Anorexia & Bulimia in Pregnancy

Pathophysiology

1. Pathology
    - Similar to causes outside of pregnancy
    - Anxiety about weight gain and body shape changes during pregnancy may cause worsening or relapse of disease
    - Conversely, may find improved control during pregnancy as mothers become concerned about health of the child
    - Unable to distinguish pregnancy from being "fat"
2. Incidence
    - 4% of women in childbearing years suffer from eating disorders
    - Complicate about 1% of pregnancies
    - May not come to medical attention until pregnancy
    - Women with eating disorders can have impaired fertility and libido and are therefore less likely to achieve a successful pregnancy
3. Risk factors
    - Similar to non -pregnant patients
4. Morbidity / mortality
    - 5% mortality per decade for anorexia and bulimia
    - Increased risk of preterm birth and small for gestational age
    - Increased risk of cesarean delivery
    - Postpartum depression, especially with bulimia
    - Miscarriage, especially with bulimia

Diagnostics

1. History
    - Starting pregnancy at a below normal body weight
    - Lack of weight gain over two visits
    - History of eating disorder
    - Unexplained electrolyte abnormalities
2. Physical exam
    - Poor dental enamel
    - Knuckle calluses
    - Brittle hair and nails or hair loss
    - Bradycardia and arrhythmias
3. Diagnostic testing
    - Laboratory
        - Complete blood count, electrolytes, BUN, creatinine
        - May see nutritional anemia, leukopenia, hypokalemia, hypomagnesemia or hypochloremic alkalosis
    - 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

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