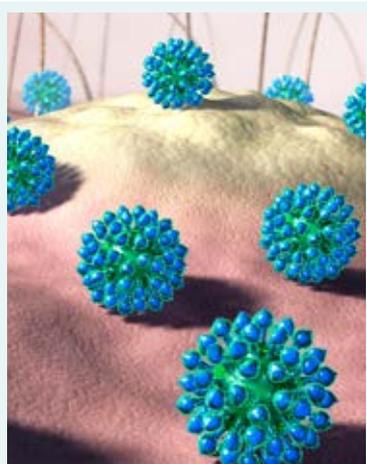


# education

**FROM THE JOURNALS** Edited highlights of Richard Lehman's blog on <http://bmj.co/Lehman>



## More HPV tests, fewer smears

A large observational study from Kaiser Permanente reaches the conclusion that after one or more negative tests for human papillomavirus (HPV), screening for cervical cancer could be spaced out to every five years or longer. In the coming era of HPV vaccination and more accurate HPV detection, cervical cancer could become a true rarity. But the interim period might last a while yet, depending on the mix of local and national policies: trying to follow them takes more storage capacity than my brain has left.

• *Ann Intern Med* doi:10.7326/M17-1609

## Never mind what's in them dear, just swallow the capsules

The capsules here contained wholesome faecal microbiome to prevent recurrent *Clostridium difficile* infection. A trial in 116 patients shows they achieve the same 96.2% success rate as the same thing inserted via a colonoscope. Good shit, as we used to say back in the hippy days. The capsules were rated as “not at all unpleasant” by 66% of the Canadians in this trial, and 44% said the same of colonoscopy.

• *JAMA* doi:10.1001/jama.2017.17077

## An aura of hope for migraine

I've always been ashamed of having migraine. It seems such a poor excuse for not doing things. I used to plan my life around not getting overtired, or even elated, for fear of the zig zags and the days of thudding pain and dejection that might follow. I'd stay on and work badly rather than admit to having an attack. It was better to be thought moody and difficult—which I am too, of course. My story is a very common one, and nothing compared with the horrors endured by those with truly severe chronic migraine.

News of a potential breakthrough in migraine treatment will be welcomed by millions. I'm old enough to remember the arrival of triptans in the early 1980s. They had their uses—and weird effects—but haven't proved the hoped-for panacea. Now come the mabs: erenumab, eptinezumab, fremanezumab, and galcanezumab. These target calcitonin gene-related peptide (CGRP), a widely distributed neurotransmitter which influences both neuronal modulation of pain and vascular activity.

If this sounds vaguely familiar, it is because of the gepants. These are not the famous pants worn by Superman to defy the G force, but CGRP receptor antagonist drugs like olcegepant and telcagepant, which have been around for a few years. So how do the new mabs perform? There have not been any head-on trials with the gepants, but here are two short placebo controlled studies with different endpoints (sighs).

Fremanezumab is an antibody that goes straight for the peptide, and it was trialled in people with “chronic migraine,” ie, lots of it every month. The percentage of patients with a reduction of at least 50% in the average number of headache days per month was 38% in the fremanezumab quarterly group, 41% in the fremanezumab monthly group, and 18% in the placebo group. A

lot of the press headlines have got confused over the arithmetic here, and no wonder.

The second trial used erenumab, which targets the CGRP receptor rather than the peptide itself, for episodic migraine. Again, the arithmetic takes some navigating. “The mean number of migraine days per month at baseline was 8.3 in the overall population; by months 4 through to 6, the number of days was reduced by 3.2 in the 70 mg erenumab group and by 3.7 in the 140 mg erenumab group, as compared with 1.8 days in the placebo group.” There seem to have been fewer injection site reactions compared with fremanezumab, but the real worry is that antibodies beget antibodies, and we don't know how long these mabs will remain effective or what long term harms they might have.

• *N Engl J Med* doi:10.1056/NEJMoa1709038

• *N Engl J Med* doi:10.1056/NEJMoa1705848

## “No I won't”: how to make patients cross

Like most doctors of my generation, I was never taught communication skills. I suspect the same still goes for most doctors around the world. And even in British general practice training, which probably leads the field, I don't think many courses teach the gentle art of saying no. Here is a snapshot of one academic family practice organisation in California, which collected data about denial of patient requests by 56 clinicians. This happened in 15% of encounters, and by and large it caused patients to leave dissatisfied. Who would have guessed? In 20 years' time, will anything have changed? Only by a slow process of skills training and a culture shift which I've taken to calling the shared understanding of medicine.

• *JAMA Intern Med* doi:10.1001/jamainternmed.2017.6611

# Eating disorders in young people

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**Eating disorders are a group of conditions in which negative beliefs about eating, body shape, and weight accompany behaviours including restricting eating, binge eating, excessive exercise, vomiting, and laxative use. Eating disorders are particularly common among adolescent girls, although they can also occur in boys and men. This update presents a structured approach to diagnosis and management of children and young people with eating disorders.<sup>2</sup>**

## How are eating disorders classified?

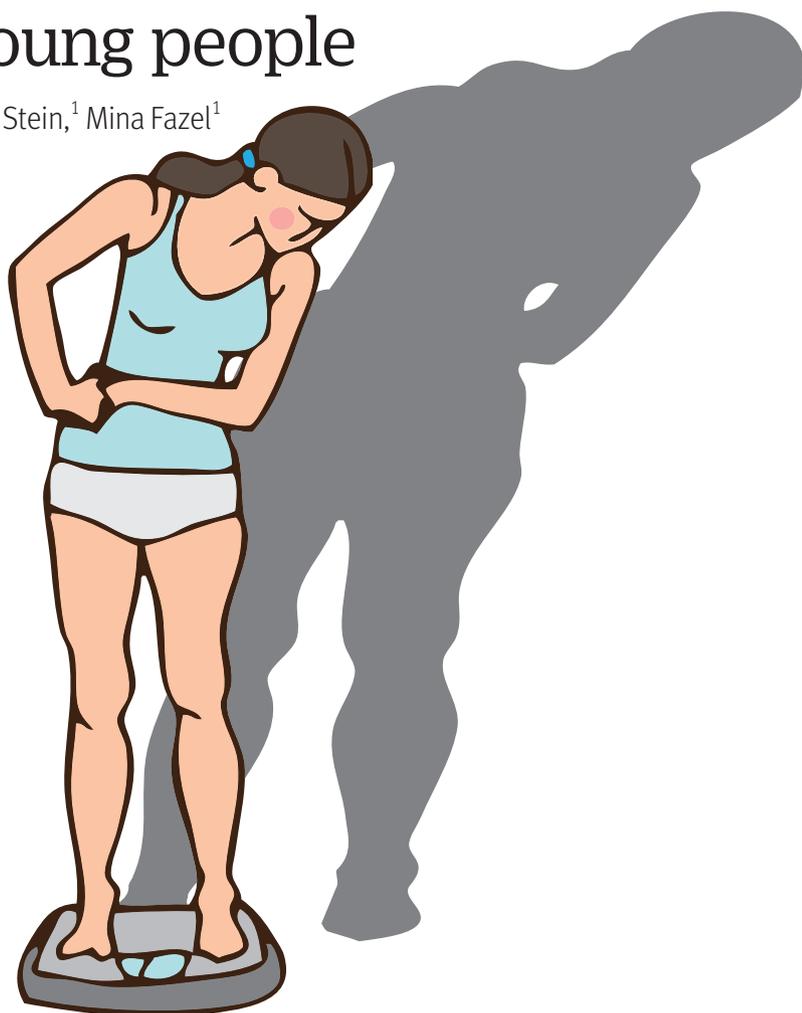
In anorexia nervosa, weight is “less than minimally expected,” dietary intake is restricted, and there are disturbances in the way weight and shape are experienced. Bulimia nervosa comprises binge eating with compensatory behaviours aimed at reducing weight, such as vomiting or excessive exercise, while binge eating disorder includes binge eating but without compensatory behaviours. In the *Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM-5)*,<sup>5</sup> a new category “other specified feeding or eating disorder” (OSFED) replaces “Eating disorder not otherwise specified” for an eating disorder that causes distress and impairment, but which does not meet the full criteria for other diagnoses.

## How common are eating disorders?

Eating disorders are relatively common among adolescent girls: a recent Dutch community study using new (broader) DSM-5 criteria found a lifetime prevalence among 19 year old women of 5.7% compared with 1.2% in men (table 1, see [bmj.com](http://bmj.com)).<sup>7</sup> Incidence rates of eating disorders in UK primary care increased from 32.3 per 100 000 in 2000 to 37.2 in 2009.<sup>8</sup>

## WHAT YOU NEED TO KNOW

- Prompt referral of patients with suspected eating disorders to specialist services is important as early treatment substantially improves prognosis.
- Eating disorders have relatively high mortality and associated morbidity (due to physical and psychological consequences and suicide).
- Indications for urgent referral to specialist mental health services for children and young people include rapid weight loss, body mass index <75% of expected body weight, and binge eating and purging several times a day.



0.5 HOURS



See <http://learning.bmj.com> for linked learning module

## How are eating disorders diagnosed?

Diagnoses are made on clinical history corresponding to ICD-10/DSM-5 criteria.<sup>5</sup> Clinicians should consider a possible eating disorder (see Practice Pointer, p 414) in patients presenting with a change in weight (increase, decrease, or failure to keep in line with growth), erratic eating (skipping meals or binge eating), preoccupation with shape or weight, vomiting, low mood, or withdrawal from friends and family, periods stopping, or if complaining of feeling cold.

## Differential diagnoses and comorbidities

In the case of weight loss, the differentials include diabetes, hyperthyroidism, coeliac disease, and malignancies, and the primary care physician should screen for these on history, examination, and investigations as detailed below. Eating disorders are associated with increased rates of other mental disorders, including depression,<sup>10 11</sup> anxiety,<sup>11 12</sup> obsessive compulsive disorder,<sup>11-14</sup> and alcohol misuse/dependence.<sup>11-15</sup>

## What are the psychological and physical complications?

A meta-analysis found that, in patients with anorexia nervosa, rates of death are 5.9 times higher than would be

expected in an age and sex matched population, and, in patients with bulimia nervosa and other eating disorders, rates are 1.9 times higher.<sup>17</sup>

**Psychological**—Low weight can cause substantial psychological consequences, such as low mood, suicidal ideation and behaviour, low self esteem, irritability, increased anxiety, social withdrawal, and rigidity of thinking,<sup>18</sup> all of which can contribute to further weight loss.

**Physical**—Chronic undernourishment can lead to disruption of all major organ systems.<sup>19</sup> Rapid weight loss can be particularly damaging, as can purging, overhydration and the misuse of laxatives and diuretics.<sup>20</sup> The cardiovascular system responds to a low basal metabolic rate in underweight patients with a decreased heart rate and blood pressure,<sup>20</sup> autonomic dysregulation, postural hypotension, postural tachycardia,<sup>21</sup> and increased risk of syncope.<sup>20</sup> Hypokalaemia as a result of vomiting, or diuretic or laxative misuse, and low weight in the absence of hypokalaemia, can lead to prolonged QTc, which can in turn lead to ventricular arrhythmias and sudden death.<sup>22</sup> Hypocalcaemia and hypomagnesaemia are less common but also contribute to arrhythmias.<sup>20</sup>

Gastritis or gastro-oesophageal reflux disease is particularly common if there is vomiting.<sup>21</sup> Physical consequences of purging also include Mallory-Weiss tears. Gastrointestinal bleeding can lead to anaemia; and malnutrition can also cause neutropaenia and anaemia, resulting from impaired bone marrow function. Very rarely, malnutrition can lead to pancreatitis.<sup>20</sup>

Amenorrhoea is no longer in the diagnostic criteria for anorexia nervosa in DSM-5, but remains a common feature, probably due to hypothalamic-pituitary-ovarian dysfunction.<sup>24,25</sup>

Decreased bone mineral density is common in anorexia nervosa, and patients are almost twice as likely to have a bone fracture as healthy controls.<sup>26</sup>

Chronic malnutrition leads to muscle wasting and weakness.<sup>4</sup> Overhydration with calorie free fluids can lead to hyponatraemia, with associated risk of seizures.

### What investigations aid diagnosis and management?

The table below and the infographic on p 412 outline examination and investigation of children and young people presenting with features of an eating disorder.

### Risk assessment

Risk assessment helps inform immediate and long term treatment decisions. Features of high physical risk that might indicate a need for inpatient medical admission<sup>20</sup> are detailed in the table and infographic.

Full psychiatric assessment, including of suicidal thoughts and plans, is important as people with anorexia are at higher risk of suicide than the general population.<sup>17</sup>

### What treatments are available?

Population studies consistently find that many people meeting diagnostic criteria do not receive any kind of treatment (around 56% in the Netherlands<sup>7</sup>; 28% in the US<sup>32</sup>).

Intervening early is associated with better treatment outcomes.<sup>3,4</sup> Outcomes in anorexia nervosa are poor if the patient does not receive effective treatment within the first three years.<sup>3,4</sup> Principles of managing eating disorders that families might find helpful include strengthening family relationships away from the pressures of food, and focusing on enjoyable activities together; conceptualising eating problems as separate from the young person, so that parent and child can “team up” against the disorder; eating regular, balanced meals as a family where possible; avoiding regular weighing and other forms of body checking as these can increase concerns about weight and shape.

**Outcomes in anorexia nervosa are poor if treatment is not received within three years**

Examination of children and young people presenting with possible features of an eating disorder (further details in the Junior MARSIPAN guidelines <sup>20</sup> )		
Examination	Possible features	High risk features (consider medical admission)
General observations	Might appear totally well Possible muscle wasting Lanugo hair Russell's sign (callus on back of hand) suggests self induced vomiting Tooth decay and parotid gland swelling (in vomiting) Submandibular gland swelling Indicators of another cause of underweight: pallor, thyroid signs, organomegaly Dehydration can be difficult to detect	
Pulse, temperature, and blood pressure	Decreased basal metabolic rate in starvation leads to decreased core temperature, slowed pulse, low blood pressure (<2nd centile)	Pulse <50 beats/min Low blood pressure (<0.4th centile) Postural hypotension (drop ≥15 mm Hg) Postural tachycardia (increase >20 beats/min) Delayed capillary refill Temperature <35.5°C
Height and weight: body mass index (BMI)	Percentage BMI should be calculated as (actual BMI×100)/median BMI (50th centile) for age and sex Normal/increased BMI (bulimia nervosa/OFSED) Weight “less than minimally expected” for height in anorexia nervosa	• Weight <75% of expected (although note that weight for height is a poor proxy for medical instability) • Rapid weight loss (0.5-1kg/week)
Musculoskeletal system including the “sit up” and “squat stand” tests (fig, p 413)	Muscle weakness is common in underweight patients Patient might be unable to sit up from lying or to rise from a squat position Back or bone pain from spinal compression or osteoporotic fractures	Spinal compression or osteoporotic fractures
Abdomen	Tenderness/bloating due to gastritis (most often if vomiting) Constipation or ileus	Gastric dilatation

OFSED: Other specified feeding or eating disorder

# Eating disorders

Initial assessment in primary care

**Young person presents to primary care with suspected eating disorder**

- Eating disorders can affect men and women
- May present alone or with parent/guardian
- Parent/guardian may present alone with concerns

### Take history

**Ask about:** Changes in eating, Food eaten yesterday, Vomiting, Exercise, Repeated weighing or body checking, Preoccupation with weight and shape

Are they trying to lose weight? If so, what would be their ideal weight? Use of diet pills and laxatives

Stopping prescribed medicines, Suppressing hunger with caffeine, smoking, or excessive water drinking

Developing a therapeutic relationship is important:

Thank you for being brave enough to tell me about this

Be honest about the limits of confidentiality:

Can we think together about letting your parents know?

### Assess mental health and social functioning

- ⚠ Suicidal ideation/plans
- Anxiety, Depression
- Current stressors: School, Family, Peers, Abuse

### Examine for physiological consequences

<b>General physical appearance</b> Signs of malnourishment Check hair and teeth, Dehydration May appear well	<b>Height and weight</b> May be less than minimally expected ⚠ Less than 75% weight for height May be normal or increased	<b>Skin</b> Pressure sores Russell's sign
<b>Cardiovascular</b> Slow pulse ⚠ <50 beats/min ⚠ Delayed capillary refill ⚠ Postural tachycardia Decreased core temperature Low blood pressure ⚠ <0.4 <sup>th</sup> centile ⚠ Postural hypotension	<b>Musculoskeletal</b> Muscle weakness Sit/squat test fail Back or bone pain ⚠ Spinal compression ⚠ Osteoporotic fractures	<b>Gastrointestinal</b> Tenderness Constipation or ileus ⚠ Gastric dilation

### Consider further investigations

look for signs of eating disorder or differential diagnoses

<b>Full blood count</b> Anaemia, Thrombocytopenia Neutropaenia ⚠ If significant	<b>Urea and electrolytes</b> ⚠ Hyponatraemia, ⚠ Hypokalaemia Dehydration, Electrolyte disturbance
<b>Bone profile</b> ⚠ Hypophosphataemia Low calcium, magnesium, or phosphate	<b>ESR*</b> Possible organic cause Bacterial infection
<b>Blood glucose</b> ⚠ Hypoglycaemia	<b>ECG†</b> ⚠ Cardiac arrhythmia Prolonged QTc ⚠ >450 ms Signs of electrolyte disturbance Sinus bradycardia ⚠ <50 beats/min
	<b>Thyroid function tests</b> Hyperthyroidism

### Differential diagnosis

Alternative explanations for weight loss include:

- Diabetes, Coeliac disease, Hyperthyroidism, Malignancies

Eating disorders are associated with increased rates of other mental health disorders, including:

- Depression, Anxiety, Obsessive compulsive disorder, Alcohol misuse/dependence

### Management and referral

If you think they have an eating disorder, consider referral to a specialist child and adolescent eating disorder team. Most young people with eating disorders can be treated as outpatients. Signs and symptoms marked with ⚠ may require emergency treatment.

Disclaimer: This infographic is not a validated clinical decision aid. This information is provided without any representations, conditions, or warranties that it is accurate or up to date. BMJ and its licensors assume no responsibility for any aspect of treatment administered with the aid of this information. Any reliance placed on this information is strictly at the user's own risk. For the full disclaimer wording see BMJ's terms and conditions: <http://www.bmj.com/company/legal-information/>

\* ESR = Erythrocyte Sedimentation Rate † ECG = Electrocardiogram



### HOW PATIENTS WERE INVOLVED IN THE CREATION OF THIS ARTICLE

Caitlin Skea (16), recovered patient, her mother, Sally Skea, and another parent of a young person with an eating disorder who wished to remain anonymous, read drafts of the article and made valuable suggestions, including how we worded specific ideas (see box on [bmj.com](#)). Caitlin Skea also wrote the What Your Patient Is Thinking article (p 416).

### EDUCATION INTO PRACTICE

- How might you incorporate a focused history and examination for signs of eating disorder into a brief consultation with a young person?
- Are you aware of the specialist services in your local area for people with suspected eating disorders?
- What advice might you give to parents who are concerned their child is at risk of developing an eating disorder?

### Psychological treatments

#### Anorexia nervosa

Family based treatment, or “anorexia nervosa focused family therapy”<sup>33</sup> is recommended by the National Institute for Health and Care Excellence (NICE) as the first line treatment for anorexia nervosa in children and young people.<sup>2</sup> Family treatment emphasises the importance of parents initially taking responsibility for refeeding, before gradually handing back responsibility to the young person. This is best done in an atmosphere of collaboration and minimisation of blame, for which support from the clinical team is often required.

NICE guidance recommends cognitive behavioural therapy for eating disorders if family therapy as described above is contraindicated, unacceptable, or ineffective.

#### Bulimia nervosa

A review<sup>34</sup> concluded that there have been fewer randomised controlled trials investigating the efficacy of treatments for bulimia nervosa in children and young

people,<sup>34</sup> but NICE guidelines<sup>2</sup> suggest offering family therapy for bulimia nervosa, or cognitive behavioural therapy for eating disorders if family therapy is unacceptable, contraindicated, or ineffective.

### Psychotropic medication

Psychotropic drugs are not recommended for the treatment of anorexia nervosa in primary care. A meta-analysis found no difference between placebo and either antidepressant or anti-psychotic medication on weight gain in anorexia nervosa,<sup>40</sup> and no differences in anorexia nervosa symptomatology between anti-psychotics and placebo.<sup>41</sup>

There is very little evidence for pharmacotherapy in young people with bulimia nervosa, but fluoxetine might be considered by specialist services if other treatments are not working.

### Weight restoration in underweight patients

For underweight individuals, re-establishing a healthy weight is considered by experts to be a key part of treatment,<sup>35</sup> although psychological treatment is crucial to ensuring a full recovery.<sup>46</sup> Regular monitoring of electrolytes, phosphate, and magnesium is advised because of the risk of refeeding syndrome<sup>19,20</sup> when there has been rapid weight loss and a period of minimal food intake. Monitoring should be undertaken in specialist care. Recommended rates of weight regain range from 500 g to 1400 g per week,<sup>21,47</sup> depending on the setting.

**Guidance recommends that all under 18s start treatment within four weeks**

#### Legal framework

Most jurisdictions acknowledge that serious or life threatening eating disorders can be treated compulsorily with refeeding, under the relevant legal framework, when the patient is not able to consent to treatment.

### When to consider admission?

Experts advise that all young people with a probable eating disorder be referred to local specialist mental health services, with results of tests (table 3. see [bmj.com](#), and infographic). Guidance in England recommends that all under 18s start evidence based treatment within four weeks.<sup>49</sup> Most patients with eating disorders can be treated as outpatients. Inpatient or day patient services might be needed in more severe cases or if the patient does not improve with outpatient care.<sup>19</sup> Inpatient treatment in a medical or paediatric ward is necessary where there is high medical risk.<sup>2</sup> Indications for urgent referral to specialist mental health services for children and young people include rapid weight loss, body mass index <75% of expected, and binge eating and purging multiple times a day. Indications for referral for emergency paediatric assessment include pulse <50 beats/min, arrhythmia, or postural tachycardia >20 beats/min; blood pressure <80/50 mm Hg or postural drop >20 mm Hg; temperature <35.5°C; QTc >450 ms; significant hypokalaemia; significant neutropaenia.<sup>19</sup> In such cases, simultaneous referral to both paediatrics and mental health services is recommended.<sup>20</sup>

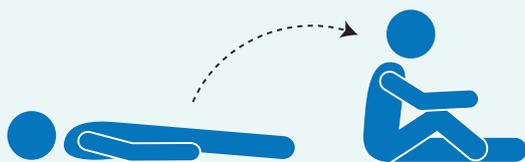
Competing interest statement: None declared.

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Find the full version with references at <http://dx.doi.org/10.1136/bmj.j5245>

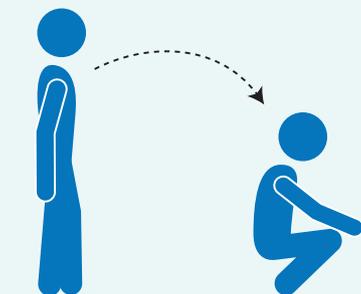
#### Sit up

Patient lies down flat on the floor or couch and sits up without, if possible, using their hands



#### Squat stand

Patient squats down and rises without, if possible, using their hands



The “sit up” and “squat stand” test

● PRACTICE POINTER, p 414  
● WHAT YOUR PATIENT IS THINKING, p 416

# Assessment of a young person with a possible eating disorder

Helen Bould,<sup>1</sup> Claudia Newbegin,<sup>3</sup> Mina Fazel,<sup>1</sup> Anne Stewart,<sup>2</sup> Alan Stein<sup>1</sup>

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This is an edited version; the full version is on [bmj.com](http://bmj.com).

**A mother presents to discuss her 13 year old daughter's changed eating patterns. The daughter is involved in a lot of sport at school, but is no longer eating properly and seems withdrawn. Her daughter appears to be losing weight, but she does not want to be weighed and alludes to thinking she is fat. Her daughter doesn't know she has come to see you; the mother wants to know what she can do without you seeing her daughter, as she is worried her daughter will become upset if others are involved.**

Building a therapeutic relationship with a young person with a possible eating disorder and their family is key to enabling a thorough assessment and good management but it introduces difficult issues regarding confidentiality and risk. This Practice Pointer is aimed at non-specialist doctors and will offer advice on building therapeutic relationships in consultation with a young person, and with their parent(s). The advice is based on expert experience.

## Developing the therapeutic relationship

### *A young person and parent/carer presenting together*

#### Sensitive information gathering

The most important task in the first appointment is to establish rapport with the young person and their parent(s) such that they feel able to talk about these difficult subjects. Ideally, questions will be directed to the young person, but be alert to times when the parent has a different opinion.

#### *Extent and speed of weight loss*

This can be difficult for the family to assess as they are seeing the person daily. Ask whether clothes are now too big, and when they were last weighed. Practice records of previous weight and height can be useful. Weight loss of 1 kg or more per week is particularly worrying. Weighing and measuring height are useful; however some young people find this very challenging. It can be helpful to offer the option not to be told their weight. Remind them that weight fluctuates during the day, and that different scales often give different weights. Some young people might conceal their weight loss by drinking extra fluids before weighing or carrying heavy things in pockets. Ideally



0.5 HOURS



See <http://learning.bmj.com> for linked learning module

## WHAT YOU NEED TO KNOW

- When a child or young person presents alone, it is important to be honest with them from the start about the limits of confidentiality
- Parents can become used to the “new normal” of disordered eating; it is important to explain risks
- Focus ideas about treatment on helping the young person feel better about themselves rather than particularly on their weight

weighing should be done after removing outer layers and shoes, and repeated weighing over several weeks can give a more accurate picture.

#### *Food restriction and binge eating*

Explore the young person's relationship with food and try to quantify their daily intake.

Questions might include: What did you have to eat yesterday? Are you trying to cut back? Are there foods you don't eat any more? Have you got more interested in food preparation or cooking? Does it ever feel like your eating gets out of control?

#### *Weight loss behaviours*

Explore the possibility of harmful exercise behaviours, purging, or use of weight loss medication/supplements. Questions might include: What happens if you can't exercise? (Distress at injuries or other engagements interfering with exercise can indicate feeling driven to exercise rather than enjoying it.) Have you been making yourself sick, taking laxatives, diet pills, or water tablets, or drinking excessive water to prevent hunger? Have you been drinking excessive caffeine, smoking heavily, or using weight loss medications bought online?

Ask for detail about any behaviour related to the weight loss, for example: How long has it been happening, and how often? When do you normally vomit, and why? Shame might lead to the young person underestimating frequency.

#### *Motivation and preoccupation with shape and weight*

Begin with an open question around why the person is engaging in the behaviour. Then probe further with questions like: Are you trying to lose weight? Do you feel like you're too fat? An unrealistically low target weight or a belief that they are very overweight would point towards a disorder. What do you see when you look in the mirror?

### Social history

Ask about family relationships (How are things in the family generally?)

Peers (Are you being picked on? Are you withdrawing?)

School (How is your school work? Are you getting into any trouble? Are there current pressures, eg, exams?)

Social media (What sort of things do you look at online?

Pictures of models, social media, advice on weight loss?)

### Family history

Is there a family history of eating disorders, dieting, or being overweight?

### Mood and risk of suicide

Eating disorders are often comorbid with anxiety or depression. Ask about mood, self harm, and suicidal ideation. Plans to end their life indicate a need for urgent psychiatric assessment.

### Safeguarding

Always consider whether there are any safeguarding concerns when seeing a child or young person. Ask direct questions about any history of emotional, physical, or sexual abuse, or neglect, explaining that this is part of your routine practice when you see a young person. This might not be appropriate in the first meeting, but should be raised once you have established a trusting therapeutic relationship.

### Physical complaints and differential diagnosis

It is important to identify and treat physical complications and to consider possible differential diagnoses, such as diabetes, hyperthyroidism, diarrhoea and vomiting, and inflammatory bowel diseases (see Clinical Update and infographic for further information).

### Approach to a child/adolescent presenting alone

A non-judgmental and respectful manner is crucial in developing rapport.

- Thank them for being brave enough to tell you.
- Confidentiality—As in all appointments where you see a child or young person alone, it is important to be honest from the start about the limits of confidentiality.
- Ideally, you will be able to agree with the young person that they, you, or both of you together let their parent(s) know what is happening. (“I think it’s really important that we find a way to let your parent(s) know about what’s going on. They are worried and want to help—can you think of a way we could do that?”) Parents play an important role in managing risk and helping the young person get better, and they might offer useful collateral.
- Make sure you can maintain contact with them—do you have their mobile number?
- Depending on the severity, risks involved, and the young person’s age, it might be necessary to break confidentiality, balancing this against the risk of losing trust. It might be appropriate to prioritise establishing a relationship with the young person over a few meetings. A conversation with a colleague, or calling your local child and adolescent mental health team might help you make this decision.



GETTY IMAGES

### Focus ideas about treatment on helping the young person to feel better about themselves

### Approach to a parent or carer presenting alone

Parent(s) sometimes present alone with concerns about their child’s eating and weight. Reassure the parent that they have done the right thing in coming to see you.

If the consultation reveals that the young person has lost weight, is restricting food, vomiting, taking laxatives, exercising excessively, or has physical problems or low mood, then the young person will need to be seen for follow-up. Parents can become used to the “new normal” of disordered eating, and might need help understanding the risks.

Let the parent(s) know that, although a young person might be angry with being required to seek help, they often feel reassured that parent(s) care enough to insist on it.

When raising concerns about eating, it is difficult but important for parents to stay calm and authoritative even though they might feel very anxious and frustrated. They could open a conversation with “you haven’t seemed yourself recently—is there a problem we can talk about?”

### EDUCATION INTO PRACTICE

- How might you assess the speed and extent of weight loss in a young person who does not want to be weighed?
- Are you aware of how to access resources that could support you in discussing eating disorders with parents and young people?
- How might you assess for risk of suicidal ideation in young people with an eating disorder?

## HOW PATIENTS WERE INVOLVED IN THIS ARTICLE

Caitlin Skea (16), recovered patient, her mother, Sally Skea, and another parent of a young person with an eating disorder who wished to remain anonymous, read drafts of the article and made valuable suggestions, including the wording of specific ideas.

We need to keep you healthy and help you feel better about yourself.” If there are physical symptoms (eg, periods stopping) this can be a good reason for seeking medical help.

Meeting a young person for the first time having met alone with their concerned parent presents its own challenges. The young person might be unhappy that you have apparently formed an alliance with the parent. Try open questions; what the young person thinks their parent is worried about and why; what their worries are about opening up to you. Avoid commenting on weight. Focus ideas about treatment on helping the young person to feel better about themselves. Try also to see the young person alone at some point.

### Initial management after diagnosis of an eating disorder

If you think that a young person has an eating disorder, promptly refer them to your local child and adolescent eating disorder team, as early intervention is associated with improved outcome. Refer to the associated Clinical Update for guidance on referral. In the meantime, you can usefully share your concern about the risks of food restriction and weight loss behaviours. Encourage a gradual increase in oral intake in those who have not been severely restricting. If there has been severe restriction, return to normal eating needs to be done carefully under the care of a specialist team due to risk of refeeding syndrome.

You can highlight the ineffectiveness of vomiting, laxatives, and diuretics in weight loss, and explain the usefulness of regular, normal meals and snacks to minimise the risk of binges. Consider whether vomiting is affecting any prescribed medications, such as an oral contraceptive.

Arrange a follow-up appointment and for blood tests and an electrocardiogram.

### The role of a parent or carer in treatment process

It can be helpful for families to conceptualise the eating problems as separate from the young person, so that parent and child can team up against it. Some young people find it helpful to think of the eating disorder as having a bullying “voice.”<sup>1</sup> This can be difficult initially when the young person might not believe they are unwell. It is challenging and stressful looking after a child with an eating disorder—encourage the parent(s) to look after themselves and ask for help of their own if needed; recovery can take many months. An alliance of both parents (or alongside a respected relative or professional) can be more powerful than one parent acting alone.

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## WHAT YOUR PATIENT IS THINKING

# I thought I wasn't thin enough to be anorexic

Caitlin S and her mother, Sally, talk about what helped, and what didn't help, when the 17 year old developed anorexia



**O**n 15 December 2015, two weeks after I was referred to CAMHS (Child and Adolescent Mental Health Services) and six months after my periods had stopped, I messaged my mum a random question: “Am I anorexic?” I expected my mum to reply: “No, of course you're not.” Two minutes later, however, the answer came back. “Yes, I'm sorry darling, it's true.” That was the first time I realised that I was ill.

I was 15, and I'd started dieting in April. By June, I'd stopped having periods. By September, I felt cold all the time and my mum was worried enough to involve my general practitioner. She saw the doctor and then took me separately. By November, my weight had dropped and I was urgently referred to CAMHS.

### Struggling to accept my condition

Why did I find it so hard to accept I had an eating disorder? Partly it was because even though anorexia was being discussed in my CAMHS sessions, I hadn't understood that this was because I had it. The doctors weren't trying to deceive me, but because I was ill, things were foggy and I was less able to understand what they were trying to tell me. I needed to be spoken to directly. It might have helped to say

“Caitlin, you have anorexia. Do you understand what I mean by that?”

Perhaps the main reason I didn't believe I was anorexic was because I didn't look that unwell. The stereotypical person with anorexia is incredibly skinny—so skinny that you can see their bones. It's the image that's used in schools for education on eating disorders.

But I never looked like that. I'm just 5 foot tall. Despite losing 20% of my body weight, having a resting pulse of 40 beats/min, low blood pressure, and no periods for a year, my body mass index remained within the normal range at 19.

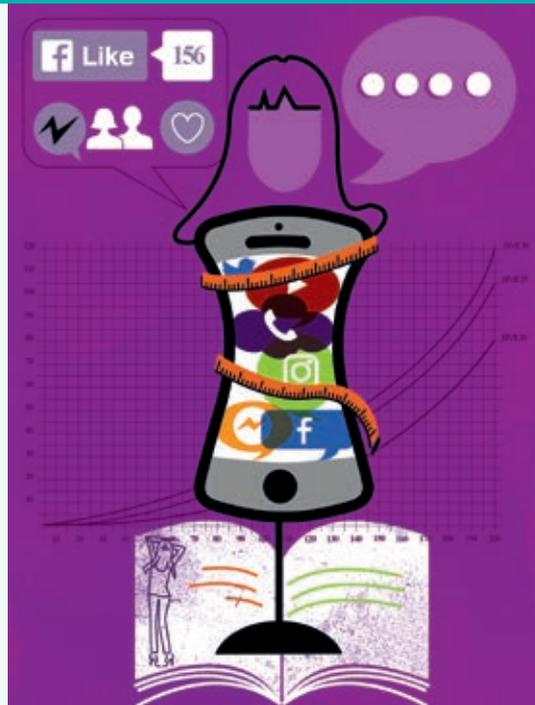
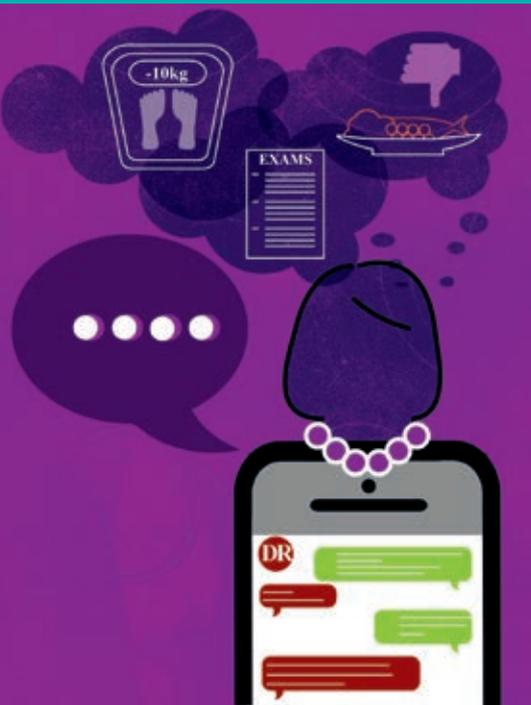
If I had known that people can have anorexia but do not look like they do, maybe I would not have been so reluctant to accept I had it.

### Barriers to trusting my doctors

My first meeting at CAMHS was led by a male doctor. He was highly qualified, kind, and understanding. However, it was embarrassing and uncomfortable for me to talk about my body and self confidence to a male doctor. Also, various medical professionals I met during treatment used the phrase, “It's okay, I know how you feel.” This frustrated and upset me. I wanted to scream: “No, you don't.” When I first heard it, I shut down and did not engage for the rest of the session. They couldn't know how I felt as they were not me, so how could I trust them?

## EDUCATION INTO PRACTICE

- Caitlin didn't realise she could have a diagnosis of an eating disorder with a normal body mass index. How might you explain a diagnosis to a young person who has a normal body mass index?
- How might you approach a parent who presents with concerns about their child's eating and exercise patterns?
- How might you sensitively ask about social media use? What advice do you give to young people about social media use?



ROSE LLOYD

### Social media and eating disorders

The triggers for my eating disorder were a drop in self confidence and an ambition to get trim for the summer before my GCSEs. I wasn't overweight, but I was obsessed with magazines and social media, where I first saw pictures of very slim women who did not look anything like me. They had no curves, no thighs, no fat, yet they were considered very beautiful. I was determined to change my shape to look like them. I thought that was a healthy thing to do.

Doctors need to ask about social media and explain that these images are often altered or unrealistic. I often wonder, if I had known about Photoshop, would I have become ill? If I knew these women were not real, would I have wanted to change so much? If the media did not portray women in this unrealistic light, would my life be different now? Would I have had anorexia?

### Sally gives her perspective on Caitlin's illness and treatment

It was difficult to persuade Caitlin to see the GP. I saw the doctor alone first and together we hatched a plan that in a second appointment, she would ask me to leave and speak to Caitlin alone about the risks of not eating and not having periods to her bones and fertility. This was helpful because treating

### WHAT YOU NEED TO KNOW

- Patients might need to hear that even with a normal body mass index they can still be very unwell. The difference between pre-illness weight and body mass index is key
- Young people can feel sensitive about their bodies. It may be appropriate to offer them a choice of male or female doctor
- Consider the impact of social media on young people's self image and mental health, and explicitly ask about the role of social media in their life

Caitlin as an adult created trust between them and helped Caitlin feel more in control.

### Determination to succeed

I believe the external triggers to Caitlin's eating disorder were a combination of GCSE exam stress and social media influences. As she reduced her food intake, her meals became ritualistic. Her breakfast and lunch were the same every day. Everything she ate was a specific size, a specific way, a specific thing, even down to using the same table mat. Caitlin's drive and determination to succeed is a strong quality, but it can also be her weakness because it helped her stick rigidly to her regime. I remember her saying, proudly: "I'm stronger than other people as I can say no to food and stick to it."

She was putting images on Instagram and got a lot of endorsement from people who didn't know she was ill. This made

**She got a lot of endorsement online from people who didn't know she was ill**

things more difficult for us, as parents, to deal with.

It was hard to get Caitlin onto the scales but she was becoming increasingly withdrawn socially and was calling me daily to ask if she could leave school. When she finally agreed to be weighed, I saw she'd lost almost 10 kg in six months. I rang the GP, who immediately referred her to CAMHS.

### Attending CAMHS sessions

I attended all of Caitlin's CAMHS sessions; her dad came to several of them too. We agreed this with CAMHS as the best approach to treating Caitlin, and she accepted this. The meetings were draining and emotional. I wasn't always popular, and she felt embarrassed sometimes, but I believe my input was helpful and looking back, so does she now. We were able to offer insights into her behaviour that Caitlin wasn't even aware of, such as her total withdrawal from social groups, and to correct matters when Caitlin bent the truth about what she was doing.

### Talking about the harm anorexia causes

When it came to talking about the harm anorexia was causing her, doctors had more credibility than me and her dad. She thought we were worrying unnecessarily as that's what parents do.

Her male consultant was a good doctor, but Caitlin found it easier to relate to the female psychologist and dietitian, especially when talking about things like periods and body shape.

After a year in CAMHS, and after having written a detailed relapse prevention strategy that she and I signed copies of, Caitlin was discharged in November 2016. Longer term recovery has naturally taken a while, but she is now back to her previous healthy weight. We remain conscious of her tendency to put excessive pressure on herself and external triggers such as stress. Caitlin can't remember much about the time she was poorly—I'm told memory loss is common—but she knows she felt absolutely terrible and doesn't want to go back there.

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● CLINICAL REVIEW, p 410

● PRACTICE POINTER, p 414

Endgames  
will return on  
6 January  
2018

### Hairdressing hazards and the hand

A 59 year old hairdresser presented with painless lumps on his right index finger. He reported a 20 year history of recurrent infection of the lumps, treated with multiple antibiotics. Examination revealed a firm, lobulated mass on the ulnar border of his right index finger extending across the proximal nail fold, with a sinus exiting proximally (figure). Excision under local anaesthetic revealed

foreign hair strands of multiple different colours, confirming the diagnosis of a periungual pilonidal sinus.

Periungual pilonidal sinus is a highly recurrent occupational hazard for hairdressers, animal groomers, and shearers, where freshly cut hairs penetrate the eponychium and trap subcutaneously. Interdigital pilonidal sinus (Barber's disease) is the more common

presentation. Physicians are urged to promote preventive measures such as the use of gloves, regular handwashing, and careful removal of hairs.

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Patient consent obtained.

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### The useless hand of Oppenheim

A demyelinating plaque in the dorsal columns of the cervical spinal cord compromises proprioception and can cause a profound loss of useful function in one, or sometimes both hands, despite preservation of motor pathways and other sensory modalities. This classic, if rare, presentation of multiple sclerosis was first described by Hermann Oppenheim (above) in 1911. Apart from its diagnostic value, it illustrates the importance of sensory pathways and proprioceptive feedback in fine motor control (*Pract Neurol* doi:10.1136/practneurol-2016-001494).



### Exercise and falls

It's no surprise to learn that falls in very elderly people (90 years and older) living in a Californian retirement community were commoner if they had a history of heart disease, stroke, arthritis, or visual difficulties, or if they were taking hypnotic, antipsychotic, or antidepressant drugs. More interesting is the finding that the risk of falling was related to levels of physical activity a quarter of a century earlier (*Age Ageing* doi:10.1093/ageing/afx039). People who, in their 60s and 70s, had been active every day were only about half as likely to fall when in their 90s, even after adjustment for comorbidities and medication.

### Uterine fibroids

Among 5500 women taking part in a study of health during early pregnancy, just over 10% had at least one fibroid detected by transvaginal ultrasonography. Although a similar proportion of participants experienced a miscarriage, there was no association between the two conditions. After adjustment for maternal age, ethnicity, alcohol use, and prior termination of pregnancy, presence of a fibroid had no influence on the risk of miscarriage (*Am J Epidemiol* doi:10.1093/aje/kwx062). Current views about surgical removal of fibroids before a pregnancy is undertaken may need to be re-evaluated.

### Reducing body mass index

More than a third of patients who had bariatric surgery achieved a body mass index (BMI) of less than 30 within a year, according to a registry study in the state of Michigan (*JAMA Surg* doi:10.1001/jamasurg.2017.2348). The best predictors of reaching this goal were a preoperative BMI of less than 40 and having a sleeve gastrectomy, gastric bypass, or duodenal switch. Adjustable gastric banding was less effective. Fewer than one in 10 of people with a preoperative BMI above 50 succeeded in reducing it to below 30 after surgery.

### Breast feeding and atopic disease

People whose mothers had taken part in a large trial of an intervention to promote breast feeding were contacted when they reached adolescence to investigate a possible long term influence on atopic

disease (*JAMA Pediatr* doi:10.1001/jamapediatrics.2017.4064). Assessed at an average age of 16, duration of breast feeding had no effect on lung function—measured either by spirometry or by self reported symptoms of asthma. Although the risk of flexural eczema was reduced, the prevalence of this condition was less than 1% in both intervention and non-intervention groups.

### Stress in healthcare staff

“Stress means a state in which a person feels tense, restless, nervous, or anxious, or is unable to sleep at night because his/her mind is troubled all the time. Do you feel this kind of stress these days?” This question, delivered by short message service to the mobile telephones of people working in primary care in Sweden, turned out to be a reliable way of predicting sick leave, depression, and exhaustion (*Occup Med* doi:10.1093/occmed/kqx111). The prevalence of work related stress is high among healthcare workers and a quick and simple way of detecting it ought to be useful both for research and practice.

Cite this as: *BMJ* 2017;359:j5559

