

Eating disorders: Are they age-restricted?

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Eating disorders are thought to affect only the young. Although the mean age of presentation is 17 years for anorexia nervosa and 18 to 25 years for bulimia nervosa, many women >65 years suffer from these disorders.¹ Often, geriatric patients with a history of eating disorders during their youth that partially remitted have the same disorders re-emerge during their golden years. Because many practitioners think of eating disorders as a younger person's illness, we could miss an opportunity to help these individuals when screening our geriatric patients.

DSM-5² categorizes feeding and eating disorders as:

- binge eating disorder
- anorexia nervosa
- bulimia nervosa
- other specified feeding and eating disorders
- pica
- avoidant/restrictive food intake disorder.

Binge eating disorder's main feature is recurrent binge eating, which is the sense that one has lost control when consuming a larger amount of food within a discrete time period than what most people might eat in the same time period. Binge eating may include eating rapidly, feeling uncomfortably full, feeling embarrassment from the amount of food consumed, eating alone and/or feeling self-disgust. Because these patients lack compensatory behaviors, such as purging, they could be at risk of obesity.

Anorexia nervosa is defined as the restriction of energy intake relative to necessary

energy requirements, leading to significantly low body weight in the context of age, sex, developmental trajectory, and physical health, as well as an intense fear of gaining weight or persistent behaviors interfering with weight gain.

Bulimia nervosa is repetitive loss of control when eating large amounts of food (more than most would eat in a period), with compensatory behaviors to prevent weight gain. It is possible that the value attached to youthful slenderness leads to dissatisfaction among older women as their bodies change; bingeing might provide a sense of control during a time of uncertainty.

Body mass index typically is highest at middle age and slowly declines. In part, this decline is caused by a reduction in energy intake because of modifications in eating habits and lowered appetite often seen during aging. Older women eat 30% fewer calories than younger women.^{3,4} Social isolation, chronic disease, and depression also contribute to diminished food intake. It is important to remember that distorted body image can occur in older individuals as well. Anorexia nervosa has the highest



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fatality rate among psychiatric conditions,⁵ and geriatric patients could be at particularly high risk.

Assessment

Assess for eating disorders in a geriatric patient by exploring the patient's perception of body image and ruling out underlying causes of weight loss and medical comorbidities. Take a detailed history, including:

- body image and disordered thinking about food
- abnormal behaviors or rituals surrounding food
- history of eating disorders, psychiatric illness, or hospitalization
- medical history
- current and past medications
- illicit drug use or addiction to prescription medications.

Collateral informants, such as partners and adult children of the patient, may yield important information. Because geriatric patients often take several medications, contacting the primary care physician is important in the integrated care of the patient.

A thorough physical and mental status examination will provide information about the patient's physical appearance. For example, if the patient appears emaciated or weak, the content and process of thoughts related to food will help rule out other etiologies, such as psychosis, depressive disorders, or anxiety. Vital signs and a full physical examination are needed when

caring for patients with an eating disorder, regardless of age, but particularly in medically fragile geriatric patients. Because osteoporosis and osteopenia are concerns for many older patients, it's important to collaborate with the primary care physician early to help minimize bone loss.

Treatment

While ensuring medical stability of the patient, psychotherapy is the treatment of choice for eating disorders in geriatric patients. Moderate to severe binge eating disorder can be treated with lisdexamfetamine. For bulimia nervosa, consider a combination of SSRI and psychotherapy. There is no FDA-approved medication for treating anorexia nervosa; therefore identifying and treating underlying medical causes and/or psychiatric comorbidities can help improve prognosis. Despite this, 1 study showed 20% of geriatric patients with an eating disorder die of complications from eating disorders.⁶

References

1. Currin L, Schmidt U, Treasure J, et al. Time trends in eating disorder incidence. *Br J Psychiatry*. 2005;186(2):132-135.
2. Diagnostic and statistical manual of mental disorders, 5th ed. Washington, DC: American Psychiatric Association; 2013.
3. Morley JE, Thomas DR. Anorexia and aging: pathophysiology. *Nutrition*. 1999;15(6):499-503.
4. Morley JE. Peptides and aging: their role in anorexia and memory. *Peptides*. 2015;72(10):112-118.
5. Arcelus J, Mitchell AJ, Wales J, et al. Mortality rates in patients with anorexia nervosa and other eating disorders. *Arch Gen Psychiatry*. 2011;68(7):724-731.
6. Lapid MI, Prom MC, Burton MC, et al. Eating disorders in the elderly. *Int Psychogeriatr*. 2010;22(4):523-536.

Conduct a thorough physical and mental status examination to rule out underlying causes of weight loss