New recommendations for management of eating disorders (anorexia nervosa, bulimia nervosa) from NICE

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The UK’s National Institute for Health and Care Excellence (NICE), one of the most authoritative institutions in the field of evidence-based medicine, has issued standards for management of patients with anorexia and bulimia nervosa.

Note

This article was exposed to the machine translation

Background

Eating disorders is a group of mental disorders characterized by abnormal eating behavior and related problems in the physical and psychological health. According to the International Classification of Diseases (ICD-10) basic types include anorexia nervosa, bulimia nervosa, binge eating / vomiting associated with other psychiatric disorders, and other forms of eating disorders. On this last point, ICD does not specify what other disorders can include, but, probably, it is psychogenic overeating, avoidant/restrictive food intake disorder, psychogenic loss of appetite, etc..

The most common are anorexia and bulimia. First disorder is characterized by restriction of food intake and significant weight loss, and the second - episodes of overeating and purification (eg, taking laxatives or vomiting stimulation). Key diagnostic criteria for these disorders are presented in Table 1.

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<th>Anorexia</th>
<th>Bulimia</th>
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<tbody>
<tr>
<td>A</td>
<td>Weight loss or in children inadequate weight gain, which leads to the loss of at least 15% of the normal or expected weight according to age and height</td>
<td>Recurrent episodes of overeating (at least 2 times a week for the last 3 months) in which a large amount of food consumed for short periods of time</td>
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<td>B</td>
<td>Weight loss is self-induced by restriction in food intake</td>
<td>Persistent concern regarding food and strong desire or uncontrollable craving for food</td>
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<td>C</td>
<td>Self-perception of being too fat, preoccupation about fatness which leads to self-imposed low weight threshold</td>
<td>Patient attempts to counteract the weight gain by inducing vomiting, induce bowel movements, periodic fasting or using appetite suppressants, thyroid drugs, diuretics, etc.</td>
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<tr>
<td>D</td>
<td>A variety of endocrine disorders involving the hypothalamic-pituitary-gonadal axis. In women usually manifested as amenorrhea, and in men - as loss of sexual interest and</td>
<td>Self-perception of themselves as too fat, preoccupation about fatness (which often leads to underweight)</td>
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Table 1. Diagnostic criteria for anorexia and bulimia according to ICD-10 [1].

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<tr>
<th>Criteria</th>
<th>Anorexia</th>
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It should be noted that the diagnostic criteria for eating disorders by the American Psychiatric Association, namely Diagnostic and Statistical Manual for Mental Disorders (DSM-5), slightly differ from those in ICD-10. For example, DSM-5 proposes to determine the severity of anorexia nervosa by body mass index [2]:

- Mild - BMI $\geq 17$ kg / m².
- Moderate - BMI 16-16.99 kg / m².
- Severe - 15-15.99 kg / m².
- Extreme - <15 kg / m².

Clinical guideline from NICE

Published guideline from NICE regarding eating disorders includes a detailed description of the main principles of identification and assessment of eating disorders, their treatment, the most common comorbid conditions and their treatment, management pregnant women with eating disorders, outpatient treatment and recommendations on when to use compulsory treatment [3].

First of all, according to the recommendations the treatment of eating disorders should be started as soon as possible, because these disorders are potentially life threatening.

The process of the treatment can be both ambulatory and inpatient, depending on the patient state. In severe cases, patients with eating disorders may require hospitalization in intensive care unit.

Anorexia

Anorexia management should include psychoeducation about the disorders, monitoring of weight, mental and physical risks or any other risk factors, as well as being a multidisciplinary coordinated between services and involve family members (or trustees).

In the treatment of anorexia nervosa the main goal is to achieve a healthy weight / normal BMI. Weight gain is crucial in supporting other psychological and physical changes needed for recovery.

First-line therapy for anorexia is psychological treatment (unless patient does requires hospitalization in intensive care unit). For 3 types of psychological treatment are recommended:

- Individual cognitive-behavioral therapy focuses on treating eating disorders (CBT-ED).
- Maudsley Anorexia Nervosa Treatment for Adults (MANTRA).
- Supportive clinical management of anorexia (SSCM)

**CBT-ED** typically comprises up to 40 session for 40 weeks and is held on weekly basis, but if necessary in the first 2-3 weeks can be provided 2 sessions a week. It includes changes in eating patterns, cognitive restructuring, regulation of mood, social skills training, changes in beliefs regarding the perception of their own body, self-esteem and preventing relapse. Each of these techniques is described in detail in relevant manuals for this type of therapy.

The important point is informing the patient about the risks of low weight and malnutrition (the patient should be aware of the possible health effects), increase self-efficacy and monitoring food
intake and the related beliefs and emotions. Psychotherapeutic work in this area includes homework assignment for practical implementation of learned in everyday life.

**MANTRA** usually consists of 20 sessions, with the first 10 weeks 1 session held once a week, and the next - flexible hours or when needed. The method is described in the relevant manuals. It is important to motivate and encourage patients about therapeutic work. When the patient is ready he includes in work on abnormal food patterns and other symptoms. The therapist encourages the patient to develop "non-anorexia identity". It also involves family members to help to change behavior. Family members also should be provided with psychoeducation.

**SSCM** typically comprises of 20 or more weekly sessions. This method includes evaluating, identifying and regularly review the basic problems of the patient. It aims to develop a positive relationship between patient and therapist, as well as how to give the patient understand the relationship between symptoms and disorders in food behavior. The therapist usually sets a goal of weight gain within certain limits and encourages the patient to achieve this objective. Psychoeducation, education on diet and advice are used. Therapist should provide monitoring of patient’s physical condition.

For children and young people is also family therapy, focused on the treatment of anorexia (FT-AN) is also recommended. It usually consists of 20 sessions held throughout the year. This method uses the resources of the family to help the patient to recover.

NICE does not recommend the use drugs for the treatment of anorexia nervosa. However, this does not apply to the use of medications to treat comorbid (related) conditions.

**Bulimia**

As first-line therapy (primary treatment) bulimia nervosa NICE also recommends the use of psychological treatment. However, there are some features. Thus, initially recommended the so-called "guided self-help focusing on bulimia." It should include:

- Use of materials for self-help based on cognitive-behavioral approach.
- Brief supportive sessions with a therapist (4-9 sessions lasting 20 minutes).

If self-help in any way does not suits the patient or was ineffective after 4 week course, NICE recommends the use of cognitive behavioral therapy CBT-ED. For children and young people family therapy focused on the treatment of bulimia (FT-BN) is also a therapy of choice.

NICE does not recommend the use of drugs for the treatment of bulimia nervosa. However, this does not apply to the use of medications to treat comorbid conditions.

**References**