Anorexia & Bulimia in Pregnancy

Pathophysiology

1. Pathology
   o Similar to causes outside of pregnancy
   o Anxiety about weight gain and body shape changes during pregnancy may cause worsening or relapse of disease
   o Conversely, may find improved control during pregnancy as mothers become concerned about health of the child
   o Unable to distinguish pregnancy from being "fat"

2. Incidence
   o 4% of women in childbearing years suffer from eating disorders
   o Complicate about 1% of pregnancies
   o May not come to medical attention until pregnancy
   o Women with eating disorders can have impaired fertility and libido and are therefore less likely to achieve a successful pregnancy

3. Risk factors
   o Similar to non-pregnant patients

4. Morbidity / mortality
   o 5% mortality per decade for anorexia and bulimia
   o Increased risk of preterm birth and small for gestational age
   o Increased risk of cesarean delivery
   o Postpartum depression, especially with bulimia
   o Miscarriage, especially with bulimia

Diagnostics

1. History
   o Starting pregnancy at a below normal body weight
   o Lack of weight gain over two visits
   o History of eating disorder
   o Unexplained electrolyte abnormalities

2. Physical exam
   o Poor dental enamel
   o Knuckle calluses
   o Brittle hair and nails or hair loss
   o Bradycardia and arrhythmias

3. Diagnostic testing
   o Laboratory
     ▪ Complete blood count, electrolytes, BUN, creatinine
     ▪ May see nutritional anemia, leukopenia, hypokalemia, hypomagnesemia or hypochloremic alkalosis
   o Diagnostic imaging
     ▪ Fetal ultrasound monitoring per routine OB protocol

Differential Diagnosis

1. Hyperemesis gravidarum
2. Nausea and vomiting of pregnancy
3. Psychotic disorder
4. Obsessive compulsive disorder
Therapeutics
1. Acute treatment
   - Hospitalization if metabolic abnormalities
   - Careful dietary monitoring
2. Long-term care
   - Pharmacotherapy
     - SSRIs
       - Category C
       - Suggested evidence of persistent pulmonary hypertension or neonatal withdrawal when used during 3rd trimester
     - TCAs
       - Category C with evidence of neonatal withdrawal
   - Adjunctive psychotherapy as for non-pregnant patients
   - Calcium supplementation
   - Consider team management including obstetrical provider, nutritionist, psychotherapist and infant care provider

Follow-Up
1. Return to office
   - Time frame - will need increased frequency of visits
   - Reasons for earlier follow-up
     - Evidence of fetal compromise
     - Fetal growth restriction
2. Refer to specialists
   - Uncontrolled eating disorder
   - Persistent weight loss
   - Laboratory abnormalities
   - Severe fetal growth abnormalities
3. Admission to hospital
   - Continued weight loss despite maximal outpatient therapy
   - Severe electrolyte abnormalities
4. Postpartum follow up
   - Earlier appointments to monitor disease status and chance of regression
   - Careful monitoring for mother-child interaction difficulties and maternal underfeeding of children
   - Screening for development of postpartum depression

Prognosis
1. 50% will recover fully
2. 35% improve
3. 15% maintain at the same level
4. May recur or exacerbate in future pregnancies

Prevention
1. No true prevention is available however modifying societal images may decrease overall incidence