by Hygienetown clinical director
Linda M. Douglas, RDH, BSc

Linda M. Douglas, RDH, BSc, graduated as a dental hygienist from the Royal Dental Hospital in London in 1982. After graduation she worked in periodontology before moving to Toronto, where she has worked in private practice since 1990. Douglas' desire to support patients with eating disorders has instigated her in-depth study of their effect on oral health.

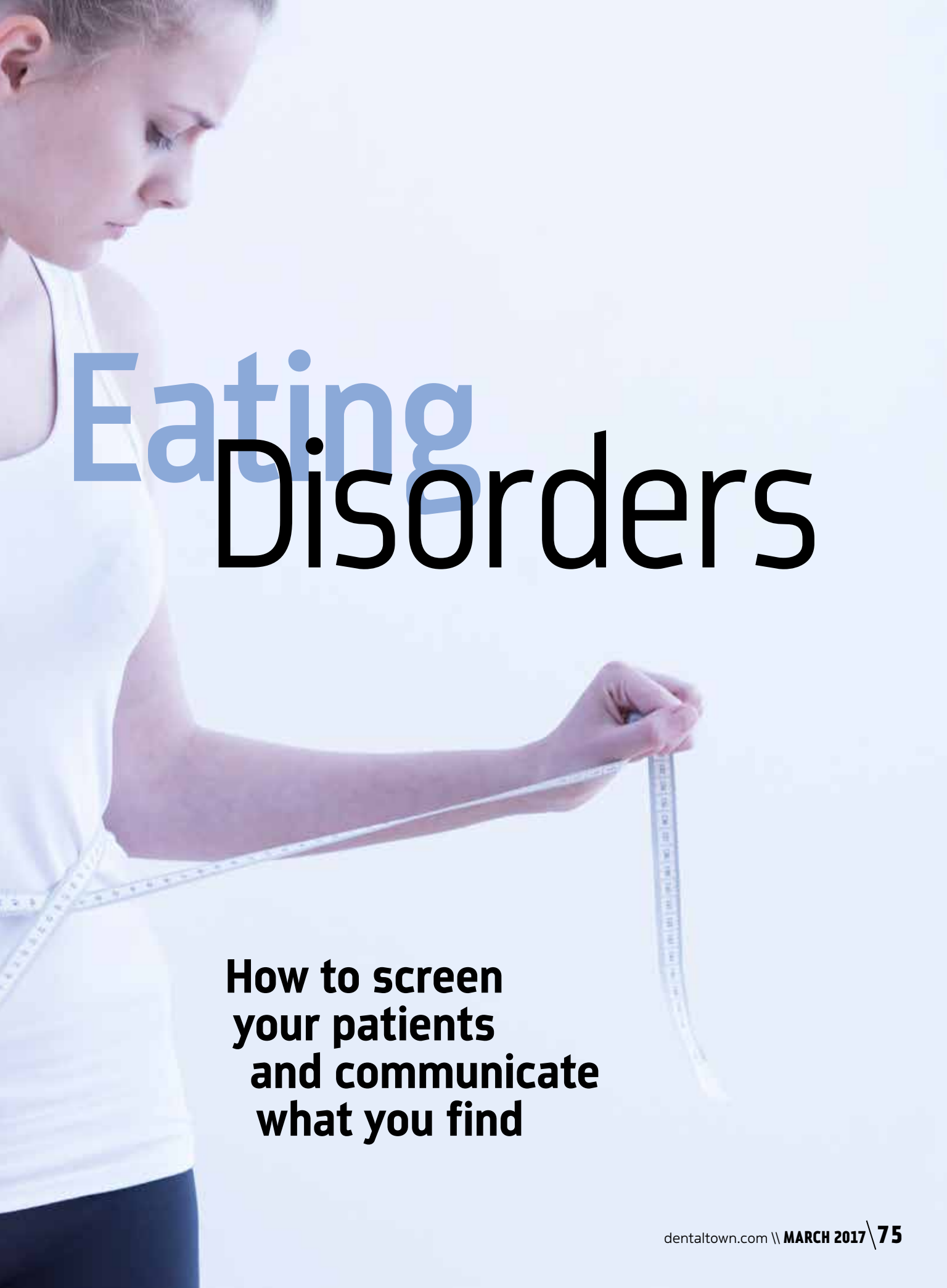
It is second nature for us to discuss periodontal disease and caries with our patients, yet we frequently see their embarrassment when we ask how often they are flossing.

Broaching a discussion about a suspected eating disorder—an understandably more sensitive topic—really challenges our communication skills. When an eating disorder is suspected, it needs to be addressed in a nonjudgmental, nonthreatening manner, yet we must still be forthright.

Much of the secrecy about this illness is related to shame, so individuals with eating disorders need to be approached with kindness and should be commended for being candid with us.[1]

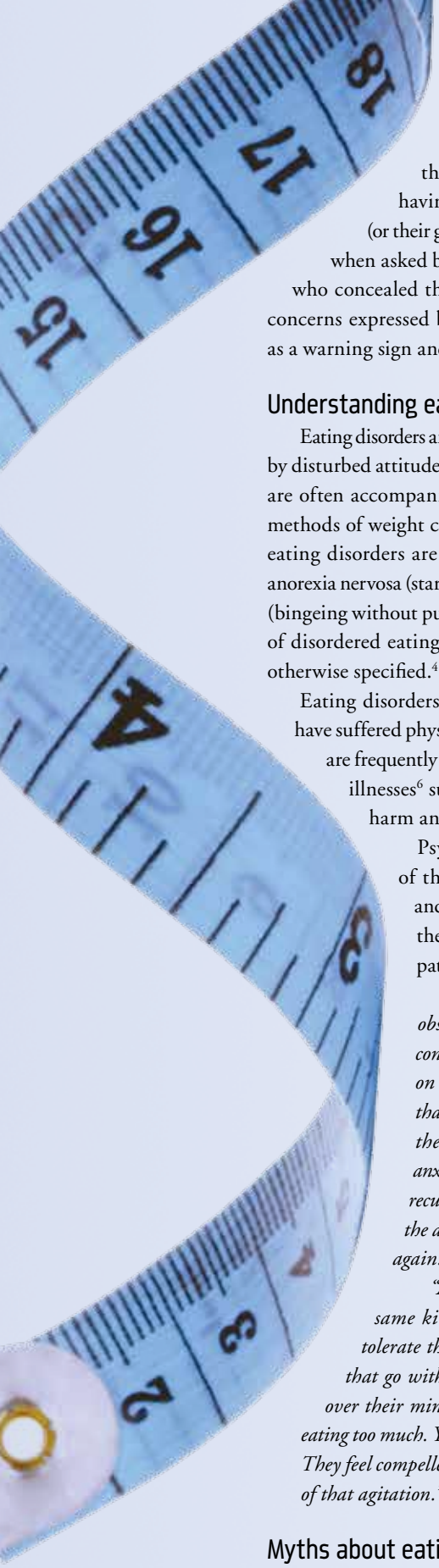
While we cannot diagnose eating disorders, we can present the findings of our examination to patients. For example, if there is dental erosion, we might mention some possible causes (such as acidic drinks or frequent vomiting) and also that the condition of the patient's teeth is similar to that of others who have an eating disorder. We can then ask if patients have, or ever have had, an eating disorder. We can also express that we appreciate how difficult the topic is to discuss, and let patients know that they are not alone; many others have eating disorders.

All of these measures give patients an opportunity for disclosure. If they choose to reveal their eating disorder to us, they should be referred to their physician to facilitate referral to specialists who treat eating disorders. If they are not ready to tell us, we can still encourage them to seek help and initiate an oral-care protocol based on our clinical findings to minimize damage to the oral hard and



Eating Disorders

How to screen your patients and communicate what you find



soft tissues.

Research has shown that of the patients who are suspected of having an eating disorder, about half (or their guardians) have given confirmation when asked by their dentist.[2] Hopefully those who concealed their eating disorder accepted the concerns expressed by their dental care professional as a warning sign and sought help later.

Understanding eating disorders

Eating disorders are psychiatric illnesses characterized by disturbed attitudes to eating and body image. They are often accompanied by inappropriate, dangerous methods of weight control. The three most common eating disorders are bulimia nervosa (binge-purge), anorexia nervosa (starvation), and binge-eating disorder (bingeing without purging).[3] There are also variations of disordered eating, as well as eating disorders not otherwise specified.[4]

Eating disorders often occur in individuals who have suffered physical or psychological trauma[5] and are frequently accompanied by other psychiatric illnesses[6] such as depression,[7] anxiety,[8] self-harm and chemical dependency.

Psychiatrist Dr. Wendy Spettigue of the Canadian Academy of Child and Adolescent Psychiatry described the experience of some of her young patients who have anorexia nervosa:

"Imagine a patient with severe obsessive-compulsive disorder who constantly thinks, 'There are germs on my hands,' and the only thing that makes it better is if they wash their hands, which decreases the anxiety temporarily; but the thoughts recur, and the only thing that relieves the agitation is washing their hands again.

"Anorexia nervosa is the exact same kind of illness where they can't tolerate the severe anxiety and agitation that go with the thoughts that have taken over their minds that constantly say, 'You're eating too much. You're gaining too much weight.' They feel compelled to restrict or purge, to get rid of that agitation."[9]

Myths about eating disorders

- Eating disorders are about food.
- Eating disorders are a matter of choice or lifestyle.
- Eating disorders are a matter of vanity or a way to get attention.
- People at a normal body weight cannot have an eating disorder.

Screening in the dental-office setting

Dental health professionals are in an ideal position to participate in detection and secondary prevention of eating disorders,[10] which could improve prognoses[11]—and even be a lifesaver, because eating disorders have the highest mortality rate of all psychiatric illnesses.[12]

However, a 2015 Norwegian study[13] found that 76 percent of dentists surveyed reported a need for more education related to eating-disorder management. Research findings from Finland[14] suggested that many dentists underestimated the number of patients they had encountered with eating disorders.

In a recent informal survey, educators in several North American dental hygiene schools have commented about time constraints in the curriculum that preclude covering eating disorders in much depth.

Clinical assessment includes the general appraisal, which begins as soon as we greet a patient. A comprehensive medical history is also needed, along with monitoring of vital signs.

Observe the following during the general appraisal:

- Gait and demeanor. Does the patient look alert, or dazed? This could be a sign of electrolyte imbalance, hypoglycemia, dehydration or malnutrition.
- Facial symmetry. Individuals who purge by vomiting often have swollen parotid glands, giving a "chubby" look to the face, although they might be underweight.
- Skin blemishes or a gray cast might occur due to malnutrition, or carotenoderma—orange skin from excessive intake of foods containing carotene.[15]
- Sparse scalp hair.
- Bloodshot eyes and petechiae of the skin around the eyes are related to forced vomiting.
- Lanugo hair, which is fine downy hair on the face, arms and torso—related to excessive loss of body fat.
- Clubbed fingers are a sign of malnutrition-related myocardial atrophy or abuse of laxatives.
- Russell's sign: a callus or abrasion on the knuckles from inserting fingers in the throat to induce vomiting.

The following two questions are worth adding to the medical history form, to assist in detecting the possible presence of eating disorders:

- Do you eat in secret?
- Are you satisfied with your eating pattern?

The SCOFF questionnaire is a simple five-question test created for use by nonprofessionals to assess the possible presence of an eating disorder. Devised in 1999, it uses an acronym for easy mnemonics and can be made available for the patient to complete in private.

The SCOFF questions:

- Do you make yourself **S**ick because you feel uncomfortably full?
- Do you worry you have lost **C**ontrol over how much you eat?
- Have you recently lost more than **O**ne stone (14 pounds) in a three-month period?
- Do you believe yourself to be **F**at when others say you are too thin?
- Would you say that **F**ood dominates your life?

Count one point for every "yes." A score of greater than two indicates a likely case of anorexia nervosa or bulimia.

Another screening questionnaire consisting of 25 questions is available at the National Eating Disorders website. Go to nationaleatingdisorders.org and look under the "Find Help & Support" drop-down menu.

Extraoral examination might reveal temporomandibular disorder or parotid-gland swelling, while intraoral examination of the oral hard and soft tissues could reveal signs of malnutrition (such as glossitis and oral ulceration), traumatic lesions on the palate caused by inserting objects to induce vomiting, or dental erosion. Comprehensive documentation should include detailed clinical notes, hard-tissue and periodontal charting, radiographs, intraoral photographs and study models to monitor damage.

These individuals need regular dental visits for continuing care and support, with essential restorative care to keep them free of pain, plus protocols for caries prevention and remineralization, and also to relieve xerostomia and dental hypersensitivity.

We should provide an environment in which patients feel comfortable. Patients with eating disorders must be regarded as medically compromised because of the risk of grave medical complications, particularly cardiac arrhythmias or cardiac arrest due to electrolyte imbalance. [16, 17]

Conclusion

Eating disorders are potentially fatal. To facilitate early detection, effective care and improved prognosis, dental care professionals need to be familiar with the warning signs of disordered eating and encourage patients to seek help. The dental team can participate in secondary prevention of eating disorders, and dental hygiene can help to minimize any related oral complications.

Thus, it is very valuable to foster a nonjudgmental environment that may facilitate disclosure and aid timely referral for treatment. ■

References

1 *Bulimia: What Dental Health Professionals Need to Know, Amy Pezzente; Oral Hygiene, November 2015*

2 *Berkman ND, Lohr KN, Bulik CM. Outcomes of eating disorders: a systematic review of the literature. Int J Eating Dis. 2007;40:293–309. Doi: 10.1002/eat.20369. [pubmed] [Cross Ref]*

3 *psychiatry.org/mental-health/eating-disorders*

4 *DSM-IV (Diagnostic and Statistical Manual, Volume 4)*

5 *Eat Weight Disord. 2012 Dec;17(4):e267-73. Repeated traumatic experiences in eating disorders and their association with eating symptoms. Carretero-García A1, Sánchez Planell L., Doval E, Rusiñol Estragués J, Raich Escursell RM, Vanderlinden J.*

6 *Women Health. 2008;48(4):467-84. Doi: 10.1080/03630240802575104. Psychiatric comorbidity in women with disordered eating behavior: a national study. Gadalla T1, Piran N.*

7 *Symptoms of depression and anxiety in anorexia nervosa: links with plasma tryptophan and serotonin metabolism. Gauthier C, Hassler C, Mattar L, Launay JM, Callebert J, Steiger H, Melchior JC, Falissard B, Berthoz S, Mourier-Soleillant V, Lang F, Delorme M, Pommereau X, Gerardin P, Bioulac S, Bouvard M; EVHAN Group, Godart N. Psychoneuroendocrinology. 2014 Jan;39:170-8. Doi: 10.1016/j.psyneuen.2013.09.009. Epub 2013 Sep 17. PMID: 24135616 [pubmed - indexed for MEDLINE]*

8 *Aust N Z J Psychiatry. 2012 Feb;46(2):118-31. Doi: 10.1177/0004867411432071. The comorbidity between eating disorders and anxiety disorders: prevalence in an eating disorder sample and anxiety disorder sample. Swinbourne J1, Hunt C, Abbott M, Russell J, St Clare T, Touyz S.*

9 *Eating Disorders Among Girls And Women In Canada. Report of the Standing Committee on the Status of Women. Hélène leblanc Chair November 2014*

10 *Cynthia A. Stegman, RDH, Med, RD, CDE; Lynne H. Slim, RDH, MS. Dentalcare.com Recognizing and Managing Eating Disorders in Dental Patients*

11 *Natalie Kaweckyj, RDARF, CDA, CDPMA, COMSA, MADAA, BA. Eating Disorders…Understanding the Dental Ramifications; dentalcare.com*

12 *Crow, S.J., Peterson, C.B., Swanson, S.A., Raymond, N.C., Specker, S., Eckert, E.D., Mitchell, J.E. (2009) Increased mortality in bulimia nervosa and other eating disorders. American Journal of Psychiatry 166, 1342-1346.*

13 *Eating disorders-knowledge, attitudes, management and clinical experience of Norwegian dentists 2015 Johansson et al BMC Oral Health 2015, 15: 124 doi: 10.1186/s12903-015-0114-7*

14 *Lähteenmäki S, Saarni S, Suokas J, Saarni S, Perälä J, Lönnqvist J, et al. Prevalence and correlates of eating disorders among young adults in Finland. Nord J Psychiatry. 2014;68:196–203. Doi: 10.3109/08039488.2013.797021. [pubmed] [Cross Ref]*

15 *Eating disorders can be diagnosed early by recognizing skin signals. Dermatology Times May 01, 2010 By John Jesitus, Remia Struma MD*

16 *Eat Disord. 2013;21(4):287-94. Doi: 10.1080/10640266.2013.797317. Medical complications of self-induced vomiting. Brown CA1,Mehler PS.*

17 *Management and treatment of eating disorders with severe medical complications on a psychiatric ward: a study of 9 inpatients in Japan. Saito S, Kobayashi T, Kato S. Gen Hosp Psychiatry. 2014 May-Jun;36(3):291-5. Doi: 10.1016/j.genhosppsych.2014.02.001. Epub 2014 Feb 10. PMID: 24630897 [pubmed - in process]*