Eating Disorders guideline (GL830)

Approval and Authorisation

<table>
<thead>
<tr>
<th>Approval Group</th>
<th>Job Title, Chair of Committee</th>
<th>Date</th>
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<tbody>
<tr>
<td>Maternity Clinical Governance</td>
<td>Chair, Maternity Clinical Governance Committee</td>
<td>8th January 2016</td>
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Change History

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Author(s)</th>
<th>Reason</th>
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<tbody>
<tr>
<td>1.0</td>
<td>Aug 2006</td>
<td>Dr May-Li Lim (Specialist Registrar), Miss Pat Street (Consultant Obstetrician)</td>
<td>Trust requirement</td>
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<td>2.0</td>
<td>Jan 2010</td>
<td>Miss Pat Street (Consultant Obstetrician)</td>
<td>Review and update of Version 1</td>
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<td>3.0</td>
<td>Oct 2013</td>
<td>Miss Pat Street (Consultant Obstetrician), Dr Sameena Kausar (Specialist registrar)</td>
<td>Review and update of Version 2</td>
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<td>4.0</td>
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<td>Miss Jane Siddall (Consultant Obstetrician)</td>
<td>Reviewed – changes throughout</td>
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<td>4.1</td>
<td>Oct 2017</td>
<td>Miss Jane Siddall (Consultant Obstetrician)</td>
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1. Introduction
Eating disorders such as anorexia nervosa, bulimia, binge-eating disorder (BED) and eating disorders otherwise specified (EDNOS) - are common in young women in developed countries. Anorexia nervosa and bulimia nervosa are the most commonly discussed in pregnancy. A common characteristic of anorexia and bulimia is the abnormal perception of body image.

Anorexia is thought to affect 1 in 130-500 young women. The onset is typically in adolescence or young adulthood i.e. in a critical phase of women’s reproductive life. These disorders are not self-limiting and have a chronic course with notable psychiatric and medical co-morbidities and sequelae. Although more common, the prevalence of bulimia is difficult to quantify because these women are often not medically unwell and so more able to hide their problem. In the context of care of pregnant women, we are more likely to encounter women with bulimia than anorexia.

2. Impact of pregnancy on patients with eating disorders
   1. Core psychological symptoms include morbid fear of fatness and strong belief that their self-worth is exclusively tied to their weight, shape or appearance. The prospect of weight gain during pregnancy terrifies many of these patients and their attitude towards breastfeeding may be more negative. Antenatal care should routinely ask questions relating to body weight, eating behaviour and weight control behaviour in early pregnancy (NICE 2004).

   2. Women in remission can have a resurgence of symptoms in pregnancy. In bulimic patients there may be recurrence postpartum. Remember Bulimic patients can have normal BMI. They are most likely to get missed.

3. Impact of eating disorders on pregnancy
   3.1 Maternal Risks
      2. Increased risk of nutritionally poor diet, so well balanced diet and pregnancy vitamin supplementation should be discussed at booking.
      3. The fear of gaining weight can often lead to misuse of laxatives and diuretics. Consequently, there may be associated complications such as electrolyte imbalance, cardiac arrhythmias, dehydration and gastroesophageal bleeding.
      4. Low folate and iron intake is associated with increased risk of anaemia.
5. The bulimic person will go through cycles of binge-eating followed by induced vomiting in the attempt to offset the potential weight gain resulting from the abnormal eating. Purging and bingeing are associated with rapid oscillations in blood sugars. This is associated with increased rates of gestational diabetes, in patients, with active or past history of eating disorders (Miscali 2007b).

3.2 Fetal risks

1. The majority of women had normal pregnancies resulting in healthy babies.

2. BMI <19 in a woman with an eating disorder at conception is associated with a significantly increased risk of delivering babies weighing below the 10th centile. Intrauterine growth restriction and low birth weight is related to low maternal BMI pre-pregnancy and in part due to smoking in second trimester.

3. Higher rates if preterm delivery, prematurity and low Apgar scores have been seen in some small number studies.

4. Protein restriction affects hypothalamic-pituitary-adrenal axis. This leads to increased fetal exposure to maternal cortisol. This is associated with lower birth-weight, microcephaly and in later life neuro-developmental problem.

5. Bulimic patients are at increased risk of complications related to gestational diabetes with higher rates of fetal abnormalities, miscarriages and stillbirth.

4. Management for those who are in remission:

1. Provide support in the form of giving information about how the weight gain is essential and physiological.

2. Provide contacts for persons such as dietician, midwife, psychologist and obstetrician in the event the woman needs advice/support.


4. Regular ultrasound scans to demonstrate fetal growth to motivate the woman to stay healthy.

5. Watch for relapse (e.g. lack of weight gain, abnormal fetal growth, electrolyte disturbance – due to laxative/diuretic misuse).

6. Consider referral to a consultant clinic

5. Management for those with an active eating disorder:

1. Refer to consultant antenatal clinic.

2. Essential to provide regular antenatal visits in both primary and secondary care settings.
3. Multidisciplinary team including named obstetrician, GP, midwife, dietician, (psychologist or psychiatrist – GP to refer if needed).


5. Regular fetal growth ultrasound scans.

6. Consider referral to:
   - dentist (poor dentition due to chronic vomiting)
   - gastroenterologist (if symptoms of esophagitis, gastroesophageal bleed)

7. Assess for risk of gestational diabetes and arrange two hour post-prandial glucose test at 28 weeks especially in patients with bulimia.

6. References: