Complete Summary

GUIDELINE TITLE

Eating disorders. Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders.

BIBLIOGRAPHIC SOURCE(S)

National Collaborating Centre for Mental Health. Eating disorders. Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. Leicester (UK): British Psychological Society; 2004. 260 p. [408 references]

GUIDELINE STATUS

This is the current release of the guideline.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory information has been released.

On October 15, 2004, the U.S. Food and Drug Administration (FDA) issued a Public Health Advisory, asking manufacturers of all antidepressant drugs to revise the labeling for their products to include a boxed warning and expanded warning statements that alert health care providers to an increased risk of suicidality (suicidal thinking and behavior) in children and adolescents being treated with these agents, and additional information about the results of pediatric studies. FDA also informed these manufacturers that it has determined that a Patient Medication Guide (MedGuide), which will be given to patients receiving the drugs to advise them of the risk and precautions that can be taken, is appropriate for these drug products. See the FDA Web site for more information.

COMPLETE SUMMARY CONTENT

** REGULATORY ALERT **
SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
EVIDENCE SUPPORTING THE RECOMMENDATIONS
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
QUALIFYING STATEMENTS
IMPLEMENTATION OF THE GUIDELINE
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT

CATEGORIES
IDENTIFYING INFORMATION AND AVAILABILITY
DISCLAIMER

SCOPE

DISEASE/CONDITION(S)

Eating disorders including anorexia nervosa, bulimia nervosa and related eating disorders, including binge eating disorder

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Treatment

CLINICAL SPECIALTY

Dentistry
Family Practice
Internal Medicine
Nutrition
Obstetrics and Gynecology
Pediatrics
Physical Medicine and Rehabilitation
Psychiatry
Psychology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Dentists
Dietitians
Emergency Medical Technicians/Paramedics
Health Care Providers
Hospitals
Nurses
Occupational Therapists
Patients
Pharmacists
Physical Therapists
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Public Health Departments

GUIDELINE OBJECTIVE(S)

To make recommendations for the identification, treatment, and management of eating disorders

Specifically, to:

- Evaluate the role of specific psychological interventions in the treatment and management of eating disorders
- Evaluate the physical management and role of specific pharmacological agents in the treatment of eating disorders
- Evaluate the role of specific service delivery systems and service-level interventions in the management of eating disorders
- Integrate the above to provide best practice advice on the care of individuals with a diagnosis of an eating disorder throughout the course of the disorder
- Promote the implementation of best clinical practice through the development of recommendations tailored to the requirements of the National Health Service (NHS) in England and Wales

TARGET POPULATION

People aged 8 years and over with eating disorders including anorexia nervosa, bulimia nervosa, or related conditions

INTERVENTIONS AND PRACTICES CONSIDERED

Screening for and Identification of Eating Disorders in Primary Care

1. Screening for eating disorders using brief screening methods, questionnaires, and clinical presentation
2. Assessment of body mass index (BMI), height, weight, and centile charts for age
3. Consideration of differential diagnoses
4. Other physical assessments such as pulse and blood pressure, core temperature, examination of peripheries, cardiovascular examination, sit-up/squat test for muscle power
5. Laboratory investigations including full blood count, erythrocyte sedimentation rate, urea and electrolytes, creatinine, liver function tests, random blood glucose, urinalysis
6. Electrocardiogram
7. Other lab tests to assess complications

General Management

1. Comprehensive assessment including physical, psychological and social needs, and assessment of risk to self
2. Monitoring of risk to mental and physical health as treatment progresses
3. Provision of education, information about self-help groups to patients and carers
4. Advice on laxative cessation
5. Considerations of pregnancy
6. Dental review and advice on dental hygiene if vomiting

7. Advice to refrain from physical activity that increases likelihood of falls in patients with bone loss
8. Inclusion of family members in treatment or children and adolescents
9. Pediatric consultation as required
10. Right to confidentiality of children and adolescents

Treatment and Management of Anorexia Nervosa

Psychological Interventions

1. Cognitive analytic therapy
2. Cognitive behaviour therapy
3. Interpersonal therapy
4. Focal psychodynamic therapy
5. Family interventions focused explicitly on eating disorders
6. Management on outpatient basis with physical monitoring

Pharmacological Interventions

Note: Tricyclic antidepressants, selective serotonin reuptake inhibitors (SSRIs), antihistamines (cyproheptadine), and antipsychotics (pimozide, sulpiride) were considered but not recommended for treatment of anorexia nervosa. Monitoring for side effects, particularly cardiovascular side effects, is recommended if any of these drugs are employed.

Management of Physical Aspects

1. Identification of patients at short-term risk of serious harm or death
2. Management of weight gain
3. Regular physical monitoring
4. Multivitamin mineral supplementation
5. Note: Use of estrogen supplementation, hormone replacement therapy, dehydroepiandrosterone [DHEA], and insulin-like growth factor are considered as treatment for bone loss, but are not recommended
6. Consultation with physician or pediatrician with expertise in treating at-risk patients as required
7. Other physical interventions, including nasogastric feeding, total parenteral nutrition, zinc supplementation, massage, and exercise (Note: Total parenteral nutrition is specifically not recommended unless there is significant gastrointestinal dysfunction. Other physical interventions are considered but not recommended because of limited or insufficient evidence.)
8. Special considerations for pregnant patients and patients with type I diabetes
9. Legal considerations involved in feeding against the will of the patient

Service Interventions

1. Outpatient treatment for most individuals
2. Inpatient treatment or day patient treatment for high-risk cases
3. Consultation with appropriate specialists
4. Additional considerations for children and adolescents

Treatment and Management of Bulimia Nervosa

Psychological Interventions

1. Encouragement of patients to follow evidence-based self-help programs
2. Cognitive behaviour therapy for bulimia nervosa
3. Other psychological treatments, such as cognitive behaviour therapy + exposure with response prevention
4. Interpersonal psychotherapy
5. Adaptation of treatment for adolescents

Pharmacological Interventions

1. Antidepressant drugs, including selective serotonin reuptake inhibitors (specifically fluoxetine). Note that other antidepressants, including monoamine oxidase inhibitors and tricyclic antidepressants, are considered but not recommended.
2. Opioid antagonists and antiemetics (considered but not recommended)

Management of the Physical Aspects of Bulimia Nervosa

1. Assessment of fluid and electrolyte balance
2. Oral supplementation to restore electrolyte balance
3. Exercise and massage (considered but not recommended because of insufficient or limited evidence of effectiveness)
4. Careful physical monitoring of pregnant and post-partum women and patients with type I diabetes

Service Level Interventions

1. Outpatient management for most individuals
2. Inpatient, day patient, or intensive outpatient management for high-risk patients
3. Psychiatric admission

Treatment and Management of Atypical Eating Disorders (Eating Disorders Not Otherwise Specified) Including Binge Eating Disorder

Psychological Interventions

1. Encouragement of patients to follow evidence-based self-help programs
2. Cognitive behaviour therapy for binge eating disorder
3. Other psychological interventions, including interpersonal psychotherapy for binge eating disorder and modified dialectical behaviour therapy
4. Consideration and management of comorbid obesity
5. Adaptation of psychological treatment to adolescents

Pharmacological Interventions

1. Antidepressants, including selective serotonin reuptake inhibitors
2. Antiepileptics (topiramate) (considered but not recommended)

MAJOR OUTCOMES CONSIDERED

- Body weight adjusted for height, usually represented as the body mass index (BMI) or the percentage of expected weight for the person's age, height, and sex (for anorexia nervosa)
- Frequency of binge eating and "purging" (self-induced vomiting or the use of laxatives to influence body shape or weight); that is, the frequency of these forms of behaviour over a set period of time (for bulimia nervosa)
- The proportion of participants who no longer practise the behaviour (sometime referred to as the "abstinence" rates)
- The frequency of binge eating, represented as for bulimia nervosa (for binge eating disorder)
- Relapse rates
- Cost-effectiveness of treatment

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

In conducting the review, the team systematically searched the literature for all English language systematic reviews relevant to the eating disorders scope that were published or updated after 1995.

Search filters developed by the review team consisted of a combination of subject heading and free-text phrases. A general filter was developed for eating disorders along with more specific filters for each clinical question. In addition, filters were developed for randomized controlled trials (RCTs) and for other appropriate research designs. (The search filters can be found in Appendix 8 of the original document.)

Electronic searches were made of the major bibliographic databases (MEDLINE, EMBASE, PsycINFO, CINAHL), in addition to the Cochrane Database of Systematic Reviews, the National Health Service Research and Development (NHS R&D) Health Technology Assessment database, Evidence-Based Mental Health and Clinical Evidence (Issue 5).

Ineligible articles were excluded, and a second independent reviewer crosschecked these for relevance. The remaining references were acquired in full and re-evaluated for eligibility. The most recently published reviews that appropriately addressed a clinical question were selected. For each systematic review used, a search was made for new studies, and the papers for these and for existing studies were retrieved.

The search for further evidence included research published after each review's search date, in-press papers identified by experts, and reviewing reference lists

and recent contents of selected journals. All reports that were retrieved but later excluded are listed with reasons for exclusion in the appropriate evidence table. Where no relevant systematic reviews were located, the review team asked the Guideline Development Group (GDG) to decide whether a fresh systematic review should be undertaken. Eligible reviews were critically appraised for methodological quality and the reliability of this procedure was confirmed by parallel independent assessment. The eligibility/quality assessment was tested on a representative sample of papers. (Appendix 10 of the original document provides the quality checklist.)

Cost Analysis

Bibliographic electronic databases and health economic databases were searched for economic evidence using the combination of a specially developed health economics search filter and a general filter for eating disorders. A combination of subject headings and free text searches were used where possible. (The search strategies and the databases searched are presented in Appendix 12 of the full version of the original guideline document.) The search for further evidence included papers from reference lists of eligible studies and relevant reviews. Experts in the field of eating disorders and mental health economics were also contacted to identify additional relevant published and unpublished studies. Studies included in the clinical evidence review and stakeholders' submissions were also screened for economic evidence.

Upon completion of the database searches, titles and abstracts of all references were screened for relevance to the scope of the guideline. The health economist then assessed relevant papers using a modified version of the Drummond et al. checklist (see Appendix 13 of the full version of the original guideline document).

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

I: Evidence obtained from a single randomised controlled trial or a meta-analysis of randomised controlled trials

IIa: Evidence obtained from at least one well-designed controlled study without randomisation

IIb: Evidence obtained from at least one well-designed quasi-experimental study

III: Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies and case-control studies

IV: Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

METHODS USED TO ANALYZE THE EVIDENCE

Meta-Analysis
Review of Published Meta-Analyses
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Synthesising the Evidence

Where possible, outcome data were extracted directly from all eligible studies that met the quality criteria into Review Manager 4.2 (Cochrane Collaboration, 2003). Meta-analysis was then used to synthesise the evidence where appropriate using Review Manager. If necessary, reanalyses of the data or sensitivity analyses were used to answer clinical questions not addressed in the original studies or reviews. Where meta-analysis was not appropriate and/or possible, the reported results from each primary-level study were entered into the Access database. Evidence tables were used to summarise general information about each study. Consultation was used to overcome difficulties with coding. Data from studies included in existing systematic reviews were extracted independently by one reviewer directly into Review Manager and crosschecked with the existing data set. Two independent reviewers extracted data from new studies, and disagreements were resolved by discussion. Where consensus could not be reached, a third reviewer resolved the disagreement. Masked assessment (i.e., blind to the journal from which the article comes, the authors, the institution, and the magnitude of the effect) was not used since it is unclear that doing so reduces bias.

Presenting the Data to the Guideline Development Group (GDG)

Where possible, the GDG was given a graphical presentation of the results using forest plots generated with the Review Manager software. Each forest plot displayed the effect size and confidence interval (CI) for each study as well as the overall summary statistic. The graphs were organised so that the display of data in the area to the left of the "line of no effect" indicated a "favourable" outcome for the treatment in question. Dichotomous outcomes were presented as relative risks (RR) and the associated 95 percent CI. A relative risk (or risk ratio) is the ratio of the treatment event rate to the control event rate. A RR of 1 indicates no difference between treatment and control.

All dichotomous outcomes were calculated on an intention-to-treat basis (i.e., a "once-randomised- always-analyse" basis). This assumes that those participants who ceased to engage in the study -- from whatever group -- had an unfavourable outcome (with the exception of the outcome of "death"). The Number Needed to Treat (NNT) or the Number Needed to Harm (NNH) was

reported for each statistically significant outcome where the baseline risk (i.e., control group event rate) was similar across studies. In addition, NNTs calculated at follow-up were only reported where the length of follow-up was similar across studies. When length of follow-up or baseline risk varies (especially with low risk), the NNT is a poor summary of the treatment effect.

Both the I^2 test of heterogeneity and the chi-squared test of heterogeneity ($p<0.10$) were used, as well as visual inspection of the forest plots, to look for the possibility of heterogeneity. I^2 describes the proportion of total variation in study estimates that is due to heterogeneity. An I^2 of less than 30 per cent was taken to indicate mild heterogeneity and a fixed effects model was used to synthesise the results. An I^2 of more than 50 per cent was taken as notable heterogeneity. In this case an attempt was made to explain the variation. If studies with heterogeneous results were found to be comparable, a random effects model was used to summarise the results. In the random effects analysis, heterogeneity is accounted for both in the width of CIs and in the estimate of the treatment effect. With decreasing heterogeneity the random effects approach moves asymptotically towards a fixed effects model. An I^2 of 30 to 50 percent was taken to indicate moderate heterogeneity. In this case, both the chi-squared test of heterogeneity and a visual inspection of the forest plot were used to decide between a fixed and random effects model.

To explore the possibility that the results entered into each meta-analysis suffered from publication bias, data from included studies were entered, where there was sufficient data, into a funnel plot. Asymmetry of the plot was taken to indicate possible publication bias and investigated further.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The Guideline Development Group (GDG)

The eating disorders GDG consisted of professionals in psychiatry, clinical psychology, nursing, social work, and general practice; academic experts in psychiatry and psychology; a patient, and a representative from a patient organisation. The carer perspective was provided through focus group discussion with carers; the group was run by the patient on the GDG. The guideline development process was supported by staff from the National Collaborating Centre for Mental Health (NCCMH) review team, who undertook the clinical and health economics literature searches, reviewed and presented the evidence to the GDG, managed the process, and contributed to the drafting of the guideline.

Guideline Development Group Meetings

Twenty-three eating disorders GDG meetings were held between March 2002 and October 2003. During the series of day-long meetings, clinical questions were written, clinical evidence was reviewed and assessed, statements were developed,

and recommendations were formulated. At each meeting, all GDG members declared any potential conflict of interests, and patient and carer concerns were routinely discussed as part of a standing agenda.

Forming and Grading the Statements and Recommendations

The evidence tables and forest plots formed the basis for developing clinical statements and recommendations. For intervention studies, the statements were classified according to an accepted hierarchy of evidence. Recommendations were then graded A to C based on the level of associated evidence (see "Rating Scheme for the Strength of the Recommendations").

In order to facilitate consistency in generating and drafting the clinical statements the GDG utilised a statement decision tree. The flowchart was designed to assist with, but not replace, clinical judgement.

Where a statistically significant summary statistic (effect size [ES]) was obtained (after controlling for heterogeneity), the GDG considered whether this finding was of clinical significance (i.e., likely to be of benefit to patients) taking into account the trial population, nature of the outcome, and size of the effect. On the basis of this consideration the ES was characterised as "clinically significant" or not. A further consideration was made about the strength of the evidence by examining the confidence interval (CI) surrounding the ES. For level I evidence, where the ES was judged to be clinically significant and had a CI entirely within a clinical relevant range, the result was characterised as "strong evidence" (S1). For non-level I evidence or in situations where the upper/lower bound of the CI was not clinically significant, the result was characterised as "limited evidence" (S2). Where an ES was statistically significant, but not clinically significant and the CI excluded values judged to be clinically important, the result was characterised as "unlikely to be clinically significant" (S3). Alternatively, if the CI included clinically important values, the result was characterised as "insufficient to determine clinical significance" (S6). Where a non-statistically significant ES was obtained, the GDG reviewed the trial population, nature of the outcome, size of the effect and, in particular, the CI surrounding the result. If the CI was narrow and excluded a clinically significant ES, this was seen as indicating evidence of "no clinically significant difference" (S4), but where the CI was wide this was seen as indicating 'insufficient evidence' to determine if there was a clinically significant difference or not (S5).

Once all evidence statements relating to a particular clinical question were finalised and agreed by the GDG, the associated recommendations were produced and graded. Grading the recommendations allowed the GDG to distinguish between the level of evidence and the strength of the associated recommendation. It is possible that a statement of evidence would cover only one part of an area in which a recommendation was to be made or would cover it in a way that would conflict with other evidence. In order to produce more comprehensive recommendations suitable for people in England and Wales, the GDG had to extrapolate from the available evidence. This led to a weaker level of recommendation (i.e. B, as data were based upon level I evidence). It is important to note that the grading of the recommendation is not a reflection of its clinical significance or relevance.

A number of issues relating to the study of eating disorders meant that the outcomes available for analysis were classified as primary or secondary. When making recommendations, the primary outcomes were given more weight during the decision process.

The process also allowed the GDG to moderate recommendations based on factors other than the strength of evidence. Such considerations include the applicability of the evidence to people with eating disorders, economic considerations, values of the development group and society, or the group's awareness of practical issues.

Method Used to Answer a Clinical Question in the Absence of Appropriately Designed, High-Quality Research

Where it was not possible to identify at least one appropriately designed study or high-quality systematic review, or where the GDG was of the opinion (on the basis of previous searches or their knowledge of the literature) that there was unlikely to be appropriately designed primary-level research that directly addressed the clinical question, an informal consensus process was adopted. This process focused on those questions that the GDG considered a priority.

The starting point for this process of informal consensus was that a member of the topic group identified, with help from the systematic reviewer, a narrative review that most directly addressed the clinical question. Where this was not possible a new review of the recent literature was initiated.

This existing narrative review or new review was used as a basis for identifying lower levels of evidence relevant to the clinical question. This was then presented for discussion to the GDG. On the basis of this, additional information was sought and added to the information collected. This may include studies that did not directly address the clinical question but were thought to contain relevant data. This led to the development of an initial draft report that addressed the following issues:

- A description of what is known about the issues concerning the clinical question
- Brief review of the existing evidence, including RCTs, non-randomised controlled studies, cohort studies, and other studies that help answer the question
- The summary of the evidence so far obtained. This was then presented in narrative form to the GDG and further comments were sought about the evidence and its perceived relevance to the clinical question.
- If, during the course of preparing the report, a significant body of primary-level studies (of appropriate design to answer the question) were identified, a full systematic review was done.
- At this time, subject possibly to further reviews of the evidence, a series of statements that directly addressed the clinical question were developed.
- Following this, on occasions and as deemed appropriate by the development group, the report was then sent to appointed experts outside of the GDG for peer review and comment. The information from this process was then fed back to the GDG for further discussion of the statements.

- Recommendations were then developed and could also be sent for further external peer review.
- After this final stage of comment, the statements and recommendations were again reviewed and agreed upon by the GDG.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Strength of Recommendations

Grade A - At least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation (evidence level I) without extrapolation

Grade B - Well-conducted clinical studies but no randomised clinical trials on the topic of recommendation (evidence levels II or III); or extrapolated from level I evidence

Grade C - Expert committee reports or opinions and/or clinical experiences of respected authorities (evidence level IV) or extrapolated from level I or II evidence. This grading indicates that directly applicable clinical studies of good quality are absent or not readily available.

COST ANALYSIS

Published economic evidence was systematically reviewed to collect cost-of-illness information and to consider the cost-effectiveness of different forms of care alongside their clinical effectiveness when formulating recommendations.

The relevant economic evidence was abstracted and presented as narrative summaries in Chapter 9 of the full version of the original guideline document.

Health economics evidence was available for the following areas:

- Cognitive-behavioural therapy
- Antidepressant therapy
- Out-patient care
- In-patient care
- Intensive day programme

Since economic literature providing information on cost and/or cost-effectiveness for forms of care within the scope of the guideline was very limited and of poor quality, further economic analysis including modeling was undertaken.

Topic for further economic analysis was selected by the GDG based on the following criteria:

- The topic has major cost implication.
- Significant uncertainty still exists after reviewing published clinical and economic literature.
- There is sufficient information of adequate quality to conduct meaningful further evidence synthesis including modeling.

- A change in policy is likely to be involved.

A decision analytic model was developed to compare the cost-effectiveness of antidepressant therapy, cognitive behavioural therapy and the combination of the two for the treatment of bulimia nervosa. The clinical evidence used in this economic analysis was consistent with the clinical effectiveness data synthesized in the guideline. Cost data were identified from the UK National Health Service's perspective. Comprehensive sensitivity analysis was carried out. The methods and results of the economic analysis are presented in Chapter 9 of the full version of the original guideline document. A limited cost implication analysis for the likely policy change was also carried out.

Result of the Cost-Effectiveness Analysis

The patient groups to which the results apply are identical to those described in the clinical evidence section of the original document.

Treatment Outcomes

The systematically reviewed clinical evidence shows that the number of patients remitting is significantly higher for cognitive behaviour therapy (CBT) than for antidepressant treatment. The end of treatment absolute risk of no remission by antidepressants was found to be 0.807 and the relative risk of no remission by antidepressant treatment versus CBT was 1.28. Although there was insufficient evidence to draw firm conclusions about the comparable longer-term treatment outcomes of CBT and antidepressant therapy, it is anticipated that the relapse rate with CBT is lower than that with antidepressants.

CBT Costs

On average, one course of bulimia nervosa-specific CBT costs 967.00 pounds sterling when provided by a suitably qualified and trained clinical psychologist.

The unit cost and resource utilization data used for this calculation are listed in Appendix 16 of the original document.

Antidepressant Treatment Costs

Due to the different service-level possibilities for prescribing antidepressant treatment for people with bulimia nervosa, multiple scenarios were considered to calculate the cost of fluoxetine therapy:

- The estimated average cost of generic fluoxetine treatment prescribed by a general practitioner is 118.48 pounds sterling.
- Fluoxetine prescribed by a psychiatrist in secondary care on an outpatient basis is estimated to be a less costly alternative of antidepressant therapy for people with bulimia nervosa, average total treatment cost of 94.66 pounds sterling, than primary care provision when prescribed by a specialist registrar level physician. However, it is estimated to be more costly option, average total treatment cost of 238.66 pounds sterling, when consultant level physician fees are used for the calculation.

No estimates exist for the health care costs due to the complications of antidepressant therapy in bulimia nervosa, and so they could not be included in the calculation.

Cost of No Remission from Bulimia Nervosa

Bulimia nervosa is a chronic psychiatric disorder; a high percentage of the people do not achieve remission at all or relapse in a few months post-treatment. Although no formal estimate exists about the magnitude of the additional health service use of people with bulimia nervosa, it is well known that people unsuccessfully treated continue to impose considerable extra costs for the health care sector (due to the need for extra eating disorder treatments, and additional medical and dental expenses due to symptomatic behaviour and comorbidities). Patients with bulimia nervosa also incur substantial extra costs for the broader society due to lost productivity and have greatly decreased quality of life. Hence it is anticipated that CBT, which has a significantly higher remission rate compared to antidepressant treatment for people with bulimia nervosa, also averts important additional health care costs.

Incremental Cost-Effectiveness of CBT Versus Antidepressant Therapy

Since CBT was estimated to be both more effective and more costly, the difference in costs and effects were compared between CBT and antidepressant therapy. However, it needs to be emphasised that these estimates do not include the potential cost savings of CBT by averting additional and longer term health service use in the National Health Service (NHS). As a consequence, the net health service cost of CBT and the incremental cost-effectiveness ratio of CBT versus antidepressants are likely to be significantly overestimated in the analysis.

The incremental cost of CBT per successfully treated bulimia nervosa case is estimated to be the following:

- 4,807.24 pounds sterling when generic fluoxetine is prescribed by a general practitioner
- 4,942.23 pounds sterling/4,126.41 pounds sterling when generic fluoxetine is prescribed by a psychiatrist in secondary care on an outpatient basis.

Comparison of the costs and effects of CBT and antidepressant therapy (AD) for two cohorts of 1,000 people with bulimia nervosa are summarised in Table 1 of the original document.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

This guideline has been validated through two consultation exercises. The first consultation draft was submitted to the National Institute for Clinical Excellence (NICE) Guidelines Review Panel, and circulated to stakeholders, special advisors,

and other reviewers nominated by Guideline Development Group (GDG) members.

After taking into account comments from stakeholders, the NICE Guidelines Review Panel, a number of health authority and trust representatives, and a wide range of national and international experts from this round of consultation, the GDG responded to all comments and prepared a final consultation draft which was submitted to NICE, circulated to all stakeholders for final comments and posted on the website for public consultation. The final draft was then submitted to the NICE Guidelines Review Panel for review prior to publication.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Evidence categories (I-IV) and recommendation grades (A-C) are defined at the end of the "Major Recommendations" field.

Care Across All Conditions

Assessment and Coordination of Care

C - Assessment of people with eating disorders should be comprehensive and include physical, psychological, and social needs and a comprehensive assessment of risk to self.

C - The level of risk to the patient's mental and physical health should be monitored as treatment progresses because it may change--for example, following weight gain or at times of transition between services in cases of anorexia nervosa.

C - For people with eating disorders presenting in primary care, general practitioners (GPs) should take responsibility for the initial assessment and the initial coordination of care. This includes the determination of the need for emergency medical or psychiatric assessment.

C - Where management is shared between primary and secondary care, there should be clear agreement among individual health care professionals on the responsibility for monitoring patients with eating disorders. This agreement should be in writing (where appropriate using the care programme approach) and should be shared with the patient and, where appropriate, his or her family and carers.

Providing Good Information and Support

C - Patients and, where appropriate, carers should be provided with education and information on the nature, course, and treatment of eating disorders.

C - In addition to the provision of information, family and carers may be informed of self-help groups and support groups, and offered the opportunity to participate in such groups where they exist.

C - Health care professionals should acknowledge that many people with eating disorders are ambivalent about treatment. Health care professionals should also recognise the consequent demands and challenges this presents.

Getting Help Early

There can be serious long-term consequences to a delay in obtaining treatment.

C - People with eating disorders seeking help should be assessed and receive treatment at the earliest opportunity.

C - Whenever possible patients should be engaged and treated before reaching severe emaciation. This requires both early identification and intervention. Effective monitoring and engagement of patients at severely low weight or with falling weight should be a priority.

Management of Physical Aspects

C - Where laxative abuse is present, patients should be advised to gradually reduce laxative use and informed that laxative use does not significantly reduce calorie absorption.

C - Treatment of both subthreshold and clinical cases of an eating disorder in people with diabetes is essential because of the greatly increased physical risk in this group.

C - People with type 1 diabetes and an eating disorder should have intensive regular physical monitoring because they are at high risk of retinopathy and other complications.

C - Pregnant women with eating disorders require careful monitoring throughout the pregnancy and in the postpartum period.

C - Patients with an eating disorder who are vomiting should have regular dental reviews.

C - Patients who are vomiting should be given appropriate advice on dental hygiene, which should include avoiding brushing after vomiting; rinsing with a non-acid mouthwash after vomiting; and reducing an acid oral environment (for example, limiting acidic foods).

C - Health care professionals should advise people with eating disorders and osteoporosis or related bone disorders to refrain from physical activities that significantly increase the likelihood of falls.

Additional Considerations for Children and Adolescents

C - Family members, including siblings, should normally be included in the treatment of children and adolescents with eating disorders. Interventions may include sharing of information, advice on behavioural management, and facilitating communication.

C - In children and adolescents with eating disorders, growth and development should be closely monitored. Where development is delayed or growth is stunted despite adequate nutrition, paediatric advice should be sought.

C - Health care professionals assessing children and adolescents with eating disorders should be alert to indicators of abuse (emotional, physical and sexual) and should remain so throughout treatment.

C - The right to confidentiality of children and adolescents with eating disorders should be respected.

C - Health care professionals working with children and adolescents with eating disorders should familiarise themselves with national guidelines and their employers' policies in the area of confidentiality.

Identification and Screening of Eating Disorders in Primary Care and Non-Mental Health Settings

C - Target groups for screening should include young women with low body mass index (BMI) compared with age norms, patients consulting with weight concerns who are not overweight, women with menstrual disturbances or amenorrhoea, patients with gastrointestinal symptoms, patients with physical signs of starvation or repeated vomiting, and children with poor growth.

C - When screening for eating disorders one or two simple questions should be considered for use with specific target groups (for example, "Do you think you have an eating problem?" and "Do you worry excessively about your weight?").

C - Young people with type 1 diabetes and poor treatment adherence should be screened and assessed for the presence of an eating disorder.

Anorexia Nervosa

Management of Anorexia Nervosa in Primary Care

C - In anorexia nervosa, although weight and BMI are important indicators of physical risk they should not be considered the sole indicators (as they are unreliable in adults and especially in children).

C - In assessing whether a person has anorexia nervosa, attention should be paid to the overall clinical assessment (repeated over time), including rate of weight loss, growth rates in children, objective physical signs, and appropriate laboratory tests.

C - Patients with enduring anorexia nervosa not under the care of a secondary care service should be offered an annual physical and mental health review by their GP.

Psychological Interventions for Anorexia Nervosa

The delivery of psychological interventions should be accompanied by regular monitoring of a patient's physical state including weight and specific indicators of increased physical risk.

Common Elements of the Psychological Treatment of Anorexia Nervosa

C - Therapies to be considered for the psychological treatment of anorexia nervosa include cognitive analytic therapy (CAT), cognitive behaviour therapy (CBT), interpersonal psychotherapy (IPT), focal psychodynamic therapy, and family interventions focused explicitly on eating disorders.

C - Patient and, where appropriate, carer preference should be taken into account in deciding which psychological treatment is to be offered.

C - The aims of psychological treatment should be to reduce risk, to encourage weight gain and healthy eating, to reduce other symptoms related to an eating disorder, and to facilitate psychological and physical recovery.

Outpatient Psychological Treatments in First Episode and Later Episodes

C - Most people with anorexia nervosa should be managed on an outpatient basis, with psychological treatment (with physical monitoring) provided by a health care professional competent to give it and to assess the physical risk of people with eating disorders.

C - Outpatient psychological treatment and physical monitoring for anorexia nervosa should normally be of at least 6 months' duration.

C - For patients with anorexia nervosa, if during outpatient psychological treatment there is significant deterioration, or the completion of an adequate course of outpatient psychological treatment does not lead to any significant improvement, more intensive forms of treatment (for example, a move from individual therapy to combined individual and family work or day care or inpatient care) should be considered.

C - Dietary counselling should not be provided as the sole treatment for anorexia nervosa.

Psychological Aspects of Inpatient Care

C - For inpatients with anorexia nervosa, a structured symptom-focused treatment regimen with the expectation of weight gain should be provided in order to achieve weight restoration. It is important to carefully monitor the patient's physical status during refeeding.

C - Psychological treatment should be provided which has a focus both on eating behaviour and attitudes to weight and shape and on wider psychosocial issues with the expectation of weight gain.

C - Rigid inpatient behaviour modification programmes should not be used in the management of anorexia nervosa.

Post-Hospitalisation Psychological Treatment

C - Following inpatient weight restoration, people with anorexia nervosa should be offered outpatient psychological treatment that focuses both on eating behaviour and attitudes to weight and shape and on wider psychosocial issues, with regular monitoring of both physical and psychological risk.

C - The length of outpatient psychological treatment and physical monitoring following inpatient weight restoration should typically be at least 12 months.

Additional Considerations for Children and Adolescents with Anorexia Nervosa

B - Family interventions that directly address the eating disorder should be offered to children and adolescents with anorexia nervosa.

C - Children and adolescents with anorexia nervosa should be offered individual appointments with a health care professional separate from those with their family members or carers.

C - The therapeutic involvement of siblings and other family members should be considered in all cases because of the effects of anorexia nervosa on other family members.

C - In children and adolescents with anorexia nervosa, the need for inpatient treatment and the need for urgent weight restoration should be balanced alongside the educational and social needs of the young person.

Pharmacological Interventions for Anorexia Nervosa

There is a very limited evidence base for the pharmacological treatment of anorexia nervosa. A range of drugs may be used in the treatment of comorbid conditions but caution should be exercised in their use given the physical vulnerability of many people with anorexia nervosa.

C - Medication should not be used as the sole or primary treatment for anorexia nervosa.

C - Caution should be exercised in the use of medication for comorbid conditions such as depressive or obsessive-compulsive features, as they may resolve with weight gain alone.

C - When medication is used to treat people with anorexia nervosa, the side effects of drug treatment (in particular, cardiac side effects) should be carefully considered because of the compromised cardiovascular function of many people with anorexia nervosa.

C - Health care professionals should be aware of the risk of drugs that prolong the QTc interval on the electrocardiogram (ECG) (for example, antipsychotics, tricyclic antidepressants, macrolide antibiotics, and some antihistamines). In patients with anorexia nervosa at risk of cardiac complications, the prescription of drugs with side effects that may compromise cardiac functioning should be avoided.

C - If the prescription of medication that may compromise cardiac functioning is essential, ECG monitoring should be undertaken.

C - All patients with a diagnosis of anorexia nervosa should have an alert placed in their prescribing record concerning the risk of side effects.

Physical Management of Anorexia Nervosa

Anorexia nervosa carries considerable risk of serious physical morbidity. Awareness of the risk, careful monitoring, and, where appropriate, close liaison with an experienced physician are important in the management of the physical complications of anorexia nervosa.

Managing Weight Gain

C - In most patients with anorexia nervosa, an average weekly weight gain of 0.5-1 kg in inpatient settings and 0.5 kg in outpatient settings should be an aim of treatment. This requires about 3,500 to 7,000 extra calories a week.

C - Regular physical monitoring, and in some cases treatment with a multi-vitamin/multi-mineral supplement in oral form, is recommended for people with anorexia nervosa during both inpatient and outpatient weight restoration.

C - Total parenteral nutrition should not be used for people with anorexia nervosa, unless there is significant gastrointestinal dysfunction.

Managing Risk

C - Health care professionals should monitor physical risk in patients with anorexia nervosa. If this leads to the identification of increased physical risk, the frequency of the monitoring and nature of the investigations should be adjusted accordingly.

C - People with anorexia nervosa and their carers should be informed if the risk to their physical health is high.

C - The involvement of a physician or paediatrician with expertise in the treatment of physically at-risk patients with anorexia nervosa should be considered for all individuals who are physically at risk.

C - Pregnant women with either current or remitted anorexia nervosa may need more intensive prenatal care to ensure adequate prenatal nutrition and fetal development.

C - Oestrogen administration should not be used to treat bone density problems in children and adolescents as this may lead to premature fusion of the epiphyses.

Feeding Against the Will of the Patient

C - Feeding against the will of the patient should be an intervention of last resort in the care and management of anorexia nervosa.

C - Feeding against the will of the patient is a highly specialized procedure requiring expertise in the care and management of those with severe eating disorders and the physical complications associated with it. This should only be done in the context of the Mental Health Act 1983 or Children Act 1989.

C - When making the decision to feed against the will of the patient, the legal basis for any such action must be clear.

Service Interventions for Anorexia Nervosa

This section considers those aspects of the service system relevant to the treatment and management of anorexia nervosa.

C - Most people with anorexia nervosa should be treated on an outpatient basis.

C - Where inpatient management is required, this should be provided within reasonable travelling distance to enable the involvement of relatives and carers in treatment, to maintain social and occupational links, and to avoid difficulty in transition between primary and secondary care services. This is particularly important in the treatment of children and adolescents.

C - Inpatient treatment should be considered for people with anorexia nervosa whose disorder is associated with high or moderate physical risk.

C - People with anorexia nervosa requiring inpatient treatment should be admitted to a setting that can provide the skilled implementation of refeeding with careful physical monitoring (particularly in the first few days of refeeding), in combination with psychosocial interventions.

C - Inpatient treatment or day patient treatment should be considered for people with anorexia nervosa whose disorder has not improved with appropriate outpatient treatment, or for whom there is a significant risk of suicide or severe self-harm.

C - Health care professionals without specialist experience of eating disorders, or in situations of uncertainty, should consider seeking advice from an appropriate specialist when contemplating a compulsory admission for a patient with anorexia nervosa, regardless of the age of the patient.

C - Health care professionals managing patients with anorexia nervosa, especially that of the binge purging sub-type, should be aware of the increased risk of self-harm and suicide, particularly at times of transition between services or service settings.

Additional Considerations for Children and Adolescents

C - Health care professionals should ensure that children and adolescents with anorexia nervosa who have reached a healthy weight have the increased energy and necessary nutrients available in their diet to support further growth and development.

C - In the nutritional management of children and adolescents with anorexia nervosa, carers should be included in any dietary education or meal planning.

C - Admission of children and adolescents with anorexia nervosa should be to age-appropriate facilities (with the potential for separate children and adolescent services), which have the capacity to provide appropriate educational and related activities.

C - When a young person with anorexia nervosa refuses treatment that is deemed essential, consideration should be given to the use of the Mental Health Act 1983 or the right of those with parental responsibility to override the young person's refusal.

C - Relying indefinitely on parental consent to treatment should be avoided. It is recommended that the legal basis under which treatment is being carried out should be recorded in the patient's case notes, and this is particularly important in the case of children and adolescents.

C - For children and adolescents with anorexia nervosa, where issues of consent to treatment are highlighted, health care professionals should consider seeking a second opinion from an eating disorders specialist.

C - If the patient with anorexia nervosa and those with parental responsibility refuse treatment, and treatment is deemed to be essential, legal advice should be sought in order to consider proceedings under the Children Act 1989.

Bulimia Nervosa

Psychological Interventions for Bulimia Nervosa

B - As a possible first step, patients with bulimia nervosa should be encouraged to follow an evidence-based self-help programme.

B - Health care professionals should consider providing direct encouragement and support to patients undertaking an evidence-based self-help programme, as this may improve outcomes. This may be sufficient treatment for a limited subset of patients.

A - Cognitive behaviour therapy for bulimia nervosa (CBT-BN), a specifically adapted form of CBT, should be offered to adults with bulimia nervosa. The course of treatment should be for 16 to 20 sessions over 4 to 5 months.

C - Adolescents with bulimia nervosa may be treated with CBT-BN adapted as needed to suit their age, circumstances, and level of development, and including the family as appropriate.

B - When people with bulimia nervosa have not responded to or do not want CBT, other psychological treatments should be considered.

B - Interpersonal psychotherapy should be considered as an alternative to CBT, but patients should be informed it takes 8-12 months to achieve results comparable with CBT.

Pharmacological Interventions for Bulimia Nervosa

B - As an alternative or additional first step to using an evidence-based self-help programme, adults with bulimia nervosa may be offered a trial of an antidepressant drug.

B - Patients should be informed that antidepressant drugs can reduce the frequency of binge eating and purging, but the long-term effects are unknown. Any beneficial effects will be rapidly apparent.

C - Selective serotonin reuptake inhibitors (SSRIs) (specifically fluoxetine) are the drugs of first choice for the treatment of bulimia nervosa in terms of acceptability, tolerability, and reduction of symptoms.

C - For people with bulimia nervosa, the effective dose of fluoxetine is higher than for depression (60 mg daily).

B - No drugs, other than antidepressants, are recommended for the treatment of bulimia nervosa.

Management of Physical Aspects of Bulimia Nervosa

Patients with bulimia nervosa can experience considerable physical problems as a result of a range of behaviours associated with the condition. Awareness of the risks and careful monitoring should be a concern of all health care professionals working with people with this disorder.

C - Patients with bulimia nervosa who are vomiting frequently or taking large quantities of laxatives (especially if they are also underweight) should have their fluid and electrolyte balance assessed.

C - When electrolyte disturbance is detected, it is usually sufficient to focus on eliminating the behaviour responsible. In the small proportion of cases where supplementation is required to restore electrolyte balance, oral rather than intravenous administration is recommended, unless there are problems with gastrointestinal absorption.

Service Interventions for Bulimia Nervosa

The great majority of patients with bulimia nervosa can be treated as outpatients. There is a very limited role for the inpatient treatment of bulimia nervosa. This is primarily concerned with the management of suicide risk or severe self-harm.

C - The great majority of patients with bulimia nervosa should be treated in an outpatient setting.

C - For patients with bulimia nervosa who are at risk of suicide or severe self-harm, admission as an inpatient or day patient, or the provision of more intensive outpatient care, should be considered.

C - Psychiatric admission for people with bulimia nervosa should normally be undertaken in a setting with experience of managing this disorder.

C - Health care professionals should be aware that patients with bulimia nervosa who have poor impulse control, notably substance misuse, may be less likely to respond to a standard programme of treatment. As a consequence treatment should be adapted to the problems presented.

Additional Considerations for Children and Adolescents

C - Adolescents with bulimia nervosa may be treated with CBT-BN adapted as needed to suit their age, circumstances, and level of development, and including the family as appropriate.

Treatment and Management of Atypical Eating Disorders Including Binge Eating Disorder

General Treatment of Atypical Eating Disorders

C - In the absence of evidence to guide the management of atypical eating disorders (eating disorders not otherwise specified) other than binge eating disorder, it is recommended that the clinician considers following the guidance on the treatment of the eating problem that most closely resembles the individual patient's eating disorder.

Psychological Treatments for Binge Eating Disorder

B - As a possible first step, patients with binge eating disorder should be encouraged to follow an evidence-based self-help programme.

B - Health care professionals should consider providing direct encouragement and support to patients undertaking an evidence-based self-help programme as this may improve outcomes. This may be sufficient treatment for a limited subset of patients.

A - Cognitive behaviour therapy for binge eating disorder (CBT-BED), a specifically adapted form of CBT, should be offered to adults with binge eating disorder.

B - Other psychological treatments (interpersonal psychotherapy for binge eating disorder and modified dialectical behaviour therapy) may be offered to adults with persistent binge eating disorder.

A - Patients should be informed that all psychological treatments for binge eating disorder have a limited effect on body weight.

C - When providing psychological treatments for patients with binge eating disorder, consideration should be given to the provision of concurrent or consecutive interventions focusing on the management of comorbid obesity.

C - Suitably adapted psychological treatments should be offered to adolescents with persistent binge eating disorder.

Pharmacological Interventions for Binge Eating Disorder

B - As an alternative or additional first step to using an evidence based self-help programme, consideration should be given to offering a trial of an SSRI antidepressant drug to patients with binge eating disorder.

B - Patients with binge eating disorders should be informed that SSRIs can reduce binge eating, but the long-term effects are unknown. Antidepressant drug treatment may be sufficient treatment for a limited subset of patients.

Definitions:

Evidence Categories

I: Evidence obtained from a single randomised controlled trial or a meta-analysis of randomised controlled trials

IIa: Evidence obtained from at least one well-designed controlled study without randomisation

IIb: Evidence obtained from at least one well-designed quasi-experimental study

III: Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies, and case-control studies

IV: Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

Recommendation Grades

Grade A - At least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation (evidence level I) without extrapolation

Grade B - Well-conducted clinical studies but no randomised clinical trials on the topic of recommendation (evidence levels II or III); or extrapolated from level I evidence

Grade C - Expert committee reports or opinions and/or clinical experiences of respected authorities (evidence level IV) or extrapolated from level I or II evidence. This grading indicates that directly applicable clinical studies of good quality are absent or not readily available.

CLINICAL ALGORITHM(S)

An algorithm is provided for: Eating disorders: summary of identification and management.

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Consistent quality of care for patients with eating disorders including anorexia nervosa, bulimia nervosa, and related eating disorders

POTENTIAL HARMS

- Drugs that prolong the QTc interval on the electrocardiogram (ECG) (for example, antipsychotics, tricyclic antidepressants, macrolide antibiotics, and some antihistamines) may compromise cardiac function in some patients with anorexia nervosa.
- Hypophosphataemia may develop rapidly during refeeding, and if severe can cause cardiac and respiratory failure, delirium, and fits.
- Ingestion of large quantities of carbohydrates, during rapid refeeding, may result in a precipitate drop in serum phosphate levels.
- The risks associated with naso-gastric (NG) tube feeding, percutaneous endoscopic gastrostomy (PEG), or spoon feeding, will be increased in the context of active physical resistance. Actions such as the pulling out the (NG) tube, interfering with or pulling out the PEG, and the physical condition of the patient increase the risk involved.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- Guidelines are not a substitute for professional knowledge and clinical judgment. Guidelines can be limited in their usefulness and applicability by a number of different factors: the availability of high quality research evidence, the quality of the methodology used in the development of the guideline, the generalisability of research findings and the uniqueness of individual patients.
- Although the quality of research in eating disorders is variable, the methodology used here reflects current international understanding on the appropriate practice for guideline development (AGREE: Appraisal of Guidelines for Research and Evaluation Instrument; www.agreecollaboration.org), ensuring the collection and selection of the best research evidence available, and the systematic generation of treatment

recommendations applicable to the majority of patients and situations. However, there will always be some people and situations for which clinical guideline recommendations are not readily applicable. This guideline does not, therefore, override the individual responsibility of health care professionals to make appropriate decisions in the circumstances of the individual patient, in consultation with the patient and/or carer.

- In addition to the clinical evidence, cost-effectiveness information, where available, is taken into account in the generation of statements and recommendations of the clinical guidelines. While national guidelines are concerned with clinical and cost-effectiveness, issues of affordability and implementation costs are to be determined by the National Health Service (NHS).
- In using guidelines, it is important to remember that the absence of empirical evidence for the effectiveness of a particular intervention is not the same as evidence for ineffectiveness. In addition, of particular relevance in mental health, evidence-based treatments are often delivered within the context of an overall treatment programme including a range of activities, the purpose of which may be to help engage the patient, and provide an appropriate context for the delivery of specific interventions. It is important to maintain and enhance the service context in which these interventions are delivered; otherwise the specific benefits of effective interventions will be lost. Indeed, the importance of organising care, so as to support and encourage a good therapeutic relationship, is at times as important as the specific treatments offered.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Local health communities should review their existing practice in the treatment and management of anorexia nervosa, bulimia nervosa, and related eating disorders (core interventions) against this guideline. The review should consider the resources required to implement the recommendations set out in Section 1 of the short version of the original guideline document (and in the "Major Recommendations" section of this summary), the people and processes involved, and the timeline over which full implementation is envisaged. It is in the interests of patients that the implementation timeline is as rapid as possible.

Relevant local clinical guidelines, care pathways, and protocols should be reviewed in the light of this guidance and revised accordingly. This guideline should be used in conjunction with the National Service Framework for Mental Health, which is available from www.doh.gov.uk/nsf/mentalhealth.htm

Suggested audit criteria are listed in Appendix C of the short version and in Appendix 10 of the long version of the original guideline document. These can be used as the basis for local clinical audit, at the discretion of those in practice.

IMPLEMENTATION TOOLS

Audit Criteria/Indicators
Clinical Algorithm

Foreign Language Translations
Patient Resources
Quick Reference Guides/Physician Guides

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

National Collaborating Centre for Mental Health. Eating disorders. Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. Leicester (UK): British Psychological Society; 2004. 260 p. [408 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2004 Jan

GUIDELINE DEVELOPER(S)

National Collaborating Centre for Mental Health - National Government Agency [Non-U.S.]

SOURCE(S) OF FUNDING

National Institute for Clinical Excellence (NICE)

GUIDELINE COMMITTEE

Guideline Development Group

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

All Guideline Development Group (GDG) members made formal declarations of interest at the outset, which were updated at every GDG meeting.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format [PDF] format from the National Institute for Clinical Excellence (NICE) Web site.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Eating Disorders. Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. NICE guideline. 2004 Jan. 35 p. Available in Portable Document Format (PDF) from the National Institute for Clinical Excellence (NICE) Web site.
- Eating disorders. Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. Quick reference guide. 2004 Jan. 16 p. Available in Portable Document Format (PDF) from the NICE Web site.
- Eating disorders. Algorithm: core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. Summary of identification and management. 2004 Jan. 4 p. Available in Portable Document Format (PDF) from the NICE Web site.

Print copies: Available from the National Health Service (NHS) Response Line 0870 1555 455. ref: N0406. 11 Strand, London, WC2N 5HR.

Additionally, Audit Criteria can be found in Chapter 10 of the original guideline document.

PATIENT RESOURCES

The following is available:

- Eating disorders: anorexia nervosa, bulimia nervosa and related eating disorders. Understanding NICE guidance: a guide for people with eating disorders, their advocates and carers, and the public. London: National Institute for Clinical Excellence. 2004 Jan. 44 p.

Electronic copies: Available in English and Welsh in Portable Document Format (PDF) from the National Institute for Clinical Excellence (NICE) Web site.

Print copies: Available from the National Health Service (NHS) Response Line 0870 1555 455. ref: N0407. 11 Strand, London, WC2N 5HR.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

This summary was completed by ECRI on January 4, 2005. The information was verified by the guideline developer on March 9, 2005. This summary was updated by ECRI on August 15, 2005, following the U.S. Food and Drug Administration advisory on antidepressant medications.

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Date Modified: 9/25/2006