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**THE ROLE OF THE PRIMARY CARE PHYSICIAN IN
DIAGNOSIS AND TREATMENT OF EATING DISORDERS**

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Abstract

The role of the primary care physician (PCP) is fundamental and central in diagnosis and treatment of eating disorders (eating disorders) — anorexia nervosa, bulimia nervosa, binge eating disorder (BED) and eating disorders not otherwise specified (EDNOS). The above role is articulated in the various moments that go from health promotion, to prevention (primary, secondary and tertiary), to early diagnosis with the identification of new cases, to the evaluation of seriousness, to the treatment of mild and medium cases severity, sending to the specialist, managing any complications and follow-up.

Keywords: Eating disorders, diagnosis, primary care physician, treatment

Introduction

1. Primary prevention

In the field of primary prevention, it is important to underline the continuous work that the (PCP) does in attention to the family and its dynamics (1-5). This attention aims to capture both the presence of any risk factors for which a potential association with the development of ED has been highlighted:

- psychiatric familiarity, early separations from caregivers, child abuse, psychosocial stress, family relationships with strong conflict between parents and between parents and children
- abuse of psychoactive substances
- chronic childhood diseases and possible early eating difficulties
- pressures towards thinness on the part of members of the family group or the relational and affective area in which the subject lives
- belonging to groups in which there is greater socio-cultural pressure towards thinness, such as models, dancers, athletes, gymnasts both the possible appearance, especially in adolescents, of warning signs, such as dissatisfaction with the body or body shape, dieting, low self-esteem, perfectionism or negative emotional states (1-5).

In the case of adolescents, it is essential to establish a relationship of trust from the first visit (often the adolescent presents himself accompanied by the parent). Equally important, for the continuity of care, is having a collaborative relationship with the basic pediatrician who can provide him, with the consent of the patient and / or family members, any previous, significant anamnestic data. To reach the adolescent at risk, the (PCP) must take advantage of every opportunity to meet, including, for example, that generated by a simple request for a certificate for the gym or by a control visit, or, even by a home visit for a fever. The role that the (PCP) can play in supporting the adolescent in the acceptance of the self, which also includes the acceptance of his own bodily forms determined by genetics, and in strongly discouraging, when normal weight, the adoption of slimming diets (1-5).

2. Screening

Screening in the setting of (PCP) is not advisable, due to the low prevalence of the pathology, but it would be useful, that at the time of the first presentation of a patient, the anamnesis is also

collected and the patient's experience is explored with respect to food and body. Often, in cases where the existence of an eating behavior disorder is suspected, it is advised to administer screening questionnaires by the (PCP).

Given the type of setting (previous knowledge of the patient and the family), it should be borne in mind that the delivery of a generic sheet (self-administered questionnaire) can be experienced by the patient, such as the introduction of an instrument that moves away, placing the doctor in a position of scrutinizing the patient and hindering the therapeutic alliance. Instead, it would be preferable for the (PCP) to know the contents of some simple screening questionnaires, to ask the right questions at the right time during the meetings with the patient (6-10).

One of these simple questionnaires is the SCOFF, developed and validated in the UK (10-12), whose name derives from the initial letter (in English) of the topics covered by the questions: the feeling of vomiting (Sick) linked to a sensation of full concern for the loss of control (Control) on the amount of food ingested, the loss of more than 6 kilos of weight (One stone) in about 3 months, the holding of fat (Fat) even when others believe us, instead, skinny and the recognition that food (Food) is the dominant thought of one's life.

In fact, the questionnaire was designed to verify a suspicion that an eating disorder may exist, rather than to make a diagnosis. A single study validated the use of SCOFF in adult women in a general medicine population (10-12), so further studies are needed before its use in primary care can be recommended.

3. Early diagnosis

Early diagnosis, when implemented in a timely manner, can lead to an improvement in prognosis, with a reduction in both mortality and morbidity. With all the existing limitations of prevalence studies, at present, the prevalence in the general population over the age of 18 is 0.9% for anorexia nervosa, 1.5% for bulimia nervosa and 3.5% for BED among women, while the corresponding rates in men are 0.3%, 0.5% and 2%; in women between the ages of 18 and 24, the rates are 2.0% for anorexia nervosa, 4.5% for bulimia nervosa and 6.2% for BED and EDNOS. It can therefore be assumed that a maximalist physician, with 1500 choices, counts

among his clients, on average, between the two and the three cases of anorexia nervosa, while the cases of bulimia nervosa, BED and EDNOS are more easily observed and identifiable in the (PCP) setting. In addition, today the family doctor encounters many minor cases in his daily work, with shaded pictures, to be framed within subthreshold eating disorders, with respect to which it is important to observe a supervisory conduct, in order not to risk medicalizing a temporary disorder, or, on the other hand, underestimate a problem at its onset (13-15).

Often, PCP does not identify, or identify with delay, many cases of mental disorders, including eating disorders. This type of behavior of the PCP has different causes. The reasons linked to the PCP are often due to inadequate preparation on the subject, or to lack of clinical experience or, again, to personal difficulties in facing psychological problems. The result is a training need for the PCP, also due to the lack of studies in the degree course in Medicine, with little training on the psychological aspects of the doctor-patient relationship and fundamentally based on a more disease-centered approach than on the patient. Greater training of the PCP on the psychological aspects of the profession, on the doctor-patient relationship as well as on the treatment of mental disorders, from university studies would be desirable. More specifically with respect to eating disorders, it would be desirable to have targeted training in university studies, first, and in specific training schools in General Medicine, then. To promote the spread of the so-called PCP training in the field, which has been and is implemented in the various projects that existed, or still exist, throughout the national territory of general medicine / psychiatry collaboration, often based on voluntary initiatives and not implemented on the territory by adequate health policies. The motivations related to the patient are often due to lack of awareness or denial of the problem or to shame, so often the patient presents the doctor with medical problems or non-specific disorders, without instead exposing the real problem to the food or to the perception of own body image. The PCP has the task of encouraging, through the strengthening of the therapeutic alliance, the patient's awareness of his real problem (16-18).

There are also motivations related to the environment, in particular to the family, which

sometimes directs its child with somatic disorders to what it considers to be the right reference specialist (eg, gastro-enterologist, gynecologist, allergist), which often leads to a diagnostic delay. Even in such cases, when the PCP is asked for a prescription for a specialist visit, it would always be useful to investigate the reasons, before delegating, thus contributing to the diagnostic delay.

Finally, it is emphasized that, in some cases, what is judged as "failure to diagnose" is instead a lack of nosographic coding, due to the so-called taxophobia of the PCP. Therefore, the diagnostic approach of the PCP is more related to the diachronic aspect (acute, subacute and chronic) and to the severity, from which the different treatment behaviors derive, than to the strictly nosographic classification.

The latest changes to the DSM since they contain assessments of progressive severity, both of anorexia and bulimia nervosa (16-18). The knowledge of the symptoms that may be related to the ED can easily lead the PCP to a suspected diagnosis when alarm signals are detected, such as severe weight loss, menstrual cycle disorders such as persistent amenorrhea, exaggerated body control behaviors or of food (practice of strict diets or presence of binge eating) or, on the other hand, behavior of avoidance of the relationship with the body and weight (the patient refuses to undress and / or climb on the scale), mood changes, anxiety, social isolation.

In the case of anorexia nervosa, the family doctor often presents a worried family member or a school friend or friend, rather than the patient himself, expressing concern about weight loss, for particular relative behaviors to food, such as skipping meals or undergoing restrictive diets; sleep disturbances or increased physical activity are reported (19-21). When weight loss is still not significant, symptoms such as intolerance to cold, constipation, amenorrhea, abdominal pain or swelling, slight dizziness, changes in the skin, hair and nails are often reported; often the patient was previously diagnosed with chronic fatigue syndrome or food intolerance. In children, failure to grow may be the first presentation.

In the case of bulimia nervosa, the patients are more adults and consult the family doctor more often on their own than patients with anorexia nervosa.

Often the patient asks for a weight loss diet, or speaks of menstrual disorders, reports non-specific symptoms, such as tiredness, drowsiness, typical symptoms of irritable bowel, such as feeling of abdominal bloating, abdominal pain, disorders of the abdomen (constipation or diarrhea), rectal prolapse or digestive disorders, which make one suspect an oesophagitis or gastro-intestinal bleeding, sometimes sore throat. Sometimes indirect signs of self-induced vomiting may be visible, such as erosions of the tooth enamel (due to the continuous exposure to the acidity of the gastric juice), erosions or calluses on the back of the hands (Russell's sign), swelling of the parotid glands, or occasionally hypokalemia detected. In both cases, mood disorders, anxiety or sleep disorders can coexist.

In male subjects, an exasperated attention to body shapes may be present, in particular to the size of the musculature, which involves a sort of obsession for physical activity, always intense, for a type of diet (mainly hyperproteic) and sometimes even the use of anabolic substances (the so-called vigoressia) (8). Therefore, the PCP can receive indirect signals, such as the request for a double or triple medical certificate for fitness to practice sports, which reveals an exaggerated and unmotivated increase in this type of practice, or the request for prescriptions by diuretics and / or laxatives, which can hide the practice of elimination behaviors, or, even, the random finding of alterations in laboratory tests, perhaps brought to the doctor by a parent (hydro-electrolyte imbalances, salivary hyperamylasemia), and, finally, there may be a request for help from family members relating to a discomfort of the child, referred to as not very definable (8).

From these indirect signals comes the need for further investigation. A conversation with family members is useful, both when they are worried and when the PCP examines the presence of warning signs. Since BED appears to be present, according to estimates in a percentage varying from 2 to 25% in obese up to 40% (US estimates) in people with severe obesity, it is important that the PCP collect a correct and complete anamnesis about the eating habits of obese patients. Obese people with BED take larger amounts of food during binges, have more chaotic and disordered eating habits, often linked to negative emotional factors and have a

higher frequency of psychiatric comorbidities. In fact, BED is often associated with depressive disorder (which could be masked), so much so that it is considered a depressive equivalent, more linked to problems related to emotions and impulse control than to weight control. Furthermore, the diagnosis of BED also involves a different therapeutic approach to obesity, representing, for example, a contraindication to bariatric surgery, since it has a negative predictive value on the outcomes of this type of approach (8).

4. The physical examination

The physical examination is fundamental to highlight any alterations that can confirm the suspected diagnosis, to assess the nutritional status, to assess the physical risk and to detect any signs of medical complications. The initial physical evaluation in anorexia nervosa must aim above all to determine the presence and the gravity of the weight loss and its physical consequences. The weight and the BMI, the percentile for age > 18 years, the arterial pressure and the heart rate, the body temperature, the examination of the extremities, the measurement of the arterial pressure, also in orthostatism (for possible orthostatic hypotension) are to be evaluated, as well as the examination of the skin and hair (dry skin, often orange in color, fluff). Signs of physical risk are a rapid weight loss (greater than 1 kg / week, in adolescents a BMI <5th percentile), the presence of marked bradycardia (less than 50 beats / m ') or cardiac arrhythmias, severe hypotension (lower at 80 mm Hg maximum PA), a body temperature below 36 ° C, the presence of acrocyanosis and edema of the extremities. In bulimia nervosa typical physical signs will be evaluated, such as the increase in parotid volume, the possible presence of the Russell sign (callus on the back of the hand), possible dental erosions, typical manifestations of the abuse of diuretics and laxatives (6-10).

Methods

1. Instrumental and laboratory examinations

The request for any instrumental and laboratory tests (paying attention not to collude with the patient who tries to medicalize his mental illness, instead of making the problem more aware) will in any case be personalized, and aimed at exploring

possible nutritional deficiencies and possible complications; sometimes it can also be used as an "ex adiuvantibus criterion" to confirm a diagnostic suspicion. Routine examinations are recommended to explore the glycemic balance (glycemia, glycated hemoglobin), the lipidic structure (total cholesterol, HDL, LDL, triglycerides), the protein framework, any vitamin deficiencies (Vit A, B, D, folate) and electrolytic (Na, K, Ca, P, Mg, Cl), salivary amylase, hepato-renal functioning (AST, ALT, total fractionated bilirubin, CPK, creatinine, urine test), in some cases the hormonal one (FSH, LH, PRL, TSH) as well as the immune status (blood count). Individually, and based on the diagnosis, any medical complications must be sought, for example, an ECG must be requested in the case of signs or symptoms of cardiac compromise (bradycardia, electrolyte abnormalities, or BMI <15 kg / m²), or bone densitometry if the BMI is <15 kg / m² or equivalent percentile or amenorrhea persists for more than six months, or a gastroscopy in case of repeated self-induced vomiting with digestive disorders (13-16).

2. The differential diagnosis

The differential diagnosis relating to weight loss must be aimed at excluding organic causes, such as infections, autoimmune diseases, endocrine diseases (eg, hyperthyroidism), malabsorption (linked to diseases such as celiac disease or inflammatory bowel diseases), neoplasms. Differential diagnosis of amenorrhea must be aimed at ruling out pregnancy, endocrine disorders (eg, hyperprolactinaemia, hyper / hypothyroidism), polycystic ovary syndrome, hypothalamic diseases (eg, prolactinoma). The differential diagnosis of mental disorders must be aimed at exploring the presence of depression, obsessive-compulsive disorder, psychosis, substance abuse or even somatization disorders (15-18).

3. Treatment

In the event that the PCP detects the presence of an eating disorder, the interview with the patient will aim above all to strengthen the therapeutic alliance and, subsequently, to facilitate the awareness on the part of the patient himself, of the real problem. The survey of the motivation to change and, therefore, to the treatment belongs to a further phase, well knowing that, compared to it, he / she can present a strong ambivalence.

Informing the patient correctly and in a scientific manner about his disorder, possible complications and treatment options, avoiding judging attitudes, can stimulate and strengthen the motivation to change and lead to making decisions shared with the patient and eventually, in the case of minors, with their family members. The PCP has responsibility for the initial assessment and initial coordination of the therapy; furthermore, he has the task of determining whether there is a need for emergency treatment or psychiatric evaluation. In the case of shared care with specialist care centers, the family doctor or general practitioner should make clear to those who are responsible for monitoring the patient and share this decision with the patient and, where appropriate with his family (1-5).

It must always be remembered that a delay in treatment can have serious consequences and try to make it happen as quickly as possible, taking care to avoid that the patient reaches serious levels of weight loss, which should be considered a priority. The PCP can inform the patient of the existence of self-help groups and support groups, and offer the opportunity to participate in such groups, where available, as they seem to favor adherence to treatment in the long term and reduce the relapse rate, reducing in the short term the disorderly BED behaviors and binge eating and elimination behaviors in mild forms of bulimia nervosa (1-5). In anorexia nervosa, although weight and BMI are important indicators of clinical risk, they should not be considered the only indicators (since they are not reliable in adults but especially in children); in assessing whether a person has anorexia nervosa, attention must be paid to other clinical assessments repeated over time, including the rate of weight loss, growth rates in children, objectionable physical signs and appropriate laboratory tests. For patients with lasting anorexia nervosa, not under therapy of a secondary care service, the family doctor should guarantee an annual physical and mental clinical review (6-10).

In most patients with anorexia nervosa the goal of treatment is to recover about half a kilogram of weight / week; you need to monitor regular physical activity and in some cases give supplements of vitamins and minerals; the patients must be advised of the possible presence of osteoporosis, so it is

necessary to avoid physical activities that predispose to falls. In almost all cases of anorexia nervosa, the referral to the specialist or specialist treatment centers is indicated by the PCP (6-10). In the case of bulimia nervosa, evaluation of the hydro-electrolyte balance is necessary, especially where patients frequently vomit or take degrees of laxatives (especially if they are under weight). When detecting a hydro-electrolyte disturbance, it is generally sufficient to focus attention on the responsible elimination behavior. In a small percentage of cases, in which supplementation is necessary to restore the hydro-electrolyte balance, oral and not intravenous administration is recommended, unless there are gastro-intestinal absorption problems. When laxative abuse is present, patients should be advised to gradually reduce the use of laxatives and inform them that the use of laxatives does not significantly reduce the absorption of calories. Patients with vomiting should undergo regular dental examinations and receive appropriate advice on dental hygiene, such as avoiding brushing their teeth after vomiting, rinsing with a non-acid mouthwash, reducing the acidity of the oral environment (for example, limiting acidic foods) (13-15).

Family physicians would be suitable for treating mild cases of bulimia nervosa, predominantly adults, and DAI in the general medicine setting, through guided self-help programs, if motivated and adequately trained (LGN 2004, grade B recommendation). Available data indicate that with guided self-help complete remission of bulimic episodes can be achieved in 20-30% of patients, and a significant reduction in their number in a variable percentage between 50 and 60% (13-15). The training of the PCP in the implementation of guided self-help programs should include a protocol or manual provided through a book or internet (eg, Fairburn "How to Win a Binge"), a manual for the therapist to guide patients using the effective treatment protocol, training in the use of the therapist's manual and monitoring supervision for any problems that arise. In fact, an optimal application of such treatment involves specific training of the PCP, which does not occur in the same way in all models of health care. In the UK such self-help interventions, considered to be "low intensity" and effective interventions, are

strongly recommended in the treatment of eating disorders (16-21).

4. Pharmacological treatment

The only drug that currently in Italy has an indication in the data sheet for the treatment of eating disorders is fluoxetine in the treatment of bulimia nervosa. And, therefore, it is the only non-off-label drug and, as such, prescribable for the national health service. The PCP may, therefore, where he deems it useful, propose to the patient this drug therapy, where the guided self-help can be considered insufficient, or in combination with it (7-10). The patient should be informed that the drug can reduce the frequency of binge eating and elimination behaviors, and that the long-term effects of this therapy are not known. Fluoxetine is to be considered the drug of first choice in the treatment of bulimia nervosa in terms of acceptability, tolerability and reduction of symptoms, the effective dose is 60 mg / day. In cases where the presence of a coexistent depressive disorder is diagnosed, the family doctor may propose therapy with antidepressant drugs (SSRIs). When the patient is sent to specialized treatment centers, it is advisable to communicate the recommended pharmacological therapy (time, duration and prescribed doses) (7-10).

Results and Conclusions

1. The sending of the patient to specialized treatment centers

The sending of the patient by the PCP to a psychiatrist specialist is much more delicate than any other sending to the other specialist figures, because it does not identify the limit of the technical skills, but rather that of the comprehensibility of the patient in his subjective and interpersonal themes. The sending of the patient to the psychiatrist may therefore risk causing a break in the continuity of the patient's relationship with his own doctor (the patient feels abandoned or not understood). Furthermore, there are also other types of risks, such as the patient's refusal to betray his own doctor, entrusting his own emotion to another; the risk of a debasement of the role of the PCP as a prescription counselor, whereas, instead, it should remain an important therapeutic reference, and, again, the risk of a double takeover, with a depersonalization of the clinical intervention,

because each of the two clinicians think that the other is the main reference.

In the case of EDs, this risk of depersonalization can be even greater, where, in specialized treatment centers, a multidisciplinary care program is implemented, which sees the patient entrusted to more specialists. Therefore, this type of sending requires even more the central role of the PCP, as a fundamental cornerstone of patient care and as a bond with family members. But the passage of setting also occurs in the opposite direction (from the specialist setting to the PCP), when the patient's conditions have improved or when the intensity of the specialist setting is no longer appropriate, so it is necessary that a valid and stable coordination is implemented. of clinical interventions, to support the unity of intervention strategies in the objectives, in the facts and in the experiences of all the subjects involved in the treatment, first of all the patient and his trusted doctor. It follows the need to implement an integrated care network that includes all levels of care (16-21).

The PCP assumes responsibility for the initial assessment and initial treatment link, which includes the possible need for a medical emergency or psychiatric assessment (16-21). Absolute indication to the sending, by the PCP, to the specialist or specialist care center is the severity of the case, with high risk, such as, for example, when a BMI <13.5 is detected, especially if with a rapid weight loss, of a serum K <2.5 mmol/l, a severe bone marrow dysfunction with a severe decrease in platelets, an evident proximal myopathy, or, again, the presence of significant gastrointestinal symptoms, such as a blood vomiting, of a significant risk of suicide or other complicating factors, such as substance abuse. Relative indications are the lack of improvement with the therapy carried out in the PCP setting, the identified need for individual and / or family psychotherapy or if the patient is a minor (16-21).

At the time of sending, the PCP should already be aware of the specialist referral center to which to send the patient or, better, to already have structured contacts. Where this is not possible, it is important to ensure the professionalism and multidisciplinary nature of the secondary care center (presence of psychiatrist, psychotherapist, internist, nutritionist or dietician), as well as the

presence of a contact of the secondary care center with hospital wards or qualified facilities to possible admissions; it is important that the family doctor learns about the type of therapies practiced, how much they are based on evidence of efficacy, or on which guidelines are founded ((16-21). In order not to risk the double management with risk of deresponsibility, it is essential that clarity is made about the responsibility, in sharing the care, monitoring and management of the clinical risk of the patient. When management is shared between primary and secondary care, there should be a clear agreement between the individual operators health care professionals responsible for monitoring the patient with eating disorders. This agreement should be written and shared with the patient and, where appropriate, with family members (16-21). In a fruitful collaboration, the general practitioner should be notified also of any interruptions of therapy by the patient.

2. The management of complications

First of all, as previously mentioned, the PCP possible responsibility for monitoring and managing complications should be defined in the collaboration relationship with the specialist or the person in charge of the care center. It is certainly more rare for the PCP to follow patients affected by anorexia nervosa exclusively in his setting, while it is more common for him to have the management of mild or medium-severity cases of both bulimia nervosa and BED, as in these pathologies are rarer than serious medical complications. But, even in the case of anorexia nervosa, the family doctor is always involved in the care of the patient and in monitoring the disease in the long term, as well as any relapses (13-15). It is essential that the PCP collect a complete medical history, aimed at revealing the frequency and intensity of compensatory behaviors and the possible use/abuse of substances (laxatives, diuretics, analgesics, herbal preparations, beverages carbonated). The long-term physical risks mainly concern the damage to the teeth, caused by vomiting and the use of carbonated drinks, the intestinal damage deriving from the abuse of laxatives and the potential hydro-electrolyte imbalance, which can also be fatal. Serious problems may occur with diabetes mellitus (13-15).

3. Oral-gastro-intestinal damage

The most common oral problem, in patients with eating disorders and self-induced vomiting, is the erosion of tooth enamel, caused by exposure to gastric acid juice, it can also have discoloration of the teeth and change in their shape, as well as increased sensitivity in hot and cold. The presence of tooth decay is more frequent. The collaborative relationship between the family doctor and the dentist is fundamental, in both senses; the dentist can suspect the diagnosis and talk to the family doctor or the family doctor can send the patient to the dentist for treatment of dental diseases. It is important to inform patients about the possible consequences on the teeth of self-induced vomiting, inviting them to use small preventive measures, such as rinsing the mouth after vomiting with water and sodium bicarbonate, to neutralize acidity, use specific toothpastes that reduce sensitivity and, finally, undergo a dental examination. Loss of the pharyngeal reflex and gastro-oesophageal reflux have been reported in patients with bulimia nervosa; frequent and severe vomiting can cause serious complications of the esophageal tract, perforations and esophagitis, which may require surgery. The prevalence of daily laxative abuse in patients with bulimia nervosa has been reported to be over 20%, and 75% of patients report occasional laxative use; patients generally take laxatives with the wrong assumption that there is a consequent reduction in caloric absorption (13-15). Fluid loss resulting from laxative action on the colon can provide a feeling of emptiness and weight loss. However, it has been shown that the use of laxatives is not an ineffective method of reducing the absorption of calories. Most patients use contact laxatives, rather than mass laxatives, which can lead to degeneration of colon innervation. The abuse of laxatives carries the acute complications of hydro-electrolyte disturbances and can be particularly dangerous in low-weight subjects. The abrupt cessation of laxatives in those who take them regularly can lead to reflex fluid retention and sodium retention, and consequently weight gain and edema, which can increase patient anxiety and reluctance to stop use of laxatives. To avoid these effects a gradual suspension of the use of laxatives is advisable (13-15). Excessive long-term use of

laxatives can reduce colonic motility, resulting in constipation and atony of the colon. The treatment of constipation to be recommended is regular food intake, adequate fluid intake and exercise, possibly the use of mass laxatives.

4. Hydro-electrolytic disorders

The most common changes in fluids and electrolytes occurring in bulimia nervosa are dehydration, hypokalemia, hypocloremia and alkalosis. Symptoms of dehydration, which can cause loss of volume, are hypotension and tachycardia. Patients may experience dizziness, hypotension, and weakness. In some more severe cases, renal function may be impaired. Possible suspension of diuretics and laxatives may be due to rebound hypoaldosteronism, water retention and peripheral edema (4-8). Hypokalaemia causes muscle weakness and even serious cardiac arrhythmias. Kidney function may be impaired; furthermore, the metabolic alkalosis may aggravate hypokalaemia. Abuse of diuretics, especially thiazide and loop diuretics, can cause sodium and potassium depletion; less frequently hyponatremia and hypomagnesemia occur, but both have potentially serious consequences, such as disorders of the central nervous system, cardiac arrhythmias and mood changes. Hypomagnesemia is also associated with hypocalcemia and hypokalemia. PCP should always evaluate the presence of hypomagnesemia in the face of refractory hypokalaemia. Typically, these alterations resolve when elimination behaviors are suspended. If and when necessary, oral supplementation is recommended, in some cases even with m (4-8) rehydration substances.

Complications of BED are linked to obesity. Obesity, when associated with other risk factors, such as arterial hypertension, smoking, hypercholesterolemia/dyslipidemia, diabetes, family history, leads to an increased cardiovascular risk, with a probable, long-term appearance, of cardiovascular and dysmetabolic diseases. It is easier to develop varicose veins and osteoarticular problems due to overload, especially in the lower limbs; obstructive sleep apnea and respiratory failure may be present. At the gastro-enteric level it is possible to find the presence of hepatic steatosis, gallbladder stones or digestive problems related to distension of the gastric walls. Do not overlook the possible worsening of

depressive disorder, or failure to respond to the treatments carried out. The PCP participation in the treatment, through ongoing relationships with the specialist or the interdisciplinary care team, reinforces the patient's feeling of being protected and supported by his own doctor (4-8).

5. Follow-up

During the specialist treatment, the PCP has the task to carry out a continuous support to the patient, in the reinforcement of the care undertaken and to inform the specialist (s) of any missed adhesions to the therapy; after the remission and the conclusion of the specialized therapy, the task of the PCP is the monitoring of the good behavior of the patient's behavior, which must be reassured and invited to distrust dysfunctional thoughts about the weight and shape of the body that should resurface (4-8).

In conclusion, PCPs have learned to dialogue with psychiatrists, to exchange their respective points of view, to realize, not without conflict and diversity of opinions, but always in the clarity of the joint objectives, a common vision of intent, aimed above all at maximizing the effectiveness of interventions and patient adherence to therapy. The joint visit of the PCP, the PCP and the psychiatrist in the PCPs office represents a topical moment of treatment, as the patient, especially the most resistant, overcoming even the stigma linked to mental health centers, he felt welcomed by a cohesive double support, in the sharing of approach and methods and in respect of his own areas of intervention. However, beyond scientific evidence, guidelines and protocols, to be a true multidisciplinary team, a strong motivation for collaboration, a continuous process of awareness of one's own role and of one's dynamics and a constant comparison.

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