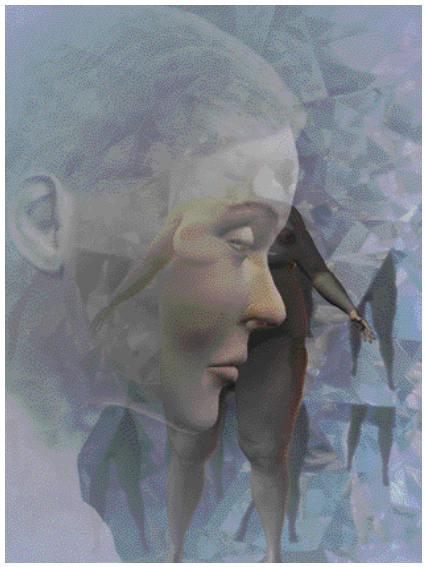
A young anorexic woman experiencing fainting spells

COMMENTARY BY **JANICE RUSSELL** MB BS, MD, FRACP, FRANZCP, MFCAP

It is important to engage Julie to explain your concerns about her blood pressure and discuss the reasons why it might have fallen, along with the associated risks.



PHOTOLIBRARY

Case scenario

Julie is a 24-year-old mother of two who was taken to the local GP surgery one morning by concerned local supermarket staff after she had fainted in the check-out queue. When first seen, and indeed for the next two hours, Julie remained too light-headed to even sit up without feeling she was going to faint again.

On examination, Julie was noted to be pale and thin, and her blood pressure was 85/60 mmHg, although there was no tachycardia. She was not pregnant and in fact said that she had not had a period for several months. On further questioning, she admitted to several previous fainting episodes at home over the preceding fortnight and also to a long-term problem with anorexia.

How should Julie be assessed and managed?

Commentary

Julie appears to have chronic anorexia nervosa with hypotension secondary to sympathetic down-regulation. Dehydration, further weight loss, purgation, cardiac arrhythmia, anaemia, intercurrent illness, and depression or recent life stressors leading to decreased food and fluid intake are likely to be reasons why her condition is becoming increasingly symptomatic. It would be important to engage Julie to explain the concerns about her blood pressure and discuss the reasons why it might have fallen and the associated risks. Such risks could include injury to osteoporotic bones and collapsing when she goes out with her children or when she is driving.

Assessment

The following vital signs will need to be assessed: blood pressure and pulse rate (both lying and standing to look for autonomic dysregulation – i.e. a fall of >20 mmHg in blood pressure and a rise of >20 bpm in heart rate on standing), hydration, weight, height, BMI, signs of emaciation and purging, peripheral oedema, and mental and cognitive state. She will need a full blood count, electrolytes/urea/creatinine measurements, blood sugar level, liver function tests, thyroid function tests, ECG, cardiac enzyme measurements, serum amylase and serum and urine osmolalities.

The acute medical situation should be managed first – that is, the need for more food and fluid (easier said than done) and the issue of elevating her blood pressure by remedying the cause, which should be apparent on clinical examination and investigations.

Questions that need answering

It will be important to enquire about Julie's weight history (if you don't already know) and what methods she uses to lose weight – that is, does she purge (vomit or take laxatives) or overexercise, does she binge eat, are substances involved, what does she actually eat, what has she eaten and drunk today, has she vomited or taken laxatives today and if so how many? How much does she regularly exercise and how much has she exercised today?

It is also important to find out about family members – for example, is there a partner or co-parent in the picture? How can this partner be involved and how much should the partner be involved – that is, could she be in an abusive relationship? Do or can other family members or friends provide support?

If there is time at this consultation (and at some point later if there is not), it will be important to try to look at her previous treatment experiences and the time course of her illness. Has any treatment been successful? Is there a therapist who has helped and why? Does she see a psychologist, dietician or physician? Did she give birth to her children (which suggests she has been more weight recovered in the past), were there

Professor Russell is Clinical Professor, Discipline of Psychological Medicine, University of Sydney, and Director of Eating Disorder Programs, Missenden Unit, Royal Prince Alfred Hospital and Northside Clinic Greenwich, NSW.

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problems conceiving, were her children the product of IVF? Does she feed them appropriately?

Treatment

Julie may not readily accept definitive treatment even if a hospital bed in a specialised treatment program can be found, although a crisis such as this can be helpful in that regard. Given that she can barely remain upright, duty of care might come into effect if she resists emergency hospital treatment. Will compulsory treatment, either under guardianship or the Mental Health Act, be necessary? This is a difficult situation, particularly if she cannot be engaged or can't see that there is a problem. Julie's partner, if there is one, or a parent, sibling or friend might need to be involved, despite any objections she may have, if she cannot leave the GP's office without fainting again.

Julie will almost certainly need to be taken promptly to Accident and Emergency (A&E) by ambulance (unless her partner, friend or family member can convey her there) with a detailed letter from her GP and following a telephone call. If she is taken by ambulance, it will be important to establish whether her children need to be picked up from school, preschool or day care. This situation is particularly problematic with the time constraints of general practice. Given that most hospitals do not have a specialised unit for the treatment of eating disorders, particularly for adults, or staff with any interest or expertise in this area, the GP will need to be the patient's advocate in ensuring appropriate management.

At A&E she will need urgent assessment, investigation and management. This will comprise rehydration, correction of electrolyte disturbances, and investigation of intercurrent illness, with the aim of increasing blood pressure. Short-term dietary advice should be provided, such as increasing intake by the addition of nutritional supplements and advice to cease purging and/or exercising (again much easier said than done).

If Julie has private health insurance, the situation will be easier with respect to definitive treatment (if she agrees to this), but private hospital eating disorder units usually have waiting lists. Although admissions can be prioritised, medically compromised patients cannot usually be accepted, so Julie's blood pressure will need to be maintained at a higher level before she can be admitted. If Julie does not have private health insurance, she should be put on a waiting list for admission to a public hospital specialised service. Interim management will be difficult until admission can be expedited. Alternative care of her children will probably need to be arranged and Julie's partner, family members or friends will need instruction and encouragement on how best to care for her at home – that is, helping her implement the above and assisting her in attending follow-up appointments with the GP, physician and multidisciplinary private or public eating disorder specialty service. Frequent monitoring and co-ordination by her GP will be essential, along with support for all involved parties.

If Julie refuses to confront her problem, the outlook is likely to be poor with further need for emergency intervention and further detriment to her health and her ability to care for her children.

Conclusion

In all, Julie's case is a very challenging but regrettably not all that uncommon problem. It is one that is not helped by the lack and inaccessibility of appropriate services and the impossibility of providing adequate containment in the community for medically compromised patients suffering from a condition in which motivation for treatment is at best ambivalent.

The GP's role in monitoring and providing support, health advice and psychoeducation is invaluable, but may still feel like a bandaid approach to the problem. Many GPs have skills in counselling and psychological techniques such as anxiety management, cognitive behavioural therapy, dialectical behaviour therapy and problem solving, which can be used with varying effects depending on the patient's level of motivation and general condition.

Support for family members and carers, however, is usually well received and useful in such a harrowing predicament. Even if there is no specialised treatment program, it may be possible to contact a State or Territory eating disorder service to get advice concerning treatment options (see the box on this page). Any treating healthcare professional should be contacted ideally with the patient's permission. Nevertheless, it is the beleaguered GP who bears the brunt of these frustrating and often alarming treatment situations. MT

Useful resources for eating disorders

Centre for Eating and Dieting Disorders
www.cedd.org.au
NSW co-ordinators: Jeremy Freeman (jfree@email.cs.nsw.gov.au) and Sarah Maguire (servicedevelopmentofficer@gmail.com)

Eating Disorders Foundation
www.edf.org.au/
Phone: 02 9412 4499
To find a resource centre in your area visit: www.edf.org.au/links/

Butterfly Foundation
www.thebutterflyfoundation.org.au/
Phone: 03 9822 5771
To find a resource centre in your area visit: www.thebutterflyfoundation.org.au/where_to_get_help

COMPETING INTERESTS: None.

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