

# Eating Disorders in Scotland

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Summary of Recommendations for  
Management and Treatment

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[www.nhshealthquality.org](http://www.nhshealthquality.org)

# Introduction

This document summarises the recommendations made in the NHS Quality Improvement Scotland (NHS QIS) report Eating Disorders: Recommendations for Management and Treatment. Copies of the full report are available from [www.nhshealthquality.org](http://www.nhshealthquality.org)

# General Principles of Management

## Individualised care and treatment

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NHS QIS

Care and treatment should be tailored to the needs of the individual patient

## The multidisciplinary model of care

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NHS QIS

Care for individuals with eating disorders should be based on a multidisciplinary model

## Management of physical aspects of an eating disorder

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NICE 1.1.4.1

Where laxative abuse is present, patients should be advised to gradually reduce laxative use and informed that laxative use does not significantly reduce calorie absorption(C)

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NICE 1.1.4.2

Treatment of both subthreshold and clinical cases of an eating disorder in people with diabetes is essential because of the greatly increased physical risk in this group (C)

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NICE 1.1.4.3

People with type 1 diabetes and an eating disorder should have intensive regular physical monitoring because they are at high risk of retinopathy and other complications (C)

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NICE 1.1.4.4

Pregnant women with eating disorders require careful monitoring throughout the pregnancy and in the postpartum period (C)

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NICE 1.1.4.5

Patients with an eating disorder who are vomiting should have regular dental reviews (C)

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NICE 1.1.4.6

Patients with an eating disorder who are vomiting should be given appropriate advice on dental hygiene, which should include: avoiding brushing after vomiting; rinsing with a non-acid mouthwash after vomiting; and reducing an acid oral environment (for example, limiting acidic foods) (C)

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NICE 1.1.4.7

Healthcare professionals should advise people with eating disorders and osteoporosis or related bone disorders to

refrain from physical activities that significantly increase the likelihood of falls (C)

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NHS QIS

Eating disorders teams should have close liaison with community dental services to ensure that patients with an eating disorder have access to appropriate dental services

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### **Children and adolescents**

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NHS QIS

Weight and height should be measured at intervals over time in children and adolescents presenting with an eating disorder and the results recorded on growth charts

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NHS QIS

Individuals involved in school health should receive training in eating disorders and communication networks established with specialist teams

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### **Transition between services**

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NHS QIS

There should be reciprocal arrangements between specialist services in different geographical areas in order to ensure no disruption of treatment and to avoid loss of contact with patients with eating disorders

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NHS QIS

Close liaison should take place between adolescent and adult services to ensure transfer at an appropriate stage rather than at an arbitrary age cut-off

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### **Information**

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NHS QIS

All healthcare professionals should be able to access and recommend high quality information and warn against dangerous information for patients and their families

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See further resources p 15

## Role of the GP and the Primary Care Team

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### NHS QIS

Primary care teams should include patients with severe chronic eating disorders on their registers of people with severe and enduring mental illness

### Opportunistic intervention

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#### NICE 1.1.6.3

Young people with type 1 diabetes and poor treatment adherence should be screened and assessed for an eating disorder (C)

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### NHS QIS

Opportunistic questioning in primary care should start with unthreatening questions and develop further using a recognised eating disorders questionnaire

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See further resources p 16

### Investigations

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#### NHS QIS

Physical assessment, tailored to the severity of the illness, should be routinely performed in patients with eating disorders

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#### NHS QIS

Very low weight (BMI<15), rapid weight loss (more than 0.5 kg in a week), frequent vomiting (more than once per day) and severe laxative abuse necessitate frequent physical monitoring

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#### NHS QIS

Baseline DXA scans should be carried out on all patients with anorexia nervosa

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#### NHS QIS

DXA scans should be repeated in patients with anorexia nervosa every two years to monitor for further bone loss until bone recovery has been achieved

## Referral to specialist services

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### NHS QIS

Referral to specialist services is indicated when the following clinical features are present.

#### **Anorexia Nervosa**

- continuing weight loss
- severe emaciation, eg BMI < 16
- marked vomiting or laxative abuse
- physical complications, eg hypotension
- when primary care interventions have failed
- when depression is marked and/or a risk of self harm
- co-morbid conditions such as pregnancy or diabetes

#### **Bulimia Nervosa**

- symptoms severe and persistent
- duration longer than 6 months
- other dyscontrol behaviours, eg shoplifting, wrist cutting, overdoses
- when depression is marked
- when simple advice/diaries have failed
- rapid weight loss even if not yet satisfying criteria for anorexia nervosa

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### NHS QIS

Referral to specialist services is very strongly indicated when the following are present.

#### **Anorexia Nervosa**

- BMI < 13.0
- rate of weight loss continuing at >1 kg per week
- vomiting more frequently than once per day
- heavy laxative use
- prolongation of QTc interval or other significant ECG abnormality
- core temperature < 34°C
- muscle weakness - unable to rise from a squat without use of arms for leverage
- pulse rate less than 40 per minute or systolic blood pressure (BP) less than 80 mm/Hg
- major abnormality of biochemistry or haematology
- signs of significant cognitive impairment

### **Bulimia Nervosa**

- persistent suicidal thinking
- persistent deliberate self-harm
- rapid weight loss although not yet satisfied criteria for anorexia nervosa
- major abnormality of biochemistry or haematology

### **Where to get further help**

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#### NHS QIS

With illnesses that are severe and/or treatment resistant, GPs should seek specialist advice or referral

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#### NHS QIS

Patients should be advised of all types of help and support available such as self-help groups and internet resources

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#### NHS QIS

Information on eating disorder services in Scotland should be easily accessible for healthcare professionals and patients

# Anorexia Nervosa

## Outpatient care

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### NHS QIS

Integrated care pathways should be developed for the care of patients with anorexia nervosa

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### NHS QIS

Care for patients with anorexia nervosa should consist of:

- good general supportive care
  - motivation enhancement alongside appropriate psychological treatments
  - good medical management, and
  - good nutritional care
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### NHS QIS

Responsibility for physical assessment and monitoring should be clarified between primary care and mental health services

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## Psychological treatments

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### NHS QIS

A choice of psychological treatments for anorexia nervosa should be available as part of mental health services in all areas

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## Pharmacological treatments

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### NICE 1.2.3.1

Medication should not be used as the sole or primary treatment for anorexia nervosa (C)

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### NICE 1.2.3.2

Caution should be exercised in the use of medication for co morbid conditions such as depressive or obsessive – compulsive features as they may resolve with weight gain alone (C)

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### NICE 1.2.3.3

When medication is used to treat people with anorexia nervosa, the side effects of drug treatment (in particular, cardiac side effects) should be carefully considered and discussed with the patient because of the compromised cardiovascular function of many people with anorexia nervosa (C)

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#### NICE 1.2.3.4

Healthcare professionals should be aware of the risk of drugs that prolong the QTc interval on the ECG; for example, antipsychotics, tricyclic antidepressants, macrolide antibiotics and some antihistamines. In patients with anorexia nervosa at risk of cardiac complications, the prescription of drugs with side effects that may compromise cardiac functioning should be avoided (C)

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#### NICE 1.2.3.5

If the prescription of medication that may compromise cardiac functioning is essential, ECG monitoring should be undertaken (C)

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#### NICE 1.2.3.6

All patients with a diagnosis of anorexia nervosa should have an alert placed in their prescribing record concerning the risk of side effects (C)

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#### NICE 1.2.4.2

Regular physical monitoring, and in some cases treatment with a multi-vitamin supplement in oral form, is recommended for people with anorexia nervosa during both inpatient and outpatient weight restoration (C)

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#### NHS QIS

Mineral supplements may be required especially in the early stages of re-feeding for anorexia nervosa

### **Intensive treatments (including assertive outreach, day programmes or inpatient care)**

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#### NHS QIS

Patients with anorexia nervosa who require intensive treatment should have access to assertive outreach, day hospital care and inpatient care intensive treatment

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#### NHS QIS

Admission to hospital should be considered when:

- the patient's condition is life threatening as a result of either starvation and/or purging and/or exercise and/or infection or other physical health problems
- a self-harming overdose is suspected. Relatively small overdoses are potentially life threatening in starvation
- inpatient treatment is required for treatment of a comorbid condition such as psychosis, obsessive compulsive disorder (OCD) or severe depression

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NHS QIS

Each specialist service should ensure that its operational policies include plans for clear communication between themselves and general medical services

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NHS QIS

When patients are admitted for treatment of anorexia nervosa this should be at a setting which is as near home as possible to facilitate involvement of relatives and carers and to ensure close liaison and continuity with those involved in treatment before and after the inpatient phase of treatment

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NICE 1.2.5.5

People with anorexia nervosa requiring inpatient treatment should be admitted to a setting that can provide the skilled implementation of refeeding with careful physical monitoring (particularly in the first few days of refeeding), in combination with psychosocial interventions (C)

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**Anorexia nervosa in children & adolescents**

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NICE 1.2.2.13

Family interventions that directly address the eating disorder should be offered to children and adolescents with anorexia nervosa (B)

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NHS QIS

Adolescent anorexia patients should be admitted to an adolescent unit which has experience of managing the condition

# Bulimia Nervosa

## Self help

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### NICE 1.3.1.1

As a possible first step, patients with bulimia nervosa should be encouraged to follow an evidence-based self-help programme (B)

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### NICE 1.3.1.2

Healthcare professionals should consider providing direct encouragement and support to patients undertaking an evidence-based self-help programme as this may improve outcomes. This may be sufficient treatment for a limited subset of patients (B)

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## Psychological treatments

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### NICE 1.3.1.3

Cognitive behaviour therapy for bulimia nervosa (CBT-BN), a specifically adapted form of CBT, should be offered to adults with bulimia nervosa. The course of treatment should be for 16 to 20 sessions over 4 to 5 months (A)

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### NHS QIS

Additional sessions of CBT should be offered if the patient is benefiting from the treatment and likely to make further progress

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### NICE 1.3.1.4

When people with bulimia nervosa have not responded to or do not want CBT, other psychological treatments should be considered (B)

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### NICE 1.3.1.5

Interpersonal psychotherapy (IPT) should be considered as an alternative to CBT, but patients should be informed it takes 8–12 months to achieve results comparable with cognitive behaviour therapy (B)

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### NHS QIS

When co-morbidity is present in patients with bulimia nervosa other psychological treatments in addition to CBT may be considered

## **Pharmacological management**

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### NICE 1.3.2.1

As an alternative or additional first step to using an evidence-based self-help programme, adults with bulimia nervosa may be offered a trial of an antidepressant drug (B)

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### NICE 1.3.2.2

Patients should be informed that antidepressant drugs can reduce the frequency of binge eating and purging, but the long-term effects are unknown. Any beneficial effects will be rapidly apparent (B)

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### NICE 1.3.2.5

No drugs, other than antidepressants, are recommended for the treatment of bulimia nervosa (B)

## Atypical eating disorders, including binge eating disorder

### Self help

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#### NICE 1.4.2.1

As a possible first step, patients with binge eating disorder should be encouraged to follow an evidence-based self-help programme (B)

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#### NICE 1.4.2.2

Healthcare professionals should consider providing direct encouragement and support to patients undertaking an evidence-based self-help programme as this may improve outcomes. This may be sufficient treatment for a limited subset of patients (B)

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### Psychological treatments

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#### NICE 1.4.2.3

Cognitive behaviour therapy for binge eating disorder (CBT-BED), a specifically adapted form of CBT, should be offered to adults with binge eating disorder (A)

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#### NICE 1.4.2.4

Other psychological treatments (interpersonal psychotherapy for binge eating disorder and modified dialectical behaviour therapy) may be offered to adults with persistent binge eating disorder (B)

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#### NICE 1.4.2.5

Patients should be informed that all psychological treatments for binge eating disorder have a limited effect on body weight (A)

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#### NHS QIS

Psychological treatments for binge eating disorders should be provided as a group intervention where possible

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### Pharmacological treatments

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#### NICE 1.4.3.1

As an alternative or additional first step to using an evidence-based self-help programme, consideration should be given to offering a trial of an SSRI antidepressant drug to patients with binge eating disorder (B)

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#### NICE 1.4.3.2

Patients with binge eating disorders should be informed that SSRIs can reduce binge eating, but the long-term effects are unknown. Antidepressant drug treatment may be sufficient treatment for a limited subset of patients (B)

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## Management of long-term eating disorders

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### NHS QIS

There should be a clear and preferably written agreement between the patient, the GP and the secondary care service about the nature and frequency of monitoring

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### NHS QIS

The following are recommended as the minimum for monitoring

- 1 Re-engagement in active treatment should be offered at each contact
- 2 Weight should be monitored six-monthly
- 3 Suicide risk and mental state should be assessed six-monthly
- 4 Routine blood tests should be checked annually
- 5 A physical examination should be done annually
- 6 A DXA bone scan should be done every two years to monitor bone density and identify osteoporosis
- 7 Annual dental checks for palatal dental erosion for patients who vomit or who chew and spit whatever their weight
- 8 The results of the monitoring should be discussed with the patient and used as one part of helping the patient develop motivation for change
- 9 Active medical treatment should be offered for physical complications where appropriate though often the most appropriate treatment will be re-nutrition and weight gain

# Minimum data set

The following items should be collected at first contact with any eating disorder patient and repeated at regular intervals for patients in active treatment or being monitored. It should, wherever possible, be communicated whenever a patient is referred to a different level of service.

**Minimum Data Set for all Eating Disorders Patients**

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1 **Height**  (in metres)      2 **Weight**  (in kilos) = BMI

3 **If patient refuses to be weighed**, note this and rate:  
 Emaciated       Very underweight       Moderately underweight       Normal weight range   
 Obesity:       Mild       Moderate       Severe

4 **Weight trend** (last 2 months):  
 Rapidly falling       Slowly falling       Steady       Slowly rising       Rapidly Rising

5 **Duration of symptoms overall**  years/months      this episode  years/months

6 **Menstrual Status:**  
 Primary amenorrhea  Yes       No      **OR**  
 Current menstrual status  
 Regular cycles  Irregular / chaotic       Oligomenorrhea       Secondary amenorrhea   
 Date of last cycle

7 **Blood Pressure:** Record if standing / sitting / lying      Systolic       Diastolic

8 **Significant Complicating / risk factors:**  
 Excess Alcohol intake  Yes       No  
 Drug Misuse  Yes       No  
 Depressive Disorder  Yes       No  
 Other (please specify)

9 **Bingeing Behaviour:** Record frequency per week

10 **Purging Behaviour:**  
 Record Nature of purging       Record frequency per week

11 **Exercise:** Is excessive exercise being used to promote weight loss?  Yes       No  
 If yes record frequency per week

12 **Clinical Global Impression:**

<b>CGI 1: Severity of Illness</b> Considering your total clinical experience with this particular population, how ill is the patient at this time?	<b>CGI 2: Global Improvement</b> Rate total improvement since the start of treatment. Compared to his (her) condition, how much has he (she) changed?
Score	Score
1. Normal / not at all ill <input type="checkbox"/>	1. Very much improved <input type="checkbox"/>
2. Borderline ill <input type="checkbox"/>	2. Much improved <input type="checkbox"/>
3. Mildly ill <input type="checkbox"/>	3. Minimally improved <input type="checkbox"/>
4. Moderately ill <input type="checkbox"/>	4. No change <input type="checkbox"/>
5. Markedly ill <input type="checkbox"/>	5. Minimally worse <input type="checkbox"/>
6. Severely ill <input type="checkbox"/>	6. Much worse <input type="checkbox"/>
7. Among the most extremely ill patients <input type="checkbox"/>	7. Very much worse <input type="checkbox"/>

13 **Blood Tests:** Minimum is Full Blood Count and U&Es

## Further resources

The following websites contain comprehensive and sensible information.

- 1 Eating Disorders Association [www.edauk.com](http://www.edauk.com)
- 2 Scottish Eating Disorders Interest Group  
[www.sedig.members.beeb.net](http://www.sedig.members.beeb.net)
- 3 Royal College of Psychiatrists [www.rcpsych.ac.uk](http://www.rcpsych.ac.uk)
- 4 NHS Health Scotland [www.healthscotland.com](http://www.healthscotland.com)
- 5 Institute of Psychiatry/Maudsley Hospital  
[www.iop.kcl.ac.uk](http://www.iop.kcl.ac.uk)
- 6 [www.something-fishy.org](http://www.something-fishy.org)
- 7 US Department of Health and Human Services  
[www.girlpower.gov](http://www.girlpower.gov)
- 8 Eating Disorders Association of the Republic of Ireland  
[www.bodywhys.ie](http://www.bodywhys.ie)
- 9 The Somerset and Wessex Eating Disorders Association  
[www.swedauk.org](http://www.swedauk.org)
- 10 National Eating Disorders Organisation USA  
[www.nationaleatingdisorders.org](http://www.nationaleatingdisorders.org)
- 11 Anorexia Nervosa Intensive Treatment Team  
[www.aniff.org.uk](http://www.aniff.org.uk)
- 12 National Institute of Health and Clinical Excellence  
[www.NICE.org.uk](http://www.NICE.org.uk)

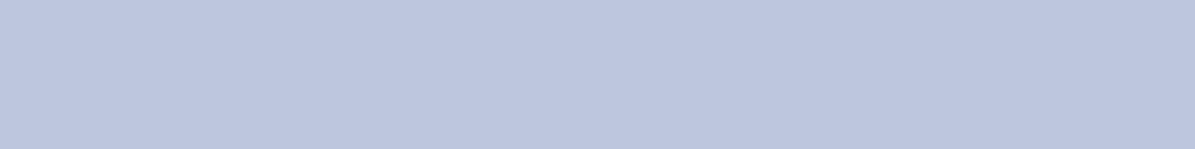
## SCOFF questionnaire

If patients score 2 or more positive answers then an eating disorder is likely

- 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?

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## **NHS Quality Improvement Scotland**

Glasgow Office  
Delta House  
50 West Nile Street  
Glasgow G1 2NP

Phone: 0141 225 6999  
Textphone: 0141 241 6316

Email: [comments@nhshealthquality.org](mailto:comments@nhshealthquality.org)  
Website: [www.nhshealthquality.org](http://www.nhshealthquality.org)

Edinburgh Office  
Elliott House  
8-10 Hillside Crescent  
Edinburgh EH7 5EA

Phone: 0131 623 4300  
Textphone: 0131 623 4383