TREATING CHILDHOOD ANOREXIA NERVOSA IN GENERAL PRACTICE

Education about the illness, medical monitoring and psychological support form the mainstays of treatment:

Education

The following issues form part of an ongoing discussion with parents and patient:

- The gravity of the disorder
- The need for monitoring of food intake and persistence in the face of frustration
- The value of a balanced diet, including all food groups (incl. fats) and education about what constitutes healthy eating
- The impact of anorexia nervosa on development and individual organ systems
- Moving the parents from an “episodic disorder model” to a chronic rehabilitative model
- Emphasizing that anorexia nervosa is also about self-esteem and family support as well as eating, food, body weight and shape.
- Identifying anorexia nervosa as “the enemy” against which parents and child need to join you in the fight. There is a continuous danger that the parents will end up joining with the child in fighting against the treating physician, rather than join the therapist in treating the disorder.
- Identifying illness denial, difficulties of emotional expression and disgust with self as the key features.

Medical parameters

- Set reasonable weight range goals and then stick to those ranges rigidly. Don’t allow treatment resolve to be eroded by insidious decrements. Weight gain on outpatient basis of 350-500 grams per week is acceptable.
- Initial monitoring of eating disordered young people should be weekly and then, after weight restoration, fortnightly or monthly. Three visits with three failures to gain weight at any point should raise the issue of referral for inpatient treatment.
- Physiotherapy assessment for paraspinal muscles to prevent kyphosis and scoliosis.
- Electrolytes and especially phosphates should be reviewed in order to avoid risk of cardiac dysrhythmia.
Psychological family parameters

- Families can be invaluable in helping refeed their child, although they may require support from the GP to do this or in many cases a family therapist trained in eating disorders.
- Sometimes families often have to be relieved of having to struggle with their children. Instead of parents battling over food, weighing, by the doctor, is used to determine future management.
- Parents are continually encouraged to separate out the “anorexia” from their child.
- Parents are encouraged not to join with their child against all who would help, but rather to form a partnership with professionals against the anorexia nervosa.
- Understanding illness denial, profound distortion of body image and the self-disgust associated with weight gain, and conveying that understanding to the client and their family, will be essential for success in week-to-week management.

When to refer to or consult a pediatrician or specialist unit

Referral is an individual matter determined by previous experience and the severity of the child’s condition. However, the following may provide guidance for the busy general practitioner:

- The child has failed to gain weight on three successive visits
- The child has lost greater than 3kgs in one month
- Prolonged history of food restriction raises the need for densitometry, neuropsychometry and ovarian ultrasound.
- Body weight dropping below 85% predicted weight for height (note height may be significantly below height for age due to impaired growth and BMI may be misleading).
- Sustained bradycardia or cardiac dysrhythmia.
- When you are worried and concerned that there has been a loss of control of the clinical process.
- When the alliance with the parents or child is compromised or the child is actively avoiding treatment.