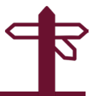
3: Summary sheet for GPs

Who is this for?
General practitioners assessing and managing patients with severe eating disorders.

a. Risk assessment

The key tasks in primary care are diagnosis, risk assessment and initial management. For a patient who may have an eating disorder, rapidly exclude other causes and look for weight concern, reluctance to eat and purging. Look at the items on the risk assessment tool (Chapter 2) and apply the ones relevant to the patient. For young patients, obtain parents' accounts, but see the patient alone to hear their concerns. Establish a system for ensuring follow-up of tests done in primary care.

See Chapter 2 and Appendix 3



b. Location of care

If diagnosis is clear and risk appears low, refer to secondary care and monitor in primary care until the referral is responded to. Secondary care should provide a named contact while waiting. If risk is moderate or high, consider urgent referral to eating disorders unit or referral to emergency department.

See Chapter 3

c. Safe refeeding

Refeeding someone with an established eating disorder of very low weight usually requires specialist oversight. However, GPs may be asked to work together with the specialist team to offer medical monitoring. For a patient who becomes unwell during refeeding, consider refeeding syndrome, gastrointestinal problems and electrolyte imbalance if the patient may be purging.

See Chapters 4 and 5

d. Behavioural manifestations of eating disorders

Behaviours common in eating disorders, such as self-induced vomiting, may be identified in patients receiving outpatient care. Electrolytes should be measured and the treating team contacted. Over-exercising and rejection of food offered can be very difficult to manage and parents may need support and guidance, including signposting on online resources, to deal with difficulties manifest at home, in collaboration with the treating team.

See Chapter 6

e. Families and carers

Families and carers of patients with eating disorders often require support and information in primary care. They may be extremely anxious because their loved one may appear to be very unwell but not willing to accept treatment. Understanding the wellbeing needs of parents/carers is important for their own and their loved one's treatment. For a young patient, parents will almost always be involved and may require advice about how to make sure that the child receives adequate care.

See Chapter 7

f. Compulsory admission and treatment

A patient with an eating disorder who is at high risk and refusing treatment may require assessment under the Mental Health Act or equivalent. The role of the GP may be to make contact with emergency psychiatric services to request this or to respond to such services if they are requesting the GPs involvement, as well as providing the necessary documentation, and supporting and informing the patient and their family/carers.

See Chapter 8

g. Diabetes mellitus type 1

Diabetes complicates the management of any eating disorder. Insulin or hypoglycaemic drugs may be avoided by the patient to promote weight loss, and this can lead to failure of diabetic control. In the long term, increased severity of diabetic complications can occur. GPs, physicians and psychiatrists must work closely together to optimise the outcome in these complex clinical situations.

See Chapter 9 and Annexe 3