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Eating Disorders at the 21st Century

Anorexia Nervosa: Curious Past, Hopeful Future

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Anorexia nervosa (AN) has a history as interesting as the Cheshire cat's smile: now you see it, now you don't. Morton's first generally accepted account of AN appeared in the English language in 1689. Over the next 140 years AN was sequentially compressed into a medical category ("postpartum pituitary necrosis"), wedged into psychoanalytic theory, made an exclusively female disorder, relegated to a *forme fruste* of several other disorders (schizophrenia, depression), and fought over regarding etiology, pathogenesis, and treatment. Recently it has spread like a virus to developing countries. Males have been reunited into the AN camp in the last 40 years.

AN is a prototype of disorders of motivated behavior, all of which serve as a final common pathway for a variety of developmental, familial, intrapsychic, and societal conflicts. At its core, AN arises from a conflict between the individual's neurobiological forces, which regulate weight stability, and social norms, which mandate thinness. The probabilistic nature of a single person developing AN from multiple risk facts may mean no single causative factor will ever be found.

A Syndrome Waiting to Happen

AN can be appreciated as a syndrome that blossoms when

predisposing features are acted upon by specific precipitating factors, which then sustained by a combination of biomedical and psychosocial factors. Occasionally AN begins inadvertently, without a flame, but always with kindling ready to light. Recently, the list of predisposing factors has been shown to include genetic vulnerabilities, primarily of the serotonergic system. The best estimates of the heritable vs. acquired elements hover around 50% for each, with wide differences suggested by different studies.

In contrast to other disorders that are present or absent, subsyndromal eating disorders and negative attitudes toward weight and shape place a qualitative burden on the everyday lives of a majority of adolescent and adult women who do not meet the full criteria for an eating disorder. The most widely held norm among many young women in our society is not honesty, virtue, or materialism, but the desire for thinness (already present in 50% of 5th graders), a belief that is not merely abstract, but one with

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Update

Adequate Weight Restoration Improves AN Prognosis

Hospitalized patients with anorexia nervosa who reach a body mass index (BMI) of 19 kg/m² or above have better total bone mineral density and are healthier psychologically than patients released at lower weights, according to Australian researchers. Dr. G. Gross and colleagues followed 61 female patients hospitalized for treatment of anorexia nervosa, and were able to gather data on 50 (80%). Most women who achieved a BMI of 19 or more during hospitalization had a good overall outcome, with restoration of weight and reproductive function. They had better total bone density and better results on a number of psychological tests than women who were discharged from the hospital with lower weights. Total body nitrogen was restored in most patients (the average nitrogen index was 0.97). Total bone mineral density remained below optimal in all women who had a dual-energy x-ray absorptiometry (DEXA) measurement, and total body potassium was reduced when compared with age-matched normal controls. Although most women no longer met the criteria for AN in terms of low weight and amenorrhea, a low discharge weight seemed to correlate with persisting concerns about body shape and weight. The study was reported at the annual meeting of the Eating Disorders Research Society in San Diego in November.

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Subscriptions—see page 8.

Eating Disorders at the 21st Century

Bulimia Nervosa: A Quest to Improve Intervention & Treatment

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Approximately 20 years have passed since Gerald Russell's seminal 1979 article described bulimia nervosa (BN) as a separate diagnostic entity. While descriptions of such patients had appeared in the literature before this, Russell's article documented BN as a distinct syndrome and opened a whole new area of inquiry in eating disorders that continues to this day.

Upon reflection, one can interpret the available literature that has accumulated since 1979 as suggesting that considerable progress has been made. Indeed, the database on BN has grown dramatically over these two decades. However, serious questions remain, particularly questions related to prevention and treatment. These questions should lead us to refocus our efforts as we enter the new century.

Prevalence. BN is a fairly prevalent disorder that affects from 1% to 2% of young women, and usually appears in late adolescence or young adulthood (Becker et al, 1999; Walsh & Devlin, 1998). It occurs far more commonly among women, and appears to cluster in females in western industrialized societies, although there is some evidence that the disorder is becoming more prevalent in the Third World. We also know that the rates of both anorexia nervosa (AN) and BN are exaggerated in first-degree relatives of patients with BN, suggesting that risks for the two disorders are transmitted together (Strober et al, in press).

Indeed, recent results suggest a substantial genetic risk for BN, with a heritability of perhaps 50%, although the results have been inconsistent (Bulik et al, 1998; Sullivan et al, 1997; Fairburn et al, 1999). While many BN patients are categorized as impulsive, obsessive-compulsive traits are also commonly seen and appear to persist in some after recovery (von Ranson et al, 1999).

Abnormalities of the serotonin system. From the neurobiological standpoint, abnormalities of the serotonin

system have been reported, including increased levels of CSF 5-hydroxyindoleacetic acid at long-term follow-up, suggesting the possibility of ongoing—and perhaps predisposing—serotonergic dysfunction (Kaye et al, 1998). These results are particularly intriguing since we know that serotonin is involved in the modulation of various processes, including temperament and impulsivity, as well as feeding.

And, as has been well documented over the last 20 years, BN is associated with high rates of comorbidity, including affective disorders, anxiety disorders, and personality disorders (Wonderlich & Mitchell, 1997). It is also well known that at long-term follow-up many individuals with the disorder remain symptomatic even though they may not meet full syndromal criteria (Keel et al, 1999).

Treatment Advances

Much of the research in the
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Research suggests that psychosocial interventions are superior to pharmacological interventions when both are available.

serious behavioral and emotional consequences. Males are equally dissatisfied with weight and shape, but divided between a desire for increased or decreased weight. Epidemiologic studies suggest that 0.5% to 1.0% of young women develop full AN, with most studies indicating increased prevalence over the past decades. Approximately 5% of young women have a mild version of AN. One problem is that the diagnostic criteria keep changing, largely because of the need to impose categories on a continuum but also because the criteria are the result of a compromise between scientific and political concerns. The varying requirement for the weight to qualify for AN constantly alters the epidemiology.

What's New in Diagnosis?

Three new areas in diagnosis include: stable diagnostic criteria (albeit practical and usefully arbitrary); the demonstration that 3 months of amenorrhea is not necessary for a diagnosis of AN; and the description of reverse anorexia (muscle dysmorphia) in males. Still unsettled is the question of whether binge eating disorder is a separate disorder, and where it belongs. I believe it should be categorized as a third component of bulimic disorders (bulimia nervosa with purging, bulimia nervosa with other compensations, and bulimia nervosa with no compensations, also called binge eating disorders).

Gender bias and problems with definition. Unfortunately, there is continued gender bias. There is no endocrine or hormonal abnormality for males, so the diagnosis for men should either match the female criterion or the female criterion should be eliminated. The eating disorders not otherwise specified (EDNOS) category is much too

broad—most are subsyndromic varieties of AN or BN, but don't fit into narrow research criteria. Finally, there is a failure to broaden the definition of AN to a more meaningful definition. Here is a suggestion: AN should be defined as any decrease from a healthy set point driven by desire for thinness that leads to functional biological and psychological impairment; i.e., a person who is normally 20% above population mean, and then loses weight to 10% below, has no periods, is cold, decreased cogni-

New in diagnosis: stable diagnostic criteria, the demonstration that 3 months of amenorrhea is not necessary for a diagnosis of AN, and reverse anorexia (muscle dysmorphia) in males.

tion, etc., has true AN. We are working on this, and hope to publish a proposed revision of EDNOS soon. Several groups at risk of AN are also often overlooked, including minorities, males, and older women.

What's New in Treatment?

Improvements in treatment have included elimination of most single-modality treatments (nutrition alone, psychotherapy alone) in favor of validated multidisciplinary treatment. There is an increasing consensus about the validity and utility of CBT as the core of most AN psychotherapies. Another improvement is a move away from extreme medicalization of AN treatment. It is the impression of some of those in the field that the death rate has decreased with good initial care plus good follow-up over several years. We have learned that there is a lack of benefit from treatment with antidepressants during the acute treatment phase, and a possible benefit during relapse prevention.

Better care available. Another positive treatment trend includes growth of the spectrum of care programs: inpatient, partial hospital, outpatient, and outreach. Other

positives include increasing recognition of gender-specific needs of males and females, and that anorexia nervosa coexists with specific comorbid disorders, such as obsessive-compulsive disorders, borderline personality disorder, and with substance abuse

Pessimism despite progress. An unduly pessimistic attitude about treatment lingers in some quarters despite the robust evidence that cure (defined as cultural normality) is regularly achieved for most patients who remain in experienced treatment for 3 to 5 years. There is

increasing agreement on the need for multidisciplinary treatment, including scientific nutritional rehabilitation, psychological change via cogni-

tive-behavioral and interpersonal therapy, behavioral relearning, and occasionally, individualized psychopharmacology, more for the comorbidity symptoms than for the core eating disordered thinking. As with cancer treatment, immediate improvement must be matched by sustained improvement on global measures at a five-year mark. Acute treatment, followed by a relapse prevention program run by experts, is more economical in the long run as well as exceedingly more effective than revolving-door, short-term stabilization.

Uncertainties and changes.

Some areas of treatment are still uncertain. For example, what are the conditions for transition from inpatient to day (partial) programs? (*Am J Psychiatry* 1999; 156:1697). There is also debate about normal food eaten normally vs. liquid supplements, and the validity of setting target weight ranges. Other uncertain areas include the degree of restoration of ventricular dilatation and decreased cortical mass, gray vs. white.

Some areas call for change. Diagnosis and treatment are still often delayed. There is a lack of parity for payment of psychiatric treatment in general, and eating

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Binge Eating Disorder: Progress and Prospects

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In 1959, Albert Stunkard noted three distinct patterns of eating behavior among obese patients: night eating, binge eating, and eating without satiation. Since that time, research on binge eating has proliferated. Operational criteria have been developed in order to facilitate its assessment in both obese and non-obese individuals. Investigations by Spitzer and colleagues (Spitzer et al, 1992, 1993) led to the inclusion of binge eating disorder (BED) in the DSM-IV as a proposed diagnostic category for further study and as an example of an eating disorder not otherwise specified (EDNOS).

BED is characterized by persistent and recurrent episodes of binge eating in the absence of regular inappropriate compensatory behavior such as vomiting. Related features of the disorder include eating until uncomfortably full, eating when not physically hungry, eating alone because of embarrassment, and feelings of disgust, depression or guilt, after overeating. BED tends to have a chronic and fluctuating course, and is associated with increased psychopathology including depression, anxiety, and personality disorders.

Most seek treatment for overweight. Although BED is not limited to obese individuals, it is most common in this group. In fact, the majority of people with this disorder who seek help do so for treatment of overweight rather than for binge eating. About one-third of individuals seeking university-based behavioral weight control treatment binge eat. In community samples, the prevalence of BED has been found to be 1% to 2%.

Moreover, recent research suggests that, in contrast to the other eating disorders, which are more prevalent among whites, BED is as common among black and Hispanic women as in white women.

CBT Is Front-line Treatment

Eating disorder treatments tailored specifically to BED, such as cognitive behavior therapy (CBT)

Emphasis should be placed on disseminating effective approaches such as CBT and IPT, which are not yet widely available.

and interpersonal psychotherapy (IPT), improve binge eating, but have little effect on weight. CBT has been the best-studied approach and is currently considered the front-line treatment. Self-help approaches based on cognitive behavioral techniques, such as *Overcoming Binge Eating* (Fairburn, 1995) may be useful for some patients. It is important to note that standard weight loss treatments such as behavior therapy and bariatric surgery do not exacerbate binge eating problems, but are associated with short-term reductions in binge eating and improvements in mood. Thus, both eating disorder and obesity treatments appear to be beneficial in BED.

Drug treatment. Data on pharmacological treatment of BED are limited. Antidepressants may be effective, though less so than psychotherapy. Results are pending from studies investigating the combination of medication and psychotherapy.

BED as a Separate Diagnosis

Available research suggests that

there is a group of individuals with impairment or distress linked to the disorder, and numerous studies have detailed the associated features of this syndrome. However, as “We study what we define” (Walsh & Kahn, 1997), it seems advisable for researchers to study the full range of clinically significant overeating. Further investigations comparing obese and non-obese patients with and without BED are needed. Such research may help clarify the distinctions between BED and bulimia nervosa, non-purging type. Prospective studies are needed to clarify the direction of associations among binge eating, weight, and mood in the general population, including men and ethnic minorities. Finally, family history and twin studies will be invaluable in determining the heritability of the disorder.

The Future

With respect to treatment of BED in the next millennium, more emphasis should be placed on disseminating effective approaches such as CBT and IPT, which are not widely available. There is also a need to develop algorithms for matching patients to treatments. Further study of treatment non-responders is also warranted in order to improve outcome and long-term maintenance.

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Eating Disorders at the 21st Century

Eating Disorders: Looking Ahead

Joel Yager, M.D.

Editor-in-Chief

The wonderful articles by Drs. Anderson, Mitchell, and Kalarchian and Marcus aptly capture key issues in the evolving stories of anorexia nervosa, bulimia nervosa and binge eating disorder at the verge of the millennium. We can all take some comfort in the fact that the last several decades of the 20th century have produced substantial increases in keen clinical observations and in research studies addressing these disturbing conditions.

One measure of the vigor of an intellectual field is the degree to which professions organize around their core problems. In the last few decades the field of eating disorders has spawned a bevy of new scientific journals and newsletters, given birth to several professional societies, and started to command increasing amounts of research funding. The field is alive and well.

I will not repeat the predictions that our visionaries have provided. Instead, I'd like to imagine several additional strong forces that are likely to influence and shape the directions of our etiologic and pathogenetic understanding of eating disorders, our methods of clinical evaluation and assessment, and our treatment interventions.

Biological: Unprecedented insights into molecular genetics are emerging from research laboratories. Already, more than 200 separate genes have been identified that impact eating, satiety, propensities for physical activity, energy expenditure, and related issues. Genes that influence temperament and personality are also being discovered. Closely associated with eating disorders, biological research is similarly booming in obsessive-compulsive disorders and personal-

ity traits, mood disorders, anxiety disorders, and other areas in which emotional self-regulation is impaired. Add this research to the recent description and genetic investigations into "thin sow" disease, a naturalistically occurring animal model that bears uncanny similarities to anorexia nervosa, and new biological understandings of altered physiological processes that mediate rat hyperexercise-anorexia models. All of this promises that we can anticipate new biological models and perhaps new pharmacologic approaches to eating disorders. Advances in neuroimaging and other biological technologies may add additional insights and approaches.

Psychosocial: Only in the past few decades have psychosocial interventions been standardized in treatment manuals to the point where some reliability can be assumed when one treatment is compared to another. We are now seeing the emergence of self-guided and therapist-guided treatment manuals applicable to individual and group settings, for cognitive behavior therapies and interpersonal psychotherapies for patients with anorexia nervosa, bulimia nervosa, binge eating disorder and body image problems. New manuals are being developed for specific forms of family therapy that will lend themselves to empirical testing. As these treatments are refined, the trick will be training health providers to use them in wise and sophisticated manners. Several new developments offer promise.

Information technology: We are just beginning to envision opportunities for treatments offered by emerging technologies. Patients

and their families may already be way ahead of providers, tapping into information, chat-lines and self-help sources on the world-wide web. The upside is that many become more sophisticated and informed. The downside is that much of the information available is unfiltered, and we do need to do better jobs of developing and disseminating responsible web-based information.

And for the future? First, we can anticipate increased use of computer-based screening and assessment forms to be completed by patients and their families for initial evaluations and follow-up. The purpose of these assessments is not to replace human contact, but to make optimal use of the time available, and to help standardize the information collected. Practitioners will be able to follow up and ask detailed questions about salient issues that very thorough assessment tools have revealed. Second, some practitioners are already using e-mail to enhance office-based sessions with outpatients (anticipate the publication of J. Yager, "E-mail as a Therapeutic Adjunct in the Outpatient Treatment of Anorexia Nervosa," *International Journal of Eating Disorders*, in press), and this modality may enhance provider-patient/family contact and involvement. As an extension, we can envision "bots" (personal cyberspace information robots) that prompt and guide patients through difficult periods. Third, PDAs, personal digital assistants, such as palm pilots, may offer untapped capacities to act as therapeutic adjuncts, for diary keeping and for guidance, among other possible uses. Fourth, think "distance learning" with regard to new developments and therapeutic techniques for patients, families, and providers. Professional organizations serving the needs of providers will increasingly turn to distance learning technology to update, upgrade, and uplift. And this is only the beginning.

I invite you all to come back a millennium from now to see how we're doing.

The Anthropology of Food and Body: Gender, Meaning and Power

(C. M. Counihan. Routledge Publishing; 256 pp; \$19.99; paperback; 1999.)

This series of loosely connected essays portrays the evolving work of an academic anthropologist over the last several decades, initially concerning studies of “foodways” — beliefs and behaviors surrounding the production, distribution and consumption of foods in different cultures. Then the series looks more deeply into how gender, the sense of one’s own body and oneself, and personal empowerment or oppression are impacted by who earns, makes, prepares and controls food in communities and households.

Based on fieldwork using qualitative ethnographic methods, the author’s observations start in rural Italian homes in Sardinia and then Florence in the 1970s, and later include studies of American college students’ journals, of children’s beliefs regarding food and hunger, and of women in Pennsylvania interviewed during pregnancy and postpartum.

The first chapters review a broad literature in cultural anthropology addressing food, gender, power, and intimacy across numerous cultures, providing several schemes by which we can start to appraise the studies that follow.

The later research becomes more narrative, so that as the book progresses we’re given more “stories,” which are less academic and more human. The direct links to eating disorders are few. But Counihan has read and thought enough about these links, and offers nice review chapters on what it means to be fat, thin, and female. The author also comments on western women’s “prodigious” fasting. These observations add voice to some important suggestions. “Objectification” of the body, as occurs in cultures such as those giving rise to “Holy

Anorexia” in medieval Italy or to contemporary eating disorders in today’s fashion-driven capitalist mercantile societies, is much more likely to lead to self-starvation than is the much more earthy, pleasure-linked “subjectification” involved in loving food, loving to eat, and loving to be loved by men who appreciate women who do both.

These essays could lend themselves to an enjoyable college elective seminar, whose participants should be required to verify some original field notes provided by several study subjects — six hearty, delicious-looking Italian recipes provided by Florentine women in the 1970s and 80s. Such data demands laboratory testing — in your own kitchen.

—J.Y.

ANOREXIA continued from page 3

disorders in particular. The senseless revolving door treatment continues, with medical stabilization inevitably followed by relapse. Out-of-date treatments persist, and pharmacology-only treatment approaches are common. There are relatively few head-to-head studies of contrasting treatment methods, and an overall lack of a long-term perspective: getting well, staying well, and then resumption of maturation.

The future holds challenges and promises. The scientific underpinnings of AN, including brain imaging findings and genetic contributions, increasingly demonstrate that this is a real disease, more subtle than the 19th century model of an infectious agent needing a drug, and that it is clearly not a posture of affliction by young, jaded individuals. AN has the highest death rate of any psychiatric disorder.

Prevention is a conflicted area, regarding its feasibility or impossibility. Like many broad disorders with wide social consequences, such as teen pregnancy, and substance abuse, the goal is decreased prevalence and earlier treatment rather than elimination. There is logic to the preventive challenge of armoring the 10% of the young who have the most well-defined risk factors, rather than attempting to change deeply entrenched social norms, although these may not be beyond reach with long-range methods.

The Future

The future will undoubtedly bring diagnostic clarification and unification, appreciating the spectrum of AN both in symptomatology and severity, with treatment intensity and locale matched to the severity of illness. Primary care physicians may give more and more effective care. Legislative mandates for parity of funding for all illnesses, whether of putative medical or psychological origin, especially parity for eating disorders, will evolve as the now often young, often disabled sufferers coalesce in their effective demands for full coverage of demonstrated effective treatment. A single pharmacological treatment will probably never be found because of the nature of behavioral disorders.

The treatment of AN is eminently satisfying, allowing a clinician to bring hope and enduring help to individuals based on confidence borne of evidence of treatability with an excellent prognosis for the majority. Culture-bound disorders require a new paradigm of conceptualization for etiology and treatment. As increasingly effective treatments, improved knowledge of etiologies, and scientifically based preventive interventions are incrementally advanced in the field of AN over the next decade, this quintessentially modern disorder will become less and less of an enigma. Futurists will chronicle the conquest of this disorder as one of the triumphs of the early 21st century.

last 10 years or so has focused on the development of various treatment strategies for BN. Two separate lines of research have found efficacy for certain psychosocial treatments and for pharmacotherapy. The pharmacologic agent best established for BN is fluoxetine (Peterson & Mitchell, 1999; Goldstein et al, 1996).

Psychotherapeutic approaches have focused on the use of cognitive behavioral therapy (CBT). CBT has been shown to be as effective or more effective than every other treatment to which it has been compared, although recent studies suggest equal efficacy for interpersonal therapy or IPT, an interesting observation given the fact that IPT does not directly address eating issues (Fairburn et al, 1995). Available research also suggests that psychosocial interventions are superior to pharmacological interventions when both are available (Bacaltchuk et al, 1999). However, considerable evidence indicates that problems remain with the efficacy of these treatments, in that many individuals do not respond or subsequently relapse (Wilson, 1999). Also, there is considerable evidence that empirically validated treatments are being underutilized, and that alternative means of training therapists or administering such treatments need to be developed (Arnow, 1999).

The cultural challenge. Headway has been made in our understanding of this disorder, including the underlying psychobiology, the longitudinal course, the comorbidity, and the treatment. Priorities in the 21st century will be identifying effective and practical preventative intervention strategies (Striegel-Moore & Steiner-Adair, 1998) and the improvement of our treatments, to decrease the rate of

non-response and rate of relapse. Unfortunately, the cultural background surrounding this disorder, which places a high value on slimness as a model of attractiveness for women in western industrialized societies, continues

unabated. Any means of alleviating the burden that this unfortunate cultural message places on young women in our society

Unfortunately, the cultural background surrounding this disorder, which places a high value on slimness as a model of attractiveness for women in Western industrial societies, continues unabated.

has remained elusive.

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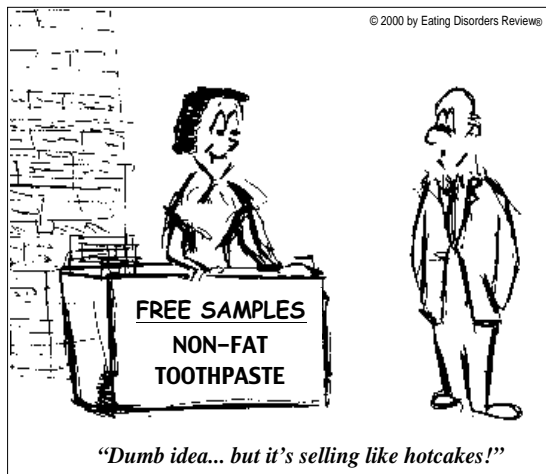
Questions & Answers

Citalopram for Anorexia Nervosa

Q: I've started doing psychotherapy with a young adolescent with anorexia nervosa who was recently discharged from the hospital. She also has major depression, and her primary care physician has recently put her on Celexa® (citalopram). Is there any evidence that this will help her anorexia nervosa? (D. I., Miami)

A: Although citalopram seems to be a very good selective serotonin-inhibitor type of antidepressant, and has become increasingly popular for outpatient depression because of its favorable side effect profile, the limited published clinical experience describing use of this drug for patients with anorexia nervosa is actually very troubling and worrisome. None of the serotonin reuptake inhibitors (SSRIs), including citalopram, are helpful in the weight restoration phase of anorexia nervosa. In a letter published in the prestigious British journal, *The Lancet*, investigators reported a clinical trial in adolescent outpatients with anorexia nervosa who were treated with psychotherapy alone or with psychotherapy combined with citalopram. Whereas the group receiving psychotherapy alone didn't gain weight, those receiving both psychotherapy plus medication actually lost weight, often in the range of 1-2 kg; this was weight they could ill afford to lose since their body mass indexes were still very low (*Lancet* 1996; 348: 1459). Based on this report, until such time as other data may become available, I would not advise using citalopram in this population. Luckily, there are many other good antidepressants from which to choose. —J. Y.

Nibbles, by Hunter



"Hunter" traveled in India last year.

Letter to the Editor Determining Ideal Weight

In the July/August 1999 issue, I noticed your answer to a question about how to ascertain "ideal" weight for a young adolescent with anorexia nervosa who has never had a period (Q&A, page 8). While I agree with much of what you say, may I also point out the value of pelvic ultrasound as a determinant of ideal weight.

Pelvic ultrasound indicates the degree of maturity of the uterus and ovaries, and can demonstrate the presence of sufficient endometrial lining and a dominant or ovulatory follicle. Anything less than these would mean that weight is unsatisfactory. We have used this way of ascertaining satisfactory weight for many years (see Lai et al, *Arch Dis Child* 1995; 71: 228) and the chapter by Nicholls et al in the second edition of Lask and Bryant-Waugh's *Anorexia Nervosa and Related Disorders in Childhood and Adolescence* (Psychology Press, Hove, UK, 2000).

The problem with using body mass index (BMI) or weight-height ratios is that these are arbitrary and while a BMI of, for example, 19, or a weight-height ratio of, for example, 95%, may be perfectly satisfactory for the majority, they will still be too low for some. Unless a pelvic ultrasound is conducted, too low a weight is being set and menstruation will not occur or recur.

The problem with using serum estradiol levels is that these are simply a "snapshot." In other words, they reflect but one component of total estrogen levels at one moment in time and can be very misleading. Pelvic ultrasound is a reflection of nutritional status during the previous two months or so and is a far more reliable and valid indicator of endocrine status and maturity.

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Dr. Yager replies:

Dr. Lask's point is well taken. Pelvic ultrasound is an easy-to-use, noninvasive addition to the tools available to clinicians for estimating ideal weight.

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By Ruth Striegel-Moore, PhD

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