Anorexia nervosa in adolescence

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Abstract

Eating disorders are complex mental health conditions with psychological, behavioural and physiological characteristics. Anorexia Nervosa (AN) represents a particular subtype of eating disorder and affects approximately 10% of the overall total. AN is significantly more common in young women than in young men and is the second most common mental health disorder in adolescent girls. It is a serious condition with the highest standardized mortality of any psychiatric condition. Optimal care requires input from a multi disciplinary team (MDT) providing collaborative medical, nutritional and psychological interventions which includes the family, dieticians, consultant psychiatrists, therapists, nurses, paediatricians and general practitioners. Important acute complications include refeeding syndrome, cardiac arrhythmias and heart failure. Family based therapy is the first line outpatient, psychological intervention for children and adolescents with AN. Nutritional rehabilitation is a fundamental component of treatment and early dietician involvement is crucial. Current outcomes for AN are variable and a firm evidence base for many areas of treatment has yet to be established.

Keywords adolescent; anorexia nervosa; eating disorder; refeeding syndrome; underweight

Classification & epidemiology

Eating disorders affect 1.6 million people in the UK of which it is estimated 10% of sufferers have AN. The UK incidence of diagnosed eating disorders increased significantly between 2000 and 2009 and there has been an increase in hospital admissions for eating disorders however, the incidence of AN has remained stable. The peak onset occurs in mid adolescence. Early onset is defined as onset less than <13 yrs of age with cases as young as 6 yrs reported. There is a marked gender bias in reported incidence. Approximately 9 in 10 of young people with eating disorders are female. It is estimated that 2 girls/1000 are likely to be newly diagnosed with an eating disorder each year making eating disorders the second most common mental health disorder in adolescent girls after depression. (Table 1)

Recognition, presentation and diagnosis

Body image concerns and dieting behaviours are so common in young people that parents or carers may be unaware of the eating disorder for many weeks and months and in the early stages may support the young person with weight loss. Anorexia nervosa is ***egosyntonic*** i.e. the illness is aligned with the young person's concept of themselves. This leads to denial of symptoms and ambivalence towards treatment and recovery. AN will often present as the parents or carers become concerned about the young person being underweight, losing weight rapidly or with concerns about eating, exercise or other behaviours. By the time the anorectic behaviours or their consequences are recognised the weight loss can be considerable with signs of physical adaptation to malnutrition and consequent physiological instability. Hence, a single consultation about eating behaviour or weight and shape concerns is a strong predictor of subsequent diagnosis of AN.

History in a young person suspected to have AN

When taking the history it is important to track when and how the initial concerns arose. The clinician should enquire about:

- Was the weight loss intentional and were there any identifiable triggers?
- How and when did they young person first attempt to control their weight?
- How much weight have they lost and over what length of time?
- What has been the recent pattern of weight loss?
- When did people become concerned? Who noticed first? When did the parents become concerned? Has the young person become concerned?
- How have people responded? What has already happened?

Young people with AN will avoid foods high in fat and/or carbohydrates and may adopt specific diets (e.g. vegetarian) to aid calorie restriction. Meal time behaviours such as wanting to control the food shopping or preparation, cooking but not eating, eating in isolation, taking a long time to complete meals, hiding food or crumbling and smearing food are common. A detailed dietary history by a dietician in conjunction with a 3-day food diary will allow current nutritional intake to be estimated.

Some young people with AN may restrict their fluid intake in an attempt to lose weight by dehydration or in the mistaken belief that water contains calorific content. Drinking excessive amounts of water can also be a feature of AN. The motivations behind this excessive water intake can vary and include using the water to suppress the sensation of hunger or to falsify weight by "water loading." They may be drinking excessively in the mistaken belief that it will "purify their system" or it may be a compulsive behaviour.

Excessive exercise is a common feature of AN and it is important identify all activities the young person undertakes during the week. The amount of exercise done alone or in secret is often underreported. Eating disorders are more common in those engaged in competitive sport and activities which require long hours of practice e.g. swimming, cycling, or distance running or are associated with an aesthetic e.g. dance, ice skating.

The clinician should enquire about bingeing and purging behaviours (self induced vomiting, using laxatives or other medications). Purging is often a hidden behaviour however parents may be alerted by the smell of vomit, the young person spending excessive amounts of time in the bathroom after meals. The use

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Diagnostic Criteria for anorexia nervosa from DSM V and ICD 10

DSM-5	ICD-10
Persistent restriction of energy intake leading to significantly low body weight (in context of what is minimally expected for age, sex, developmental trajectory, and physical health). Either an intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain (even though significantly low weight). Disturbance in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.	There is weight loss, or in children, a lack of weight gain, leading to a body weight at least 15% below the normal or expected weight for age and height. Weight loss is self induced by avoidance of fattening foods There is a self perception of being too fat, with an intrusive dread of fatness, which leads to a self imposed low weight threshold There is a widespread endocrine disorder involving the hypotahalamic-pituitary-gonadal axis manifest in women as amenorrhoea and in men as loss of sexual interest

Table 1

of laxatives, emetics and other medications is less common amongst young people with AN.

It is necessary to enquire how the young person perceives their weight, size and body shape by asking: are they happy with their body? What would they change about it given the chance? Enquire if they have specific weight, exercise or calorie intake targets.

Symptoms of dizziness are common and the clinician should enquire about episodes of syncope. Symptoms of hair loss, cold intolerance, skin breakdown and infrequent stooling are often present but may not be volunteered. Non-specific somatic pains, fatigue and sleep difficulties are common and with more marked underweight impairment of concentration, recall and cognitive processing become evident. It is important to seek symptoms to suggest other causes of rapid weight loss and underweight in young people (see Table 2). A menstrual history should be elicited in all female patients including age at menarche, early menstrual pattern and information on recent menstrual cycles (duration of bleeding and length of cycle) as well as whether the cycles have stopped and if so when? Ask if they know the weight when they last menstruated.

The medical history should include information on early life and include difficulties with attachment and feeding and enquire about traumatic feeding experiences (choking, force feeding, anaphylaxis) and any developmental concerns. Exploration of predisposing factors including family history of eating disorder, perfectionist personality traits,precipitating events such as psychological trauma (bullying, abuse or bereavements) and perpetuating factors (responses of family, coaches and friends) can help inform the formulation and aid diagnosis.

Physical examination

The young person should be weighed (in light clothing with no shoes and after voiding) and their standing height measured followed by observations of temperature, heart rate, blood pressure and lying/standing blood pressure and heart rate.

On inspection take note of the young person's appearance, body habitus and affect. Examination may reveal lanugo hair, self harm marks, acrocyanosis or secondary Raynaud's phenomenon. Specific inspection should be made for Russell's sign which are calluses over the metacarpophalyngeal joints of the index and middle fingers of the dominant hand from repeated exposure of skin to gastric contents during self induced vomiting. Assess the pulse rate, rhythm and volume for bradycardia. Inspection of the face may reveal parotid swelling (a sign of repeated vomiting) and sometimes carotinaemia. It is important to assess hydration status and capillary refill time as well as examine for signs of lymphadenopathy and thyroid dysfunction. Examine for signs of cardiac failure. Palpate the abdomen for tenderness, constipation and masses and complete a pubertal assessment. A targeted neurological examination including assessment of muscle bulk, tone and power, tendon reflexes coordination and gait along with fundoscopy, visual fields, pupillary responses and eye movements will provide reassurance that there is no neurological deficit suggestive of intracranial pathology. A pubertal assessment by the clinician is also a necessary part of the examination.

Assessment and investigation

Risk assessment

AN has the highest standardised mortality rate of any psychiatric disorder with deaths occurring from suicide and cardiovascular causes. Fortunately deaths from eating disorders in adolescence remain a rare event however the risk is increased at presentation due to the risk of refeeding syndrome. Eating disorders characterised by binge-purge cycles bring additional increase mortality and morbidity from electrolyte/acid base disturbance and visceral rupture. There are other risks of poor outcomes in young people with eating disorders which include the risk that they will not recover adequately in adolescence and will remain affected into adult life with a consequent increased risk of further morbidity and premature death.

The composite assessment of physical, psychological and treatment risk is complex and multi-dimensional. As most young people with AN can be treated on an outpatient basis assessing and analyzing this risk is a key part of the multi-disciplinary management.

Anthropometrics

The young person's height and weight should be plotted both on growth and BMI charts. Assessment of malnutrition also requires an understanding of the rate (grams per week) and extent of

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