6 'M's to keep in mind when you next see a patient with anorexia nervosa

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Anorexia nervosa is associated with comorbid psychiatric disorders, severe physical complications, and high mortality. To help you remember important clinical information when working with patients with anorexia, we propose this "6 M" model for screening, treatment, and prognosis.

Monitor closely. Anorexia can go undiagnosed and untreated for years. During your patients' office visits, ask about body image, exercise habits, and menstrual irregularities, especially when seeing at-risk youth. During physical examination, reluctance to be weighed, vital sign abnormalities (eg, orthostatic hypotension, variability in pulse), skin abnormalities (lanugo hair, dryness), and marks indicating self-harm can serve as diagnostic indicators. Consider hospitalization for patients at <75% of their ideal body weight, who refuse to eat, or who show vital signs and laboratory abnormalities.

Media. By providing information on healthy eating and nutrition, the Internet can be an excellent resource for people with an eating disorder; however, you should also be aware of the impact of so-called *pro-ana* Web sites. People with anorexia use these Web sites to discuss their illness, but the sites sometimes glorify eating disorders as a lifestyle choice, and can be a place to share tips and tricks on extreme dieting, and might promote what is known as "thinspiration" in popular culture.

Meals. The American Dietetic Association recommends that anorexic patients begin oral intake at no more than 30 to 40 kcal/kg/day, and then gradually increase it, with a weight gain goal of 0.5 to 1 lb per week.

This graduated weight gain is done to prevent refeeding syndrome. After chronic starvation, intracellular phosphate stores are depleted and once carbohydrate intake resumes, insulin release causes phosphate to enter cells, thereby leading to hypophosphatemia. This electrolyte abnormality can result in cardiac failure. As a result, consider regular monitoring of phosphate levels, especially during the first week of reintroducing food.

Multimodal therapy. Despite being notoriously difficult to treat, patients with anorexia might respond to psychotherapy—especially family therapy—with an increased remission rate and faster return to health, compared with other forms of treatment. With a multimodal regimen involving proper refeeding techniques, family therapy, and medications as appropriate, recovery is possible.

Medications might be a helpful adjunct in patients who do not gain weight despite psychotherapy and proper nutritional measures. For example:

- There is some research on medications such as olanzapine and anxiolytics for treating anorexia.
- A low-dose anxiolytic might benefit patients with preprandial anxiety.
- Comorbid psychiatric disorders might improve during treatment of the eating disorder.
- Selective serotonin reuptake inhibitors and second-generation antipsychotics

might help manage severe comorbid psychiatric disorders.

Because of low body weight and altered plasma protein binding, start medications at a low dosage. The risk of adverse effects can increase because more "free" medication is available. Consider avoiding medications such as bupropion and tricyclic antidepressants, because they carry an increased risk of seizures and cardiac effects, respectively.

Morbidity and mortality. Untreated anorexia has the highest mortality among psychiatric disorders: approximately 5.1 deaths for every 1,000 people.[1] Recent meta-analyses show that patients with anorexia may have a 5.86 times greater risk of death than the general population.[1] Serious sequelae include cardiac complications; osteoporosis; infertility; and comorbid psychiatric conditions such as substance abuse, depression, and obsessive-compulsive disorder.[2]

References

1. Arcelus J, Mitchell AJ, Wales J, et al. Mortality rates in patients with anorexia nervosa and other eating disorders. A meta-analysis of 36 studies. Arch Gen Psychiatry. 2011; 68(7):724-731.
2. Yager J, Andersen AE. Clinical practice. Anorexia nervosa. N Engl J Med. 2005;353(14):1481-1488.

This month's instantpoll

Mr. R, age 40, has a history of epileptic seizures. He takes antiepileptic medication and has not had a seizure in months, yet says he despairs that he will have another seizure—and that this has led to poor sleep habits and suicidal ideation. **Which treatment option would you choose for Mr. R?**

- ☐ Stop the antiepileptic medication and cautiously monitor Mr. R for remission of depression—and for recurrence of seizures
- ☐ Prescribe a combination of antiepileptic and antidepressant
- ☐ Add a course of cognitive-behavioral therapy to the antiepileptic regimen
- ☐ Consider electroconvulsive therapy or vagus nerve stimulation

See: **"Managing psychiatric illness in patients with epilepsy,"** *pages 30-38*

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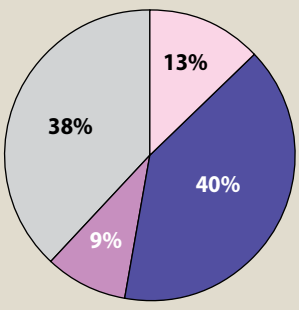
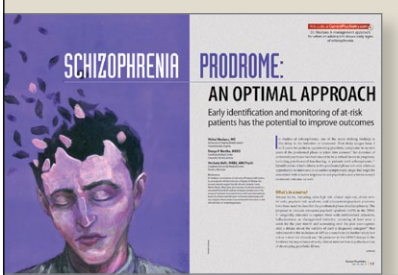
MARCH POLL RESULTS

Danny, age 17, describes paranoid thoughts and has been withdrawing from his friends and family. His grades have dropped. He admits to using *Cannabis* weekly. His parents are concerned because his maternal uncle was diagnosed with schizophrenia at age 22. **How would you help Danny and his family?**

- **13%** Arrange to see Danny every other month to monitor his condition
- **40%** Administer self-report scales to help detect early psychotic symptoms
- **9%** Start a low-dose antipsychotic
- **38%** Recommend cognitive-behavorial therapy and a low-dose antipsychotic





SUGGESTED READING:
Madaan V, Bestha DP, Kolli V. Current Psychiatry. 2014;13(3):16-30.

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