Psychiatry: a clinical handbook provides all the essential information required for a successful psychiatry rotation. Written by two recently qualified junior doctors and a consultant psychiatrist, the book offers an exam-centred, reader-friendly style backed up with concise clinical guidance.

The book covers diagnosis and management based upon the ICD-10 Classification and the latest NICE guidelines. For every psychiatric condition:

• the diagnostic pathway is provided with suggested phrasing for sensitive questions
• the relevant clinical features to look out for in the mental state examination are listed
• a concise definition and basic pathophysiology / aetiology is outlined.

Self-assessment questions are provided at the end of each chapter. An entire chapter is dedicated to OSCE scenarios to aid practising with colleagues. Printed with an attractive full colour design, the book includes mnemonics, clinical photos, diagrams, OSCE tips and key fact boxes. Psychiatry: a clinical handbook is exactly the type of book medical students, junior doctors and psychiatry trainees need to help develop a strong psychiatric understanding.

Pre-publication reviews from medical students:

This looks good – I like the layout and clarity. It’s user-friendly and covers the important stuff.” (4th year student, Leicester)

“I really enjoyed this new textbook. It’s a simple revision tool that has just enough information to prepare quickly before an OSCE. I like the mnemonics used throughout, and the use of the MSE in each of the chapters is a clever idea and really helps to put these patients into a clinical context.” (5th year student, Norwich)

“Great book at the perfect level of detail for medical students! A must buy for students hoping to improve their knowledge of key psychiatry conditions and be prepared for OSCEs.” (3rd year student, Cardiff)

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Contents

8 Personality disorders ......................................................................................................................... 113

9 Suicide and self-harm ........................................................................................................................ 119
  9.1 Deliberate self-harm .................................................................................................................. 120
  9.2 Suicide and risk assessment ....................................................................................................... 124

10 Old age psychiatry .................................................................................................................................. 130
  10.1 Delirium ............................................................................................................................................ 131
  10.2 Dementia ............................................................................................................................................ 137

11 Child psychiatry ........................................................................................................................................ 148
  11.1 Autism .................................................................................................................................................. 149
  11.2 Hyperkinetic disorder ................................................................................................................... 154
  11.3 Learning disability .......................................................................................................................... 159

12 Management ........................................................................................................................................... 163
  12.1 Psychotherapies ............................................................................................................................ 164
  12.2 Antidepressants ............................................................................................................................. 170
  12.3 Antipsychotics ................................................................................................................................... 177
  12.4 Mood stabilizers ............................................................................................................................ 185
  12.5 Anxiolytics and hypnotics .............................................................................................................. 189
  12.6 Electroconvulsive therapy (ECT) ................................................................................................. 192
  12.7 Mental health and the law (England and Wales) ......................................................................... 195

13 Forensic psychiatry ................................................................................................................................... 202

14 Common OSCE scenarios and mark schemes .................................................................................. 206

15 Exam-style questions ........................................................................................................................... 222

Glossary of terms ........................................................................................................................................... 238
Appendix A Answers to exam-style questions ....................................................................................... 244
Appendix B Answers to self-assessment questions .................................................................................. 251
Appendix C Figure acknowledgements ................................................................................................. 259
Index .......................................................................................................................................................... 261
Chapter 6

Eating disorders

6.1 Anorexia nervosa 86
6.2 Bulimia nervosa 92
6.1 Anorexia nervosa

**Definition**

Anorexia nervosa (AN) is an eating disorder characterized by deliberate weight loss, an intense fear of fatness, distorted body image, and endocrine disturbances.

**Pathophysiology/Aetiology** *(Table 6.1.1)*

The aetiology of AN is generally considered to be multifactorial, and can be divided into predisposing, precipitating and perpetuating factors (see Table 6.1.1).

<table>
<thead>
<tr>
<th>Table 6.1.1: Aetiological factors in AN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Biological</strong></td>
</tr>
<tr>
<td><strong>Predisposing</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Precipitating</strong></td>
</tr>
<tr>
<td><strong>Perpetuating</strong></td>
</tr>
<tr>
<td><em>(maintaining)</em></td>
</tr>
</tbody>
</table>

**Epidemiology and risk factors**

- AN affects ♂ more than ♀ (10:1).
- Estimated incidence is 0.4 per 1000 yearly in ♀ and approximately 9 in 1000 ♀ will experience it at some point in their lives.
- The typical age of onset is mid-adolescence.
6.1 Anorexia nervosa

Clinical features

- The defining clinical features of AN are described in the ICD-10 box.

ICD-10 Criteria for the diagnosis of AN: ‘FEED’

- Fear of weight gain.
- Endocrine disturbance resulting in amenorrhea in females and loss of sexual interest and potency in males.
- Emaciated (abnormally low body weight): >15% below expected weight or BMI <17.5 kg/m².
- Deliberate weight loss with ↓ food intake or ↑ exercise.
- Distorted body image (Fig. 6.1.1).

NOTE: The above features must be present for at least 3 months and there must be the ABSENCE of (1) recurrent episodes of binge eating; (2) preoccupation with eating/craving to eat.

- Other features include PP, SS:
  - Physical: Fatigue, hypothermia, bradycardia, arrhythmias, peripheral oedema (due to hypoalbuminaemia), headaches, lanugo hair (Fig. 6.1.2).
  - Preoccupation with food: Dieting, preparing elaborate meals for others.
  - Socially isolated, Sexuality feared.
  - Symptoms of depression and obsessions.

Fig. 6.1.1: Distorted body image.  Fig. 6.1.2: Lanugo hair.

Key facts 1: Working out BMI

Body mass index = weight (kg) ÷ [height (m)]²
BMI <18.5 kg/m² = underweight
BMI 18.5–24.9 kg/m² = normal
BMI 25–29.9 kg/m² = overweight
BMI ≥30 kg/m² = obese

OSCE tips: Anorexia nervosa vs. bulimia nervosa

<table>
<thead>
<tr>
<th>Anorexia nervosa</th>
<th>Bulimia nervosa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are significantly underweight.</td>
<td>Are usually normal weight/overweight.</td>
</tr>
<tr>
<td>Are more likely to have endocrine abnormalities such as amenorrhea.</td>
<td>Are less likely to have endocrine abnormalities.</td>
</tr>
<tr>
<td>Do not have strong cravings for food.</td>
<td>Have strong cravings for food.</td>
</tr>
<tr>
<td>Do not binge eat.</td>
<td>Have recurrent episodes of binge eating.</td>
</tr>
<tr>
<td>May have compensatory weight loss behaviours (excluding purging).</td>
<td>Have compensatory weight loss behaviours.</td>
</tr>
</tbody>
</table>
Chapter 6  Eating disorders

**Diagnosis and investigations**

- ‘Some people find body shape and weight to be very important to their identity. Do you ever find yourself feeling concerned about your weight?’ *(fear of weight gain)*
- ‘What would be your ideal target weight?’ *(overvalued ideas about weight)*
- ‘The obvious methods people use to lose weight are to eat less and exercise more. Are these things that you personally do?’ *(deliberate weight loss)*
- ‘When women lose significant weight, their periods have a tendency to stop. Has this happened in your case?’ *(amenorrhoea)*
- Also ask specifically about physical symptoms of anorexia nervosa e.g. fatigue and headaches.

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech</td>
<td>May be slow, slurred, or normal.</td>
</tr>
<tr>
<td>Mood</td>
<td>Can be low with co-morbid depression, or euthymic.</td>
</tr>
<tr>
<td>Thought</td>
<td>Preoccupation with food, overvalued ideas about weight and appearance.</td>
</tr>
<tr>
<td>Perception</td>
<td>No hallucinations.</td>
</tr>
<tr>
<td>Cognition</td>
<td>Either normal or poor if physically unwell with complications.</td>
</tr>
<tr>
<td>Insight</td>
<td>Often poor.</td>
</tr>
</tbody>
</table>

**NOTE:** A full systems examination should be carried out to find out the degree of emaciation, to exclude differential diagnoses and to look for possible complications (see Key facts 2).

- **Blood tests:** FBC (anaemia, thrombocytopenia, leukopenia), U&Es *(↑ urea and creatinine if dehydrated, ↓ potassium, phosphate, magnesium and chloride)*, TFTs *(↓ T3 and T4)*, LFTs *(↓ albumin)*, lipids *(↑ cholesterol)*, cortisol *(↑)*, sex hormones *(↓ LH, FSH, oestrogens and progestogens)*, glucose *(↓)*, amylase *(pancreatitis is a complication)*.
- **Venous blood gas (VBG):** Metabolic alkalosis (vomiting), metabolic acidosis (laxatives).
- **DEXA scan:** To rule out osteoporosis (if suspected).
- **ECG:** Arrhythmias such as sinus bradycardia and prolonged QT are associated with AN patients.
- **Questionnaires:** e.g. eating attitudes test (EAT).
6.1 Anorexia nervosa

**DDx**

- Bulimia nervosa.
- Eating disorder not otherwise specified (EDNOS): see Key facts 3.
- Depression.
- Obsessive–compulsive disorder.
- Schizophrenia: Delusions about food.
- Organic causes of low weight: Diabetes, hyperthyroidism, malignancy.
- Alcohol or substance misuse.

<table>
<thead>
<tr>
<th>Key facts 2: Complications of AN</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metabolic</strong></td>
<td>Hypokalaemia, hypercholesterolaemia, hypoglycaemia, impaired glucose tolerance, deranged LFTs, ↑ urea and creatinine (if dehydrated), ↓ potassium, ↓ phosphate, ↓ magnesium, ↓ albumin and ↓ chloride.</td>
</tr>
<tr>
<td><strong>Endocrine</strong></td>
<td>↑ Cortisol, ↑ growth hormone, ↓ T3 and T4, ↓ LH, FSH, oestrogens and progestogens leading to amenorrhoea. ↓ Testosterone in men.</td>
</tr>
<tr>
<td><strong>Gastrointestinal</strong></td>
<td>Enlarged salivary glands, pancreatitis, constipation, peptic ulcers, hepatitis.</td>
</tr>
<tr>
<td><strong>Cardiovascular</strong></td>
<td>Cardiac failure, ECG abnormalities, arrhythmias, ↓ BP, bradycardia, peripheral oedema.</td>
</tr>
<tr>
<td><strong>Renal</strong></td>
<td>Renal failure, renal stones.</td>
</tr>
<tr>
<td><strong>Neurological</strong></td>
<td>Seizures, peripheral neuropathy, autonomic dysfunction.</td>
</tr>
<tr>
<td><strong>Haematological</strong></td>
<td>Iron deficiency anaemia, thrombocytopenia, leucopenia.</td>
</tr>
<tr>
<td><strong>Musculoskeletal</strong></td>
<td>Proximal myopathy, osteoporosis.</td>
</tr>
<tr>
<td><strong>Others</strong></td>
<td>Hypothermia, dry skin, brittle nails, lanugo hair, infections, suicide.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key facts 3: Other eating disorders</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bulimia nervosa</strong></td>
<td>Recurrent episodes of binge eating and compensatory behaviour (any one or a combination of vomiting, fasting, or excessive exercise) in order to prevent weight gain (see Section 6.2, Bulimia nervosa).</td>
</tr>
<tr>
<td><strong>Binge eating disorder</strong></td>
<td>Recurrent episodes of binge eating without compensatory behaviour such as vomiting, fasting, or excessive exercise.</td>
</tr>
<tr>
<td><strong>EDNOS or atypical eating disorder</strong></td>
<td>One third of patients referred for eating disorders have EDNOS (eating disorders not otherwise specified). EDNOS closely resembles anorexia nervosa, bulimia nervosa, and/or binge eating, but does not meet the precise diagnostic criteria.</td>
</tr>
</tbody>
</table>
**Management (includes NICE guidance)**

- The management of AN is outlined using the **bio-psychosocial model** (Fig. 6.1.3).
- **Risk assessment** for suicide and medical complications is absolutely vital.
- **Psychological treatments** should normally be for at least 6 months’ duration.
- The aim of treatment as an **inpatient** is for a weight gain of 0.5–1 kg/week and as an **outpatient** of 0.5 kg/week.
- Patients are at risk of **refeeding syndrome** which causes metabolic disturbances (e.g. ↓ phosphate) and other complications (see **Key facts 4**).
- **Hospitalization** is necessary for medical (severe anorexia with BMI <14 or severe electrolyte abnormalities) and psychiatric (suicidal ideation) reasons.
- In cases where insight is clouded, use of the MHA (or Children Act) for life-saving treatment, may be required.

**Biological**
- Treatment of medical complications, e.g. electrolyte disturbance
- SSRIs for co-morbid depression or OCD

**Psychological**
- Psycho-education about nutrition
- Cognitive behavioural therapy
- Cognitive analytic therapy
- Interpersonal psychotherapy
- Family therapy

**Social**
- Voluntary organizations
- Self-help groups

**Key facts 4: Refeeding syndrome**

- A potentially life-threatening syndrome that results from food intake (whether parenteral or enteral) after prolonged starvation or malnourishment, due to changes in phosphate, magnesium and potassium.
- It occurs as a result of an insulin surge following increased food intake.
- Biochemical features include fluid balance abnormalities, hypokalaemia, hypomagnesaemia, hypophosphataemia and abnormal glucose metabolism.
- The phosphate depletion causes reduction in cardiac muscle activity which can lead to cardiac failure.
- Prevention: Measure serum electrolytes prior to feeding and monitor refeeding bloods daily, start at 1200 kcal/day and gradually increase every 5 days, monitor for signs such as tachycardia and oedema.
- If electrolyte levels are low, they will need to be replaced either orally or intravenously depending upon the severity of electrolyte depletion.

*Fig. 6.1.3: Bio-psychosocial approach to AN.*
6.1 Anorexia nervosa

Self-assessment

A 16-year-old girl, accompanied by her mother, presents to her GP complaining of fatigue for 6 months. The doctor observes the patient is rather petite and is wearing an oversized, baggy dress. No signs are found on examination. During the examination the patient mentions how fat she has become. She weighs 42 kg and measures 160 cm. Her mother is concerned as her daughter has been eating only one small meal a day and exercising excessively, and seems uninterested in her friends. Her periods have also stopped.

1. Work out the girl’s BMI. (2 marks)
2. What is the most likely diagnosis? Name two differential diagnoses. (2 marks)
3. What are the defining features of this condition? (4 marks)
4. Give four complications of this condition? (4 marks)
5. Outline the management strategy for this patient. (4 marks)

Answers to self-assessment questions are to be found in Appendix B.
6.2 Bulimia nervosa

Definition

Bulimia nervosa (BN) is an eating disorder characterized by repeated episodes of uncontrolled binge eating followed by compensatory weight loss behaviours and overvalued ideas regarding ‘ideal body shape/weight’.

Pathophysiology/Aetiology

- The aetiology of BN is very similar to AN, but whereas there is a clear genetic component in AN, the role of genetics in BN is unclear.
- When patients with BN binge due to strong cravings, they tend to feel guilty and as a result undergo compensatory behaviours such as vomiting, using laxatives, exercising excessively and alternating with periods of starvation. This may result in large fluctuations in weight, which reinforce the compensatory weight loss behaviour, setting up a vicious cycle (Fig. 6.2.1).

Epidemiology and risk factors (Table 6.2.1)

- BN typically occurs in young women. The estimated prevalence in women aged 15–40 is 1–2%.
- Whereas AN is thought to be more prevalent in higher socioeconomic classes, BN has equal socioeconomic class distribution.

<table>
<thead>
<tr>
<th>Table 6.2.1: Risk factors for bulimia nervosa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biological</td>
</tr>
<tr>
<td>Predisposing</td>
</tr>
<tr>
<td>- Female sex</td>
</tr>
<tr>
<td>- Family history of eating disorder, mood disorder, substance misuse or alcohol abuse</td>
</tr>
<tr>
<td>- Early onset of puberty</td>
</tr>
<tr>
<td>- Type 1 diabetes</td>
</tr>
<tr>
<td>- Childhood obesity</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
### Table 6.2.1: Risk factors for bulimia nervosa (continued)

<table>
<thead>
<tr>
<th>Biological</th>
<th>Psychological</th>
<th>Social</th>
</tr>
</thead>
<tbody>
<tr>
<td>Precipitating</td>
<td>• Early onset of puberty/ menarche</td>
<td>• Perceived pressure to be thin may come from culture (e.g. Western society, media and profession) • Criticism regarding body weight or shape</td>
</tr>
<tr>
<td>Perpetuating</td>
<td>• Co-morbid mental health problems</td>
<td>• Low self-esteem, perfectionism • Obsessional personality</td>
</tr>
</tbody>
</table>

### OSCE tips 1: BN and other co-morbid psychiatric conditions

BN commonly co-exists with the following psychiatric disorders and it is hence important to screen for them:
1. Depression
2. Anxiety
3. Deliberate self-harm
4. Substance misuse
5. Emotionally unstable (borderline) personality disorder.

### Clinical features

**ICD-10 Criteria for the diagnosis of BN: ‘Bulimia Patients Fear Obesity’**

1. **Behaviours to prevent weight gain (compensatory)**
   - Compensatory weight loss behaviours include: self-induced vomiting, alternating periods of starvation, drugs (laxatives, diuretics, appetite suppressants, amphetamines, and thyroxine), and excessive exercise. **NOTE:** diabetics may omit or reduce insulin dose.

2. **Preoccupation with eating**
   - A sense of compulsion (craving) to eat which leads to bingeing. There is typically regret or shame after an episode.

3. **Fear of fatness**
   - Including a self-perception of being too fat.

4. **Overeating**
   - At least two episodes per week over a period of 3 months.

Other features include:
- **Normal weight:** Usually the potential for weight gain from bingeing is counteracted by the weight loss/purging behaviours.
- **Depression and low self-esteem.**
- **Irregular periods.**
• **Signs of dehydration**: ↓ blood pressure, dry mucous membranes, ↑ capillary refill time, ↓ skin turgor, sunken eyes.

• **Consequences of repeated vomiting and hypokalaemia** (see Key facts 2 and 3).

### Key facts 1: Subtypes of bulimia nervosa

There are **two** subtypes of BN:

1. **Purging type**: The patient uses self-induced vomiting and other ways of expelling food from the body, e.g. use of laxatives, diuretics and enemas.

2. **Non-purging type**: Much less common. Patients use excessive exercise or fasting after a binge. Purging-type bulimics may also exercise and fast but this is not the main form of weight control for them.

**NOTE:** ICD-10 does not differentiate between purging and non-purging.

### OSCE tips 2: Anorexia vs. bulimia

| Amenorrhea | Binge eating |
| No friends (socially isolated) | Use of drugs to prevent weight gain |
| Obvious weight loss | Low potassium |
| Restriction of food intake | Irregular periods |
| Emaciated | Mood disturbances |
| Xerostomia (dry mouth) | Irrational fear of fatness |
| Irrational fear of fatness | Alternating periods of starvation |
| Abnormal hair growth (lanugo hair) | |

### Key facts 2: Hypokalaemia (↓ K⁺)

- A potentially life-threatening complication of excessive vomiting.
- Low potassium (<3.5 mmol/L) can result in muscle weakness, cardiac arrhythmias and renal damage.
- Mild hypokalaemia requires oral replacement with potassium-rich foods (e.g. bananas) and/or oral supplements (Sando-K).
- Severe hypokalaemia requires hospitalization and intravenous potassium replacement.

### Diagnosis and investigations

**Hx**

- ‘Do you ever feel that your eating is getting out of control?’ **(binge eating)**
- ‘After an episode of eating what you later feel is too much, do you ever make yourself sick so that you feel better?’ **(compensatory self-induced vomiting)**
- ‘Have you ever used medication to help control your weight?’ **(self-induced purging)**
- ‘Do you ever feel a strong craving to eat?’ **(preoccupation with food)**
- ‘Do you ever get muscle aches?’ ‘Do you ever have the sensation that your heart is beating abnormally fast?’ **(complications of hypokalaemia)**
- Ask specifically about complications of repeated vomiting (see Key facts 3).
- Screen for other co-morbid psychiatric conditions (see OSCE tips 1).
### 6.2 Bulimia nervosa

<table>
<thead>
<tr>
<th>MSE</th>
<th>Appearance &amp; Behaviour</th>
<th>May have appearance and behaviour consistent with depression or anxiety. Likely normal weight. Parotid swelling. Russell’s sign (Fig. 6.2.2). Sunken eyes (dehydration).</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Speech</td>
<td>Slow or normal.</td>
</tr>
<tr>
<td></td>
<td>Mood</td>
<td>Low.</td>
</tr>
<tr>
<td></td>
<td>Thought</td>
<td>Preoccupation with body size and shape. Preoccupation with eating. Guilt.</td>
</tr>
<tr>
<td></td>
<td>Perception</td>
<td>Normal.</td>
</tr>
<tr>
<td></td>
<td>Cognition</td>
<td>Either normal or poor.</td>
</tr>
<tr>
<td></td>
<td>Insight</td>
<td>Usually has good insight.</td>
</tr>
</tbody>
</table>

**Ix**
- **Blood tests**: FBC, U&Es, amylase, lipids, glucose, TFTs, magnesium, calcium, phosphate.
- **Venous blood gas**: May show metabolic alkalosis.
- **ECG**: Arrhythmias as a consequence of hypokalaemia (ventricular arrhythmias are life threatening), classic ECG changes (prolongation of the PR interval, flattened or inverted T waves, prominent U waves after T wave).

**DDx**
- **Anorexia nervosa** – with bulimic symptoms.
- **EDNOS** (*Eating Disorder Not Otherwise Specified)*.
- **Kleine–Levin syndrome**: Sleep disorder in adolescent males characterized by recurrent episodes of binge eating and hypersomnia.
- **Depression**.
- **Obsessive–compulsive disorder**.
- **Organic causes of vomiting**, e.g. gastric outlet obstruction.

**Key facts 3**: Physical complications of repeated vomiting

<table>
<thead>
<tr>
<th>Cardiovascular</th>
<th>Arrhythmias, mitral valve prolapse, peripheral oedema.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastrointestinal</td>
<td>Mallory–Weiss tears, ↑ size of salivary glands especially parotid (Fig. 6.2.2).</td>
</tr>
<tr>
<td>Metabolic/Renal</td>
<td>Dehydration, hypokalaemia, renal stones, renal failure.</td>
</tr>
<tr>
<td>Dental</td>
<td>Permanent erosion of dental enamel secondary to vomiting of gastric acid (Fig. 6.2.2).</td>
</tr>
<tr>
<td>Endocrine</td>
<td>Amenorrhoea, irregular menses, hypoglycaemia, osteopenia.</td>
</tr>
<tr>
<td>Dermatological</td>
<td>Russell’s sign (calluses on back of hand due to abrasion against teeth).</td>
</tr>
<tr>
<td>Pulmonary</td>
<td>Aspiration pneumonitis.</td>
</tr>
<tr>
<td>Neurological</td>
<td>Cognitive impairment, peripheral neuropathy, seizures.</td>
</tr>
</tbody>
</table>
Management

- The management of BN is based on the bio-psychosocial model:
  - **Biological:** A trial of antidepressant should be offered and can ↓ frequency of binge eating/purging. Fluoxetine (usually at high dose, 60 mg) is the SSRI of choice. Treat medical complications of repeated vomiting, e.g. potassium replacement. Treat co-morbid conditions (see OSCE tips 1).
  - **Psychological:** Psychoeducation about nutrition, CBT for bulimia nervosa (CBT-BN is a specifically adapted form of CBT). Interpersonal psychotherapy is an alternative.
  - **Social:** Food diary to monitor eating/purging patterns, techniques to avoid bingeing (eating in company, distractions), small, regular meals, self-help programmes.
  - From a biological perspective, electrolytes should be monitored carefully for any potential disturbances, and should be replaced accordingly where appropriate.
  - **Risk assessment** for suicide. Co-morbid depression and substance misuse are common.
  - **Inpatient treatment** is required for cases of suicide risk and severe electrolyte imbalances.
  - The Mental Health Act is not usually required, as BN patients have good insight and are motivated to change.
  - Approximately 50% of BN patients make a complete recovery in comparison with AN where roughly 20% make a full recovery.

Self-assessment

A 25-year-old female vegetarian presents to you very distressed. She describes a 3-year history of strong cravings for food, resulting in sessions of binge eating. To make herself feel better she states that she deliberately vomits five times a day and compulsively exercises for 2 hours a day.

1. Which eating disorder is the most likely diagnosis? Name two differentials. *(3 marks)*
2. What are the four diagnostic features of this condition based on ICD-10? *(4 marks)*
3. What is the most important complication of repeated vomiting? How would you test for this in a laboratory? *(2 marks)*
4. Give two further complications for repeated episodes of vomiting. *(2 marks)*
5. Outline the management of this condition in the community. *(3 marks)*

Answers to self-assessment questions are to be found in Appendix B.