**“Eating Disorders in the Obstetric and Gynecologic Patient Population”**

*Arnold E. Andersen, MD, and Ginny L. Ryan, MD*

*December 2009 – Volume 114 – Issue 6 – Pages 1353–67*

**Click Here to Read the Full Article**

<table>
<thead>
<tr>
<th>Questions written by:</th>
<th>Responses written by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Danielle Hazard, MD</td>
<td>Arnold E. Andersen, MD</td>
</tr>
<tr>
<td>Penn State University College of Medicine</td>
<td>University of Iowa Hospital</td>
</tr>
<tr>
<td>Hershey, Pennsylvania</td>
<td>Department of Psychiatry</td>
</tr>
<tr>
<td></td>
<td>Iowa City, Iowa</td>
</tr>
<tr>
<td></td>
<td>Ginny L. Ryan, MD</td>
</tr>
<tr>
<td></td>
<td>University of Iowa Hospital</td>
</tr>
<tr>
<td></td>
<td>Department of Obstetrics &amp; Gynecology</td>
</tr>
<tr>
<td></td>
<td>Iowa City, Iowa</td>
</tr>
</tbody>
</table>

1. In your practice, what screening tool do you use to identify patients with eating disorders and at what frequency? Do you screen all patients or only a select group?

**Response from Drs. Arnold E. Andersen and Ginny L. Ryan:**

**GR:** *My practice includes a mix of pediatric/adolescent gynecology patients and adult patients with infertility or other reproductive endocrinologic issues. Since working on this article with Dr. Andersen, I have become more aware of the need to screen adult women liberally for eating disorders. I do not screen all of my adult patients at this time, but, along with my colleagues, I am considering instituting universal screening for our adult population. Currently, I screen adult patients with low body mass index (BMI), psychiatric co-morbidities, unexplained ovulatory dysfunction, and hypothalamic hypogonadism. I now more frequently use the SCOFF questionnaire or pertinent questions found within that screening tool. In contrast, the exact word use in the SCOFF questionnaire seems less appropriate to my adolescent patients. In this population, I tend to screen patients with primary or secondary amenorrhea, low BMI, or unexplained oligomenorrhea, and I use a modified version of pertinent questions found within the SCOFF questionnaire.*

**AA:** *I try to assess with age-appropriate questions whether concerns about weight, food, exercise, or body image dominate their daily thinking and distort their behaviors.*
2. If you were given the opportunity to write the DSM-V criteria for eating disorders, what would they be?

Response from Dr. Arnold E. Andersen:

AA: For anorexia nervosa, the criteria would be simplified by discarding the obsolete requirement for amenorrhea, shown to be irrelevant, and to clarify the misleading “example” of 85% as the amount of weight loss required. The criteria would be:

A. Anorexia nervosa:
   1. A strong overvalued belief in the necessity of extreme thinness manifested by an intense fear of fatness even when thin;
   2. Substantial self-induced weight loss sufficient to produce general signs of medical starvation, lasting for 3 months or more, including, but not limited to, abnormal reproductive hormone function (eg, hypothermia, orthostasis, bradycardia, hypotension). In pre-teens and adolescents, failure to increase weight proportional to axial growth equivalent to weight loss;
   3. Disturbed body image: not recognizing seriousness of low weight, denial of thinness, or excess influence of body weight and shape on self-esteem;
   4. Two subtypes: pure food restricting or binge/purge.

B. Bulimia nervosa: No change.

C. Binge-eating disorder:
   1. Recurrent unwanted episodes of binge eating without subsequent compensation by purging, extreme exercise, or rigorous fasting;
   2. Occurs on the average twice a week for 3 months;
   3. Perception of lack of control over eating during the binge episodes;

D. NB: No longer a subgroup of eating disorders not otherwise specified.
3. How important is it for obstetrician–gynecologists to define the type of eating disorder (anorexia vs bulimia) a patient has? Is the management of reproductive disorders different among the types of eating disorders?

Response from Dr. Ginny L. Ryan:

GR: From the standpoint of screening, it is not necessary for the general obstetrician–gynecologist to identify the specific eating disorder affecting her patient. Recommended treatment does differ between the eating disorders, however, and this is where collaboration with an expert in psychiatry is vital. It is important for obstetrician–gynecologists to understand the important additional risks of underweight, as manifested in anorexia nervosa, to bone density, fetal growth, and overall mortality. Otherwise, optimal management of reproductive disorders involves meeting healthy weight and eating behavior goals, and this does not differ appreciably between the types of eating disorders.

4. You write that obstetrician–gynecologists should not prescribe medications for amenorrhea that “function to mask important symptoms of the eating disorder.” Being that affected women often struggle with this for a large portion of their reproductive life, what is your recommendation for contraception to a young woman with an eating disorder?

Response from Drs. Arnold E. Andersen and Ginny L. Ryan:

GR: Our point in discouraging the ready prescribing of estrogen-containing contraception to patients with amenorrhea related to their eating disorder was to emphasize that these hormones do not treat low bone density, as many have assumed, and that they mask a physiologic sign (amenorrhea) of disease and potential recovery by creating hormone withdrawal bleeds. This is not to say that combined hormonal contraceptives are not an excellent option for this patient population. These should be offered as such, along with careful counseling to inform patients and family members that related withdrawal bleeds are not “periods” that represent recovery from their eating disorder. In fact, given concerns regarding
bone density in this population, I would recommend combined hormonal contraceptive options over injectable or implantable progestin-only options, especially in the adolescent population. 

**AA:** Patients with anorexia nervosa and amenorrhea who are sexually active need to understand they may become pregnant before their first period because of the potential of ovulation prior to their first period.

5. What criteria should a woman with anorexia nervosa achieve before you will endorse ovulation induction for treatment of infertility arising from ovulatory dysfunction?

**Response from Dr. Ginny L. Ryan:**

**GR:** Decisions regarding recovery goals prior to treatment for infertility should be made jointly between a patient, her obstetrician–gynecologist, and her psychiatrist. If patient age does not force earlier treatment, it is ideal for a patient to resume spontaneous ovulation with recovery from her eating disorder. This amount of recovery does require patience and persistence, however. Short of this ideal goal, criteria regarding weight and/or eating behaviors should be made individually. Certainly, it is never safe to treat ovulatory dysfunction in a woman who is medically or psychiatrically unstable as evidenced by extremely low weight, abnormal vital signs or laboratory values, or suicidality.

6. What is your advice to newly pregnant women with eating disorders treated with fluoxetine (or other antidepressants)? Should they continue their treatment throughout pregnancy? Should they continue their treatment while breastfeeding?

**Response from Drs. Arnold E. Andersen and Ginny L. Ryan:**

**GR:** Decisions regarding whether or not to continue antidepressants during pregnancy and lactation should be individualized for each patient through discussion between the patient, her obstetrician–gynecologist, and her psychiatrist. Obstetrics & Gynecology has published two
recent reviews on the topic of antidepressant treatment in pregnancy and/or lactation, and these provide an excellent summary for the obstetrician of the data that exists. These reviews are titled, “The management of depression during pregnancy: a report from the American Psychiatric Association and the American College of Obstetricians and Gynecologists” (Yonkers et al; Obstet Gynecol 114[3]:703–13) and “Use of psychiatric medications during pregnancy and lactation” (ACOG Committee on Practice Bulletin, Obstet Gynecol 111[4]:1001–20). It is important to note that most reviews of risks and benefits of antidepressant use in pregnancy and lactation concern treatment of depression/anxiety and not eating disorders. Thus it is vital to consider the unique aspects of eating disorders in the obstetric population, such as the tendency for remission in pregnancy and relapse in the postpartum period, when individualizing treatment decisions.

AA: Depressive illness has a high risk of suicide and is the most common co-occurring disorder with eating disorders. When concern for personal safety from self-harm in depressive disorders exceeds the risk from those antidepressants found to be most safe, then the antidepressant should be continued or instituted, in conjunction with psychiatric consultation.

7. Should bone density be monitored in all women with eating disorders? What has been your experience with insurance coverage for this test for women with eating disorders?

Response from Drs. Arnold E. Andersen and Ginny L. Ryan:

GR: I have found that most local insurance providers will cover bone density testing for premenopausal women with an indication such as prolonged hypoestrogenism or amenorrhea. I have not specifically ordered these tests using a diagnosis of an eating disorder. You raise an important point, however, regarding whether such bone density testing is always indicated. For the most part, findings on bone density scan do not impact my management of oligomenorrhea or amenorrhea. However, I find these tests vital in a few situations. First, findings of low bone density provide concrete evidence that may help convince a woman who is in denial of her eating disorder. I have also found these results helpful in convincing insurance companies that a
patient requires treatment for her eating disorder. Finally, there has been the rare occasion that the bone density scan has revealed unusual results that warranted further evaluation for hypoparathyroidism, for example.

**AA:** In general, a patient with 6 or more months of weight sufficiently lowered to produce hypoestrogenemia is subject to substantial deficits in bone mineral density.