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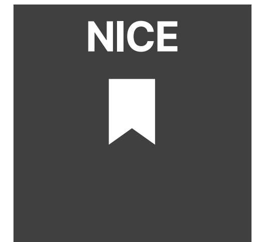

2024 exceptional surveillance of eating disorders: recognition and treatment (NICE guideline NG69)

Surveillance report
Published: 15 May 2024

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Surveillance decision

We will not update the NICE guideline on eating disorders.

Reason for the exceptional review

System intelligence/partners indicated that there was a need for NICE to look at the evidence surrounding treatment options for people with long standing anorexia. The NICE guideline does not currently make recommendations specific to this population, and this is a gap in our current recommendation content.

Methods

The exceptional surveillance process consisted of:

- Literature searches to identify relevant evidence.
- Considering the evidence used to develop the guideline in 2017.
- Assessing the new evidence against current recommendations to determine whether or not to update sections of the guideline.

For further details about the process and the possible update decisions that are available, see ensuring that published guidelines are current and accurate in developing NICE guidelines: the manual.

Information considered when developing the guideline

During guideline development in 2017, no specific recommendations were developed for people with severe and enduring eating disorders. This was because, although the committee recognised that there are people who have a severe and chronic form of anorexia nervosa, there was no evidence to suggest an association with severity of disease, and differential treatment outcomes. Therefore, the committee was of the view that the label 'SEED' ('severe and enduring eating disorder') could not be adopted.

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Evidence from 1 randomised control trial (RCT, n=63) was identified that looked at cognitive behavioural therapy for eating disorders (CBT-ED) compared to other psychological treatments for adults with severe and enduring anorexia. CBT-ED showed no difference on body mass index (BMI), depression, EDE-global and quality of life compared to specialist supportive clinical management (SSCM). At 12 months follow-up similar results were found but there was a trend for more favourable results on EDE-global in the CBT-ED treated group. No data was available on remission, general functioning, family functioning, service user experience, all-cause mortality, adverse events, resource use or relapse.

Evidence from 1 RCT (n=63) was identified that looked at SSCM compared to other psychological treatments for adults with severe and enduring anorexia. SSCM showed no difference on BMI, EDE-global, quality of life, and depression compared to CBT-ED. At 12 months follow-up, SSCM showed no difference on BMI, quality of life, and depression compared to any other intervention; and was less effective than any other intervention on EDE-global. No data was available on general functioning, family functioning, service user experience, adverse events, all-cause mortality, resource use or relapse.

During guideline development, no direct evidence was identified on what factors indicate the need for involuntary treatment, and refeeding, in people with eating disorders, and as such indirect evidence was used to help develop recommendations. Recommendations about involuntary treatment focused on highlighting the legal frameworks for compulsory treatment, and the clinical team structure and competencies that should be in place for involuntary feeding. The recommendations were written for all people with eating disorders who need involuntary treatment, and were not specific to people with severe and enduring eating disorders.

During guideline development, 16 RCTs (n=555) were identified that looked at pharmacological treatments for people with anorexia nervosa. There was insufficient evidence for the use of any pharmacological treatment as a sole treatment for anorexia, and the combined treatment of psychotherapy and a pharmacological agent also showed no benefit compared to psychotherapy alone. Therefore, a recommendation was written stating, do not offer medication as the sole treatment for anorexia nervosa.

Search and selection strategy

We searched for new evidence related to the most effective interventions for longstanding anorexia nervosa. There were no restrictions placed on the interventions.

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We found 1,136 studies in a search for RCTs, systematic reviews, and observational studies published between January 2015 and January 2024. Studies were assessed for inclusion based on relevance to the review question. Seven studies were identified for inclusion, and are summarised from the information in their abstracts.

Information considered in this exceptional surveillance review

Psychological therapies

Two studies were identified that looked at psychological therapies for the treatment of longstanding anorexia.

One study (n=351) compared a novel integrated CBT-E treatment model to traditional eclectic inpatient treatment. The CBT-E model showed a 25% reduction in length of stay and improved BMI on discharge (50% versus 16%, BMI greater than 19; Ayton et al. 2022). The study concluded that integrated CBT-E within inpatient treatment could offer more effective use of healthcare resources.

One Cochrane review looked for specific psychological therapies versus other therapies or no treatment for severe and enduring anorexia nervosa (Zhu et al. 2023). The review identified one study (n=63) that assessed an outpatient cognitive behaviour therapy for severe and enduring anorexia nervosa (CBT-SEAN) compared to specialist supportive clinical management for severe and enduring anorexia nervosa (SSCM-SE). There were no clear differences seen between the groups on clinical improvement at 12 months (risk ratio [RR] 1.42, 95% confidence interval (CI) 0.66 to 3.05) or treatment non-completion (RR 1.72, 95% CI 0.45 to 6.59). The trial was at high risk of performance and detection bias, and the review concluded that there is a need for larger high-quality trials to determine the benefits of specific psychological therapies for people with SEAN.

Current recommendations suggest either CBT-E, SSCM or Maudsley Anorexia Nervosa Treatment for Adults (MANTRA) as first line psychological therapies for people with anorexia. The NICE guideline does not currently make recommendations about how to run inpatient eating disorder clinics. There is initial evidence that the use of a CBT-E focused inpatient programme may deliver beneficial results for patients with longstanding anorexia nervosa, however, these results are based on 1 study and are not of sufficient impact to currently trigger an update.

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The topic area of psychological therapies for eating disorders is a key priority area, and will be monitored in line with the NICE manual appendix on monitoring approaches of guideline recommendations.

Drug treatment

Two studies were identified for drug treatment interventions.

One randomised cross-over trial looked at the impact on cognition and emotional state of L-tyrosine (100 mg/kg/day) in people hospitalised with chronic anorexia (n=19; Israely et al. 2017). L-tyrosine was found to cause shortened reaction time and test duration in memory tasks and improved depressive mood compared to placebo. No impacts on eating disorder measures were reported.

One randomised control trial looked at dronabinol, a synthetic cannabinoid, and whether or not taking it impacted on the levels of physical activity undertaken by people with longstanding anorexia (n=24; Andries et al. 2015). Dronabinol was not associated with a change in the duration of physical activity over the 4-week study period, but it was associated with an increase in the intensity of physical activity, resulting in an increased energy expenditure with 68.2 kcal/day (p=0.01) above placebo.

The new evidence comes from small trials, and shows either no, or negative impacts on aspects of longstanding anorexia. The 2 drugs identified in the new evidence are also not licenced for the treatment of anorexia nervosa. There is no impact on current recommendations.

Involuntary treatment

Two studies were identified looking at involuntary treatment compared to self-admission.

One study (n=23 voluntary and n=25 involuntary) looked at the eating disorder outcomes and attitudes to treatment, 4 years after discharge (Abry et al. 2023). At follow-up weight restoration was higher in voluntary treatment (p=0.01), while differences in quality of life, BMI, and mortality rates were not significant between involuntary and voluntary treatment (p>0.05). At time of admission, there were negative experiences of involuntary treatment, however the perception of the necessity of treatment increased from admission to follow-up (p<0.01) and became comparable to patients who had undergone voluntary treatment (p>0.05).

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One cohort study looked at self-admission to inpatient treatment (n=29) compared to people with long standing illness but low utilisation of inpatient treatment (n=113; Strand et al. 2020). The study found that there was a more than 50% reduction in time spent hospitalised at 12-month follow-up, compared to no changes seen in the low utilisation comparison group. However, there was no impact of self-admission on people's BMI or eating disorder morbidity. The study concluded that self-admission is a viable and helpful tool within a recovery model framework, even though it does not lead to symptom remission.

The evidence from these 2 small studies found some modest benefits of voluntary inpatient admission, however benefits weren't seen across all outcome measures. Involuntary treatment should be used as a measure of last resort for people with longstanding anorexia, and current recommendations in the NICE guideline focus on how to initiate this in accordance with the mental health act 1983. The new evidence identified does not impact current recommendations.

All interventions

One systematic review looked at all interventions for longstanding eating disorders (Kotilahti et al. 2020). The quality of the studies included was generally considered low-quality. The review found that inpatient treatment programmes (5 studies) were effective in short-term symptom reduction, but long term results were inconsistent. Outpatient and day hospital treatment programmes (5 studies) seemed promising for symptom reduction. Drug interventions (5 studies) showed some benefits, especially as adjuvant therapies. Brain stimulation (n=6) led to improvements in depressive symptoms. Other treatments (2 studies) produced mixed results.

Equalities

No equalities issues were identified during the surveillance process.

An equalities and health inequalities assessment was completed during this surveillance review. See appendix A for details.

Overall decision

Following a review of the evidence for interventions for the treatment of longstanding

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anorexia, we will not update the NICE guideline on eating disorders. The evidence identified typically involved small numbers of people and supported existing recommendations, which cover all people with anorexia. The evidence surrounding psychological therapies for people with eating disorders is already being monitored as part of our approaches to ensure guideline recommendations are up to date.

ISBN: 978-1-4731-6123-8

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