Eating Disorders in the Primary Care Setting

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KEYWORDS

• Eating disorder • Anorexia nervosa • Bulimia nervosa • Binge eating disorder

KEY POINTS

- Primary care providers, in conjunction with therapists and nutritionists, can provide treatment for patients with less complex eating disorders.
- Eating disorders more commonly are diagnosed in white adolescent girls or young women, but other ethnic groups and men are also at risk, particularly with binge eating disorder.
- A primary goal in the treatment of all eating disorders is restoration to ideal body weight.
- In the absence of psychiatric comorbidities, there are few approved medications for eating disorders.

Eating disorders (ED), a complex set of illnesses, most commonly affect adolescent girls and young women.[1,2] Because primary care providers (PCPs) are likely to be the first, and sometimes only, physicians who encounter these patients, it is important for them to be able to diagnose and treat, or refer. Early diagnosis and treatment are associated with a higher rate of recovery, and extended illness is associated with potentially devastating consequences. At the same time, not all adolescent girls, young women, and men who are preoccupied with weight and body image present with ED. Careful attention to signs and symptoms, along with a welcoming, safe environment that allows for honest dialogue, will enable the physician to identify and treat patients with ED. Treatment commonly involves a team-based approach in which the PCP plays an integral role, along with a therapist and nutritionist. More complex patients may require the expertise of a psychiatrist and other medical specialists. For the less complex patient, the PCP can lend a whole-body approach to care, including the diagnosis and treatment of comorbid psychiatric conditions, such as depression and anxiety.

This article focuses on outpatient diagnosis and management of ED in adolescent and adult populations. Diagnosis and treatment of children, particularly premenarchal girls, largely follow the guidance set for adolescents and adults; however, additional attention needs to be placed on metabolic disorders, developmental considerations, growth rate, and other early milestones in the pediatric population.[3]

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DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, 5TH EDITION, AND EATING DISORDERS

Although ED are perceived to be a very recent phenomena, accelerated by cultural norms that emphasize thinness, anorexia nervosa (AN) was listed in the first Diagnostic and Statistical Manual of Mental Disorders (DSM-1) in 1952.[4] Indeed, descriptions of AN occur throughout history. The numbers of these illnesses have, however, increased over time.[5] This increase is likely related to cultural expectations and improved awareness among health care providers. It should be noted, however, that the relatively poor prognosis of AN did not change over the 20th century.[6] Binge eating disorder (BED) was included in DSM-5, published in 2013.

DSM-5 categorizes disorders of feeding and eating into 7 main groups. This article focuses on the 3 (**Table 1**) that are most likely to present in the PCP environment:

- AN
  - Restrictive subtype
  - Binge-purge subtype (AN-BP)
- Bulimia nervosa (BN)
- BED

Although DSM-5 provides explicit criteria and terminology to help aid in classification and establishment of a diagnosis, it is important to remember that patients with ED may not meet all criteria, and presentation may therefore be mixed and variable over time. Moreover, in the initial stage of illness, a patient may present to the PCP with more traditional primary care and/or somatic complaints that could represent an early signal that an ED workup is warranted. It is important to remember that early diagnosis and treatment may to lead to improved outcomes.[7,8] Fortunately, treatment approaches to subclinical cases largely mirror that for more definitive instances. From a practical standpoint, intervening when weight loss is less and behaviors are less entrenched and medical complications less severe may prove easier than when signs and symptoms are more pronounced.

Fear of weight gain and Criterion B for anorexia must also be applied in the context of dieting, social norms, and other factors leading to weight dissatisfaction.[9] Not all fear of gaining weight is a positive finding suggestive of Criterion B. Similarly, although individuals with ED may focus on a particular area of the body with which they are dissatisfied (commonly the abdomen, hips, and buttocks), preoccupation, repetitive behaviors, and impairment in social functioning related to this dissatisfaction are more consistent with body dysmorphic disorder than an ED.[10]

Patients rarely present to the PCP with a chief complaint of “eating disorder”; more commonly, patients present with one or more primary care complaints that signal signs or symptoms of ED behavior, including fatigue, cold intolerance, menstrual irregularity, or gastrointestinal (GI) issues such as abdominal pain and constipation.[11] Others may present with changes in weight as a chief complaint. Some patients, particularly those who visit the office with a parent, may present with a direct concern about an ED. Older patients may reluctantly present at the urging of a friend or loved one, stating something similar to, “my friend thinks I have an issue with my eating,” or “my boyfriend caught me purging”. Because most patients do not present with a complaint of ED, the suspicion will likely emerge during an interview for a more traditional primary care issue during which the patient is asked about appetite and food intake. **Box 1** lists common responses to questions about food intake that warrant formal screening.