2: Summary sheet for physicians

Who is this for?
Physicians in emergency departments and acute medical wards assessing and managing patients with severe eating disorders.

a. Risk assessment

Patients with eating disorders can appear well and have normal blood tests, even if they are near to death. Fear may lead the patient to falsify their weight and over-exercise. Consult the risk assessment tool (Chapter 2) and checklist provided, using measures relevant to the patient you are assessing. In the emergency department, consult a psychiatrist or eating disorders clinician, especially before discharging a patient.

See Chapter 2 and Appendix 3

b. Location of care

The patient may be on your service because of severe malnutrition or low potassium. Adult patients with an eating disorder are usually best managed in a specialist eating disorder bed or unit, unless they are severely ill, metabolically unstable or require close medical or biochemical monitoring. If management on a medical unit is felt to be in the patient's best interests, the support of an eating disorders specialist should still be obtained urgently to advise on the psychiatric management following stabilisation and mental health legislation if required.

See Chapter 3

c. Safe refeeding

For many underweight patients with eating disorders, feeding can start between 1,400 and 2,000 kcal per day, rising by at least 200 kcal per day until weight restoration is achieved. Advice on managing nasogastric feeding is provided. The possibility of refeeding syndrome (e.g. low or falling phosphate, potassium, magnesium or calcium) should be borne in mind and for some patients with coexisting medical illness, severe malnutrition or other risk factors such as alcohol dependency, lower rates of refeeding should be considered. Underfeeding syndrome with nutritional deterioration should be avoided and specialist dietetic input is strongly advised.

See Chapters 4 and 5

d. Behavioural manifestations of eating disorders

Challenging weight-losing behaviours such as exercising, hiding food or falsifying weight is difficult in a busy medical setting. Recruit a nurse with experience in eating disorders. Write

a management plan for sharing among ward staff. Consult an eating disorder specialist. Prepare a hospital protocol proactively with the local eating disorder team.

See Chapter 6

e. Families and carers

Ask for one member of the family to be the representative. Difficulties can arise when there is high anxiety, dissatisfaction with treatment and multiple clinical opinions. To pre-empt problems, invite carers/relatives to meetings, to be included in decisions in line with the patient's wishes, and answer questions. Agree to second opinions arranged by the hospital in the normal way.

See Chapter 7

f. Compulsory admission and treatment

Preventing a patient leaving hospital and imposing treatment are closely controlled activities. The legislation around these activities differs in each devolved administration within the UK. Certain types of nurse may legally prevent a patient leaving hospital for a limited time while a medical opinion is obtained. The doctor in charge may also prevent a patient leaving the ward for up to 72 hours while a longer detention under the Mental Health Act is considered. The legislation is complex, so check what you are allowed to do before the situation occurs. If compulsory detention and treatment seems unavoidable, contact a liaison or eating disorders psychiatrist as soon as possible to discuss implementation of correct legal measures. Instigating treatment (e.g. nasogastric feeding) without the patient's consent or an appropriate legal framework puts a health care professional at risk of legal action. Mental health legislation is designed to protect both the doctor and the patient so expert advice is crucial. In the emergency department the only way to prevent a patient leaving is to use the appropriate Mental Capacity Act, but this should be a rare requirement.

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 and the risk of death is increased. Reintroduction of insulin can cause electrolyte shifts (especially potassium) and insulin should only be administered under supervision. The diabetic team should guide management, working closely with psychiatrists.

See Chapter 9 and Annexe 3