Eating disorders: a quick guide

Table 1: DSM-5 diagnostic criteria

Disorder	Diagnostic criteria
AN	A. Restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected. B. Intense fear of gaining weight or becoming fat, or persistent behaviour that interferes with weight gain, even though at a significantly low weight. C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.
BN	A. Recurrent episodes of binge eating. An episode of binge eating is characterised by both of the following: 1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances 2. A sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating). B. Recurrent inappropriate compensatory behaviours in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics or other medications; fasting; or excessive exercise. C. The binge eating and inappropriate compensatory behaviours both occur, on average, at least once a month for 3 months D. Self-evaluation is unduly influenced by body shape and weight. E. The disturbance does not occur exclusively during episodes of AN.

BED	A. Recurrent episodes of binge eating. An episode of binge eating is characterised by both of the following: 1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances 2. A sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating). B. The binge-eating episodes are associated with three (or more) of the following: 1. Eating more rapidly than normal 2. Eating until feeling uncomfortably full 3. Eating large amounts of food when not feeling physically hungry 4. Eating alone because of feeling embarrassed by how much one is eating 5. Feeling disgusted with oneself, depressed, or very guilty afterwards. C. Marked distress regarding binge eating is present. D. The binge eating occurs, on average, at least once a week for 3 months. E. The binge eating is not associated with the recurrent use of inappropriate compensatory behaviour as in BN and does not occur exclusively during the course of BN or AN.

AN, anorexia nervosa; BED, binge eating disorder; BN, bulimia nervosa.
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Table 2: Overview of eating disorders

	Demographic characteristics	Screening tools	Common physical symptoms to monitor	Psychological treatment	Pharmacological treatment
AN	Female 13–25 years BMI <18.5 (note that BMI less useful in adolescents)	SCOFF EDDS	Weight, weight trend, height in growing individuals Vital signs (incl. postural signs) Hypokalaemia Hypophosphateamia Hypomagnesaemia Renal function ECG (bradycardia and arrhythmia) Metabolic alkalosis Osteopaenia	FBT (Maudsley) for adolescents CBT IPT	No evidence for antidepressants for AN symptoms SSRIs beneficial for comorbid anxiety and depression
BN	Female 16–35 years BMI >18.5 <25*	SCOFF EDDS	Hypokalaemia Hypomagnesaemia Renal function Metabolic alkalosis Russell signs Dental caries Enamel erosion	CBT (most evidence for BN and comorbid symptoms) IPT DBT	Antidepressants (eg fluoxetine) for BN symptoms and comorbid symptoms
BED	Male and female 25–50 years BMI >25*	EDDS EAT	Complications related to obesity (diabetes, hypertension, arthritis) Limited ability to lose weight	CBT (most evidence for BED and comorbid symptoms) IPT DBT Behavioural weight management	Antidepressants for BED symptoms and comorbid symptoms

AN, anorexia nervosa; BED, binge eating disorder; BN, bulimia nervosa; SCOFF, xx; EDDS, Eating Disorder Diagnostic Scale; EAT, Eating Attitudes Test; BMI, body mass index; CBT, cognitive behavioural therapy; IPT, interpersonal therapy; DBT, dialectical behavioural therapy; FBT, family based treatment.

*BMI outside this range also occur.

Adapted from Sim LA, McAlpine DE, Grothe KB, Himes SM, Cockerill RG, Clark MM. Identification and treatment of eating disorders in the primary care setting. Mayo Clin Proc. 2010;85(8):746-51.

Table 3. High risk groups

Population	Risk
Adolescents	The peak period for the onset of eating disorders is between the ages of 12 and 25 years, with a median age of around 18 years.
Women	From school to adult life, pregnancy and menopause. Targeting preventive interventions at women with high weight and shape concerns, a history of critical comments about eating weight and shape, and a history of depression may reduce the risk for eating disorders.
Women with Polycystic Ovary Syndrome or Diabetes	Adolescents with diabetes may have a 2.4-fold higher risk of developing an eating disorder, particularly Bulimia Nervosa and binge eating, than their peers without diabetes. Polycystic Ovary Syndrome is associated with body dissatisfaction and eating disorders. Screening for abnormal eating patterns is recommended.
Athletes	People engaged in competitive fitness, dance and other physical activities where body shape may be perceived as affecting performance have a high level of risk of eating disorders.
People with a family history of eating disorders	There is evidence that eating disorders have a genetic basis and people who have family members with an eating disorder may be at higher risk of developing an eating disorder themselves.
People seeking help for weight loss	Eating disorders almost invariably occur in people who have engaged in dieting or disordered eating.

Adapted from National Eating Disorders Collaboration. Eating Disorders: A professional resource for general practitioners. Sydney: National Eating Disorders Collaboration; 2014.

Table 4. Presenting signs and symptoms

No common set of warning signs across the eating disorders

GENERAL

- marked weight loss, gain (eg >5–10% that is not medically indicated) or fluctuations
- weight loss, weight maintenance or failure to gain expected weight in a child and adolescent who is still growing and developing
- cold intolerance
- hypothermia
- weakness
- fatigue or lethargy
- dizziness
- syncope
- hot flushes, sweating episodes
- insomnia
- injuries due to overexercise

GASTROINTESINAL

- epigastric discomfort/indigestion
- early satiety, delayed gastric emptying
- abdominal pain/bloating
- gastro-oesophageal reflux
- haematemesis
- haemorrhoids and rectal prolapse
- constipation

DERMATOLOGIC

- lanugo hair
- hair loss
- yellowish discolouration of skin
- callus or scars on dorsum of hand (Russell's sign)
- poor healing
- dry skin
- bruise easily

NEUROPSYCHIATRIC

- seizures
- memory loss/poor concentration
- insomnia
- depression, anxiety, obsessive behaviour
- self-harm
- suicide ideation/attempt
- preoccupation with body shape, weight or appearance
- negative/distorted body image

ORAL and DENTAL

- oral trauma/lacerations
- dental erosion and dental caries
- perimolysis
- parotid enlargement

ENDOCRINE

- amenorrhoea or irregular menses
- loss of libido
- low bone mineral density and increased risk for bone fractures and osteoporosis
- infertility

CARDIORESPIRATORY

- chest pain
- heart palpitations
- arrhythmias
- bradycardia
- hypotension
- shortness of breath
- oedema

Reprinted with permission from: Academy for Eating Disorders (AED) Medical Care Standards Task Force. AED report 2016: Eating disorders: A guide to medical care (3rd edition). Reston, VA: AED; 2016.

Indicators for consideration for hospital admission

Refer to Table 3 and 5 in:

Hay P, Chinn D, Forbes D, Madden S, Newton R, Sugenor L, et al. Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of eating disorders. Aust N Z J Psychiatry. 2014;48(11):977-1008; available at https://www.ranzcp.org/Files/Resources/Publications/CPG/Clinician/Eating-Disorders-CPG.aspx