglycaemia (<2.5), **hyponatraemia** (<130 mmol/l admit, consider an HDU, PICU or ICU if <120–125 mmol/l) urea >10	Hypophosphataemia (0.5-0.8), hypokalaemia (3-3.5mmol/l), hypoglycaemia (2.5-3.5) hyponatraemia (130-135), urea>7 hypocalcaemia magnesium 0.5-0.8 Hb 11-9 WCC 2.0-4.0 Neut 1.0-1.5 Plat 110-130 Bilirubin >20		

	hypocalcaemia magnesium <0.5 Hb<9 WCC <2 Neut <1.0 Plat <110 hypoalbuminaemia, bilirubin >40 ALP>200 ALT>90 AST>80	ALP>110 ALT>45 AST>40		
Disordered eating behaviours	Acute food refusal or estimated calorie intake 400-600 kcal/day	Severe restriction (less than 50% of required intake), vomiting, purging with laxatives	Moderate restriction, bingeing	
Activity and exercise	High levels of uncontrolled exercise in the context of malnutrition (>2h/day)	Moderate level of uncontrolled exercise in the context of malnutrition (>1h/day)	Mild level of uncontrolled exercise in the context of malnutrition (<1h/day)	
Self harm and suicide	Self poisoning, suicidal ideas with moderate to high risk of completed suicide	Cutting or similar behaviours, suicidal ideas with low risk of completed suicide		
Muscular weakness	Unable to stand from squat or sit from lying flat	Unable to stand from squat or sit from lying flat without using upper limbs	Unable to stand from squat or sit from lying flat without considerable difficulty	