Does my patient have an eating disorder?
If you have a suspicion that your patient has an eating disorder, the Scoff questionnaire can help to prompt you to ask further detail questions.

The SCOFF questions

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?
[One point for every "yes"; a score of ≥2 indicates a likely case of anorexia nervosa or bulimia]

Further questioning will very likely indicate a diagnosis of an eating disorder.

What food is safe and what food do you avoid?
Do you vomit, take laxatives, diuretics, diet pills (and other drugs to lose weight) and exercise excessively?
Do you lose control or binge eat?

What is your current weight?
What is your ideal weight?

When did you last menstruate and have you missed any?
Have you fainted or felt dizzy?
How are your teeth?
Do you feel colder compared to others?
Do you feel weak when climbing the stairs?
How is your sleep?

Quick questioning on mood is equally important:
How have you been feeling in yourself?
How’s your motivation?
Do you have suicidal thoughts?

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1 Morgan, J; BMJ 1999;319:1467-1468 (4 December)
What do I do now?
Now that you think your patient has an eating disorder (or some kind of an eating disorder) and before referring your patient to the Eating Disorder Service at 25 Erleigh Road or Heatherwood Hospital:

Physical examination
Check weight and height for BMI in kg/m²
Check blood pressure (lying and standing) and pulse rate
Check for dehydration
Check if there is oedema
Full cardiovascular examination if there is cardiovascular compromise
Other system examinations if indicated²

Features of Medical Concern³
Eating disorder features (if these features are present in combination, the level of concern is heightened):
Marked undereating e.g. not eating at all during the day or under drinking
Frequent vomiting i.e. >once a day
Frequent laxative or diuretic misuse i.e. >once a day or less frequent if higher dose of intake
Heavy exercising when underweight
Rapid weight loss i.e. ≥ 1kg per week for for several weeks in succession

Physical symptoms or signs (if these features are present in combination, the level of concern is heightened):
Episodes of feeling faint or collapsing
Episodes of disorientation, confusion or memory loss
Awareness of the heart beating unusually or chest pains
Unusual muscle twitches or spasms
Shortness of breath
Swelling of the ankles, arms or face
Weakness and exhaustion
Difficulty climbing stairs or getting up from a chair without using the arms
Blood stained vomit

Investigations
For everybody referred
Blood tests: Urea & electrolytes and creatinine
Full blood count

For malnourished patients with BMI below 17.5
Blood tests: calcium
Magnesium
Phosphate
Liver function test
ECG

² See Appendix 1
³ Fairburn, C.; Cognitive Behavior Therapy and Eating Disorders; p. 42
For overweight patients
  Cholesterol
  Lipid profile
  Plasma glucose
  Thyroid function test

For underweight patients who have not menstruated for 6 months
  DEXA bone density scan
  Oestradiol level for females

For males who have been below BMI 17.5 for 6 months
  Testosterone level

For patients with potassium less than 3.5
  Very close monitoring of serum potassium and ECG
  Oral potassium supplement
  May require urgent medical/hospital referral

Please see the Medical Risk Assessment Table to aid assessment prepared by Professor J. Treasure in Appendix 2

What treatment does my patient require?
Always exclude medical risk, as your patient may need medical intervention first. If your patient refuses treatment consider the options below:
  1. Treatment under common law if your patient requires urgent medical treatment
  2. Treatment under the Capacity Act when there is medical risk
  3. Treatment under the Mental Health Act for refeeding, orally or parenterally, against the patient’s will to save life and or the patient has suicidal risk

Medication of the selective serotonin reuptake inhibitor type is useful in bulimia nervosa in the short-term.

Treat co-morbidities e.g. depression, obsessive compulsive disorder, substance misuse; some patients may need to be referred to the local mental health service or the substance misuse service.

Close working with the different teams involved in the care of patients with general medical conditions and eating disorder is important, if not very important (e.g. a patient with diabetes mellitus may suffer disturbance of glycaemic control during therapy for eating disorder). Other general medical conditions may co-exist e.g. celiac disease, irritable bowel syndrome and food allergy.

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4 Please also rule out Polycystic Ovarian Syndrome
5 Please see Appendix 2 on depression.
Appendix 1

Medical Risk Assessment for Eating Disorders
Professor Janet Treasure, Kings College London

<table>
<thead>
<tr>
<th>Name</th>
<th>Test * or Investigation</th>
<th>DoB</th>
<th>Concern</th>
<th>Alert</th>
</tr>
</thead>
<tbody>
<tr>
<td>SYSTEM</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutrition</td>
<td>BMI</td>
<td>&lt;14</td>
<td>&lt;12</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Weight loss/week</td>
<td>&gt;0.5 kg</td>
<td>&gt;1.0 kg</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skin Breakdown</td>
<td>&lt;0.1 cm</td>
<td>&gt;0.2 cm</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Purpuric rash</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Circulation</td>
<td>Systolic BP</td>
<td>&lt;90</td>
<td>&lt;80</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diastolic BP</td>
<td>&lt;70</td>
<td>&lt;60</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Postural drop (sit – stand)</td>
<td>&gt;10</td>
<td>&gt;20</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pulse Rate **</td>
<td>&lt;50</td>
<td>&lt;40</td>
<td></td>
</tr>
<tr>
<td>Musculo-skeletal (Squat Test and Sit up test)</td>
<td>Unable to get up without using arms for balance</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unable to get up without using arms as leverage</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unable to sit up without using arms as leverage</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unable to sit up at all</td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temperature</td>
<td></td>
<td>&lt;35</td>
<td>&lt;34.5</td>
<td></td>
</tr>
<tr>
<td>Bone Marrow</td>
<td>WCC</td>
<td>&lt;4.0</td>
<td>&lt;2.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Neutrophil count</td>
<td>&lt;1.5</td>
<td>&lt;1.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hb</td>
<td>&lt;11</td>
<td>&lt;9.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acute Hb drop (↑MVC &amp; MCH no acute risk)</td>
<td>&lt;130</td>
<td>&lt;110</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>Platelets</td>
<td>&lt;130</td>
<td>&lt;110</td>
<td></td>
</tr>
<tr>
<td>Salt /water balance</td>
<td>K+</td>
<td>&lt;3.5</td>
<td>&lt;3.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Na+</td>
<td>&lt;135</td>
<td>&lt;130</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mg++</td>
<td>0.5-0.7</td>
<td>&lt;0.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Phosphate</td>
<td>0.5-0.8</td>
<td>&lt;0.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urea</td>
<td>&gt;7</td>
<td>&gt;10</td>
<td></td>
</tr>
<tr>
<td>Liver</td>
<td>Bilirubin</td>
<td>&gt;20</td>
<td>&gt;40</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alkase</td>
<td>&gt;110</td>
<td>&gt;200</td>
<td></td>
</tr>
<tr>
<td></td>
<td>AsT</td>
<td>&gt;40</td>
<td>&gt;80</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ALT</td>
<td>&gt;45</td>
<td>&gt;90</td>
<td></td>
</tr>
<tr>
<td></td>
<td>GGT</td>
<td>&gt;45</td>
<td>&gt;90</td>
<td></td>
</tr>
<tr>
<td>Nutrition</td>
<td>Albumin</td>
<td>&lt;35</td>
<td>&lt;32</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Creatinine Kinase</td>
<td>&gt;170</td>
<td>&gt;250</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Glucose</td>
<td>&lt;3.5</td>
<td>&lt;2.5</td>
<td></td>
</tr>
<tr>
<td>ECG (if BMI&lt;15, low K+, drugs prolonging QTC prescribed)</td>
<td>Pulse rate</td>
<td>&lt;50</td>
<td>&lt;40</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Corrected QT interval (QTC)</td>
<td>&gt;450 msec</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Arrhythmias</td>
<td>+</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Differential Diagnosis TFT, ESR

- Any abnormal result is an indication for concern, monitoring and consultation/referral to specialist Eating Disorders Service.
- * The baselines for these tests may vary between labs.
- ** A tachycardia in the presence of signs and investigations of severe risk may be a harbinger of imminent cardiovascular collapse.

http://www.iop.kcl.ac.uk/sites/edu/downloads/HP
Appendix 2

Discriminatory Clinical Features Suggestive of a Co-Existing Clinical Depression\textsuperscript{7}

1. Recent intensification of depressive features (in the absence of change in eating disorder or social circumstances)

2. Heightened extreme and pervasive negative thinking (broader in content than eating related difficulties)
   - Global negative thinking
   - Hopelessness in general
   - Recurrent thoughts about death and dying
   - Suicidal thoughts and plan
   - Undue guilt about events not related to eating disorder

3. Decrease in interests and involvement of others (above anything related to eating disorder)
   - Decreased socialising
   - Disengaged in activities already pursued

4. Decrease in drive and impaired decision-making
   - Poor motivation
   - Procrastination

5. Other suggestive features
   - Tearfulness
   - Neglectful of personal care
   - Neglectful of day-to-day activities
   - Late onset of eating disorder (>30 years old)
   - Atypical manner in treatment sessions
   - Inability to undertake homework tasks through lack of drive

\textsuperscript{7} Fairburn, C.; Cognitive Behavior Therapy and Eating Disorders; p. 247
Clients

When you are underweight, you:

- find it harder to eat because your stomach has shrunk.
- feel tired, weak and cold as your body's metabolism slows down.
- may become constipated.
- may not grow to your full height.
- may get brittle bones which break easily. The bone density scan shows whether you have osteopenia, the stage before osteoporosis and is reversible, or osteoporosis itself.
- may be unable to get pregnant.
- may damage your liver, particularly if you drink alcohol.
- may die, in extreme cases. Anorexia Nervosa has the highest death rate of any psychological disorder.

If you vomit, you may:

- lose the enamel on your teeth (it is dissolved by the stomach acid in your vomit)
- get a puffy face (the salivary glands in your cheeks swell up)
- notice your heart beating irregularly - palpitations (vomiting disturbs the balance of salts in your blood)
- feel weak
- feel tired all the time
- damage your kidneys
- have epileptic fits
- be unable to get pregnant.

If you use laxatives regularly, you may:

- have persistent stomach pain
- get swollen fingers
- find that you can't go to the toilet any more without using laxatives (using laxatives all the time can damage the muscles in your bowel)
- have huge weight swings. You lose lots of fluid when you purge, but take it all in again when you drink water afterwards (no calories are lost using laxatives).

Seek urgent medical help, if you have:

- episodes of feeling faint or collapsing
- chest pains
- episodes of palpitations

Do not hesitate to seek medical help if you are uncertain about your physical problems.

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Information above for clients is adapted from the Royal College of Psychiatrists leaflet.
Carers

People whom you care for may report the following or you notice the physical problems yourselves.

People who are underweight:

- find it harder to eat because the stomach has shrunk.
- feel tired, weak and cold as the body's metabolism slows down.
- may become constipated.
- may not grow to the full height.
- may get brittle bones which break easily. The bone density scan shows whether they have osteopenia, the stage before osteoporosis and is reversible, or osteoporosis itself.
- may be unable to get pregnant.
- may damage the liver, particularly if they drink alcohol.
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People who vomit may:

- lose the enamel on the teeth (it is dissolved by the stomach acid in the vomit)
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- notice the heart beating irregularly - palpitations (vomiting disturbs the balance of salts in the blood)
- feel weak
- feel tired all the time
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- have epileptic fits
- be unable to get pregnant.

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- have huge weight swings. They lose lots of fluid when they purge, but take it all in again when they drink water afterwards (no calories are lost using laxatives).

Please don’t wait for physical problems to appear to encourage seeking help. Some of the physical problems appear later in the progress of the eating disorder. The earlier the client receives help the better the outcome of the disorder.

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Information above for carers is adapted from the Royal College of Psychiatrists leaflet.