GP CASE EXAMPLES

Case Example – ‘Hannah’

Hannah (16) was brought by her mother, concerned at Hannah’s weight loss and lack of interest in food for some months. Hannah had always been thin, but her current BMI was 18. Weight loss had begun when life stresses had made her feel fairly sad some months before and she had lost her appetite. She had since found that she felt better if she didn’t eat and had avoided doing so even when she felt hungry. There were no underlying medical problems. Hannah is an intelligent teenager who lives with mother, younger brother and stepfather and sees her father every second weekend as she has done since she was 3. She has a close relationship with all 3 caregivers and her parents divorce was fairly amicable with all the adults on friendly terms. Talking to Hannah revealed that recently her father, who remains single, had begun to drink heavily on access visits which made her quite sad and she felt a great sense of loss.

Dealing with Hannah’s issues involved a two pronged approach. Psycho-education about the evolution of eating disorders helped her understand the importance of getting her eating habits back to normal. Some simple structured problem solving and discussion of the issues with her father helped her find a way to address the problem. She decided to talk to him and explain that visits were wasted for her if he drank too much. She enlisted the help of her paternal grandmother and they agreed with her father to arrange for Hannah and her brother to spend time with her father at grandma’s house so that it would be easier for him not to drink. Hannah’s depression resolved and with some effort on her part her eating returned to normal.

Case Example: Mandy

Mandy was a young girl who presented for a laxative prescription as her usual doctor was unavailable. She reported having problems with abdominal pain and constipation and requested a stronger laxative. She had tried most over-the-counter laxatives but they were not effective.

On physical examination, Mandy looked thin and pale. Her height and weight were found to be within the normal range. She was not clinically constipated on physical examination. After telling Mandy that her constipation was probably due to a poor diet, she admitted to me that she had a problem with stress, controlling her weight and had difficulties managing her diet. She had just started a new job, was not eating regularly and was skipping meals. On further questioning, Mandy admitted she had lost a bit of weight since starting her new job. Apart from skipping meals, she had begun to restrict her calorie intake by becoming a vegan. She thought she had been suffering from food allergies. Other problems Mandy experienced were tiredness, moodiness and erratic menstrual periods.

She agreed to return to her usual GP with a letter outlining what we had discussed and for blood tests. She also agreed to see a dietitian skilled in eating disorder management. Mandy did not leave my practice with a laxative prescription, but instead left with a structured treatment plan.

Case Example: Kim

Kim has bulimia nervosa. During her teenage years, she had anorexia nervosa, although over the past few years, she’s had increasing difficulty with binge eating and some episodes of restrictive eating. She has been able to hold down a full time job for six months, and has recently started seeing a young man in a new relationship.

Kim wants some help to deal with her eating disorder, frustrated that she is still being controlled by food. She has been seeing a counselor for some months to work through some family relationship problems. However, when she went to her own doctor to discuss her needs and her frustration around her lack of control over food and her eating behaviour, her doctor told her that she did not have a serious problem and that all she has to do is eat.
When she presented, Kim was obviously very upset by what she had been told. She felt that her doctor had not listened to her and dismissed her as a weak and silly person. Her self-esteem had taken a nose-dive - she explained that it had taken her some time to work up the courage to tell her doctor her problems. After this initial presentation, Kim was seen consistently and was eventually referred to a dietitian and a psychologist skilled in cognitive behavioural therapy – because it was felt that Kim was at the stage where she really wanted to change her behaviours though she needed some specific strategies to facilitate this change.

**Case Example: Mr and Mrs Y**

The mother and father of a young woman present concerned about their daughter. They think she might have an eating disorder. Unfortunately, their daughter is in her 20s, no longer lives with the family and was not agreeable to attending the appointment. From the parents discussion it is clear that their daughters eating problem is not very severe, but would benefit from a better assessment and some intervention. Mr & Mrs Y were given some strategies that might be useful in encouraging their daughter to seek help.

Most importantly Mr & Mrs Y themselves need help and support as they were coping not only with the sudden change in their daughter’s life, but had personally undergone several challenging life stressors over the previous two years. Mrs. Y. expressed concern about her husbands deteriorating moods. On a formal assessment, Mr. Y. was found to be suffering from a major depression. He had noticed that he had become more and more withdrawn and anxious over the preceding months, and agreed to commence antidepressant therapy and accepted a referral to a psychiatrist.

Mrs. Y. and her daughter know they have a GP who cares and whom they can approach to discuss any issues of concern in the future.

**Case Example: Melissa**

Melissa is 25 years old and has had anorexia nervosa since she was 11 years. She spent the majority of her life (from 11-16 years) in hospital in England before emigrating with her mother to Australia. 9 months after arriving in Australia, Melissa was admitted to hospital in Sydney in an extremely malnourished, depressed, anxious and regressed state. After a lengthy period of refeeding and after several subsequent admissions over several years, Melissa’s weight reached a BMI of 17 and remained relatively stable. Melissa presented on referral from the inpatient service and appeared willing to attend and pleased to have turned her life around somewhat.

Melissa did well initially, then moved in with her boyfriend and began smoking marijuana, her mood and motivation deteriorating. She found that she could eat without too much regard for her anxiety when she was stoned, and so spent much of the day in that state. Melissa then experienced several episodes of depression – associated with her heavy THC use and the sexual pressures placed on her by her boyfriend (now fiancé). She began binging and purging and became suicidal on several occasions. Most seriously, after briefly leaving her fiancé and moving into a flat on her own, Melissa took an overdose of antidepressants with drugs and alcohol, but woke up several days later.

At each crisis point, Melissa presents and engages for several sessions, identifying that she needs help with chaotic eating behaviours (always restrictive, sometimes also binging and purging), her low weight, depressed mood and significant social stressors (isolation, drug & alcohol abuse and domestic violence). As measures are put into place to help Melissa, she is once again lost to follow-up despite significant attempts to maintain contact. The door will always be open for Melissa and hopefully, one day, she will be able to accept that she deserves the help that is available to her.