Eating Disorders- A Primer for the Office Pediatric Caregiver

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Hot Topics in Pediatrics

July 23, 2022

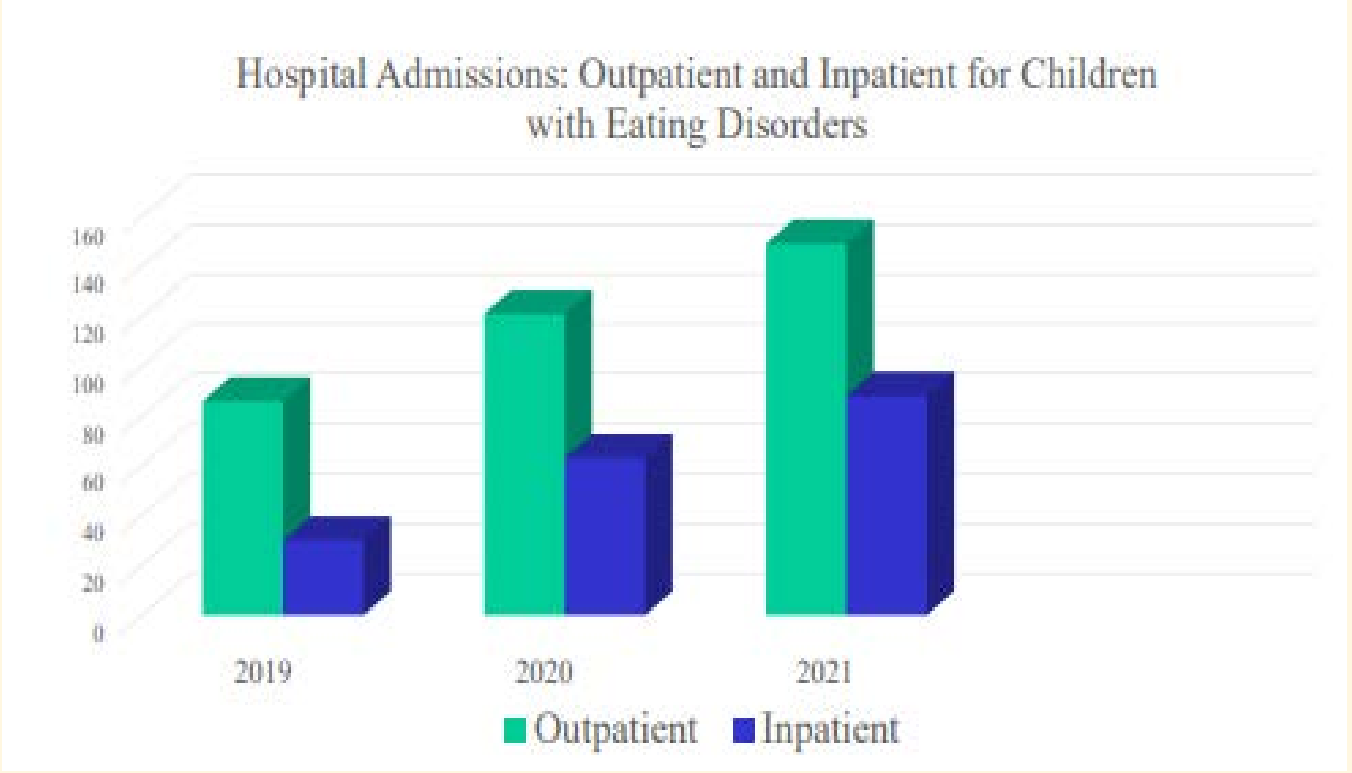
NEMOURS CHILDREN'S HEALTH

I have no disclosures

Eating disorder statistics

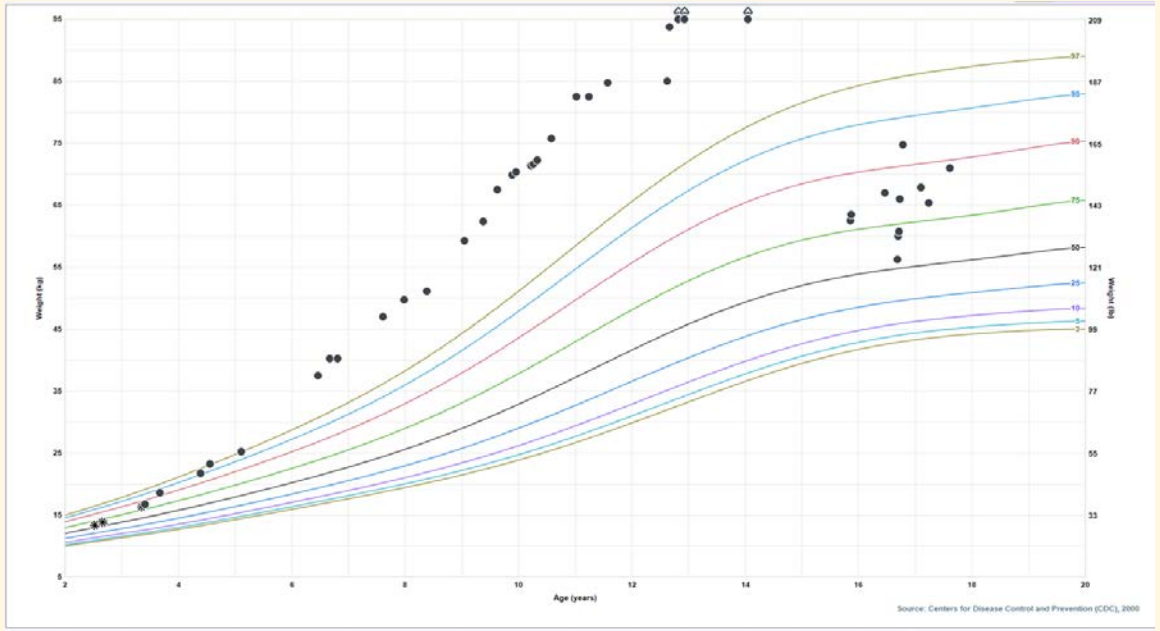
- Anorexia nervosa is the 3rd most common chronic illness among adolescents, after asthma and obesity
- 3% of adolescents are diagnosed with an eating disorder
- Eating disorders have the highest mortality rate of any psychiatric illness

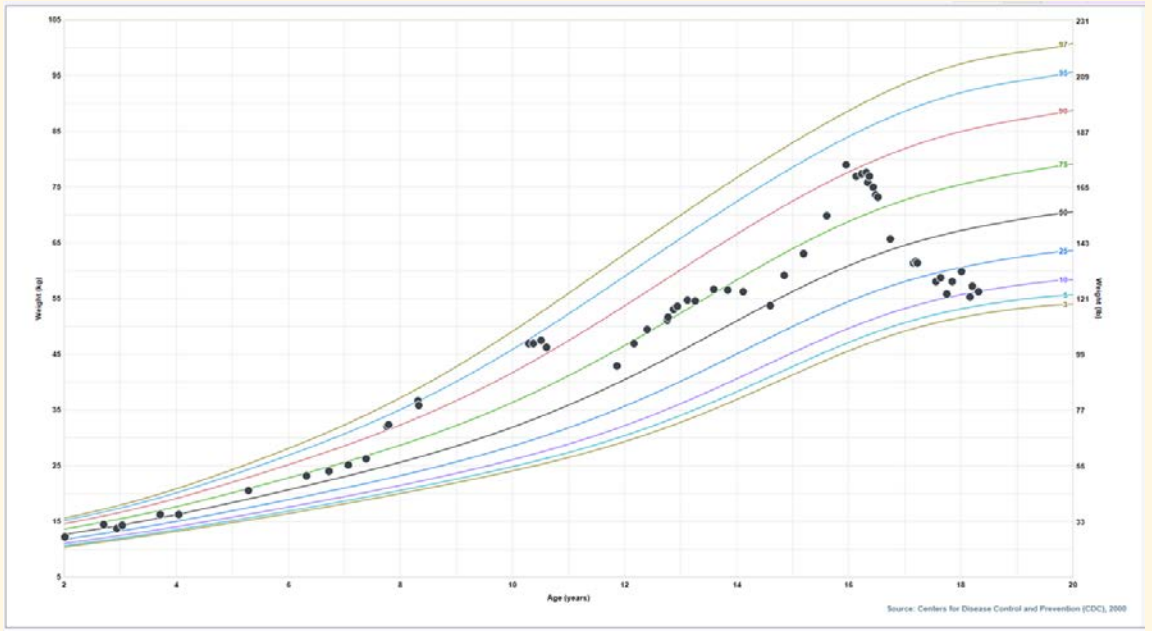
Increased eating disorders during the pandemic



Atypical anorexia nervosa

- Individuals who meet the criteria for anorexia nervosa but who are not underweight despite significant weight loss





ARFID – avoidance /restrictive food intake disorder – is an eating disorder.

- Any food avoidance that leads to malnutrition is an eating disorder
- This is not about body dysmorphia or intentional weight loss.
- Picky eaters
- Little interest in food
- Limited variety of preferred foods.
- Treatment requires food exposure and a therapist that specializes in ARFID
- Can lead to malnutrition

ARFID - continued

- Fear of choking
- Fear of vomiting
- Does not the texture of the food
- Does not like the smell of food

Early identification of eating disorders

- Associated with a shorter duration of illness and improved outcomes
- Often older patients are those who didn’t get identified when they were younger
- 50% failure rate.

Eating disorder risk factors

- Biological relatives
- Anxiety
- Perfectionism
- Body image dissatisfaction
- History of dieting
- Teasing or bullying
- Social media and pro anorexia sites

Eating disorder behaviors

- Changing *what* they are eating:
  - Becoming vegetarian
  - Cutting out entire food groups
  - Loved pasta and now won't eat it.
  - Eating "healthier"
- Skipping meals
- Exercising excessively
- Counting calories
- Checking weight

AAP recommendations

- Asking all pre-teens and adolescents about their eating behaviors and body image during their:
  - Annual examinations
  - Pre-participation sports examinations
- Weight, height, and BMI should be plotted on growth charts
- SCOFF questionnaire

SCOFF Questionnaire

1. Do you make yourself **S**ick because you feel uncomfortably full ?
2. Do you worry that you have lost **C**ontrol over how much you eat?
3. Have you recently lost more than **O**ne stone (14 lbs) in a 3-month period?
4. Do you believe yourself to be **F**at when others say you are too thin?
5. Would you say that **F**ood dominates your life?

Now that you've diagnosed your patient with an eating disorder….

- Why do you need to worry?

Complications of starvation

- Slowing metabolism
- Regular body functions are compromised
- Complications can develop in every organ system
- Gastroparesis- using stool softeners, MiraLAX. Refeeding improves
- Abdominal pain – use heating pad

PCP's role in outpatient management of eating disorders

- Obtaining baseline VS and VS every other week
  - Weigh in gowns, blind weights, after urinating
  - Give After Visit Summary to parents, not patients
- Obtaining a baseline EKG
- Obtaining baseline labs: CBC, CMP, magnesium, phosphorous
- Reinforcing no exercise – tough one – some programs won't take the patient.
- Referring to:
  - Dietician
  - Therapist

Eating disorder tips for an office visit

- Remember food is medicine
- All foods fit
- Validate – I know how hard this is for you.
- Be careful with positive reinforcement this may be triggering. For example “you look really good.”
- Encourage variety
- Encourage challenge foods and empower parents to be firm
- Separate the eating disorder from the patient.
- It’s ok to challenge the eating disorder and make it upset.
- Great book for parents is Survive FBT by Maria Ganci.

When should PCPs send a patient to the ER?

- Abnormal VS:
  - Resting heart rate < 50
  - Hypotension, orthostatic hypotension, or orthostatic tachycardia
- Abnormal EKG:
  - Bradycardia < 50
  - Prolonged QTc
- Abnormal labs:
  - K < 3.5
  - Na < 135
  - Phos < 2.3 or > 4.1
- Severe malnutrition:
  - BMI < 16
  - Rapid weight loss of >5% body weight in 10 days
- Acute food refusal or eating < 500 calories a day

When does the ER admit for medical stabilization?

- Abnormal VS
- Abnormal EKG
  - Telemetry unit for heart rate < 40 while awake or prolonged QTc
- Abnormal labs
- At-risk for refeeding syndrome

Refeeding syndrome

- Serious complication during treatment
- At-risk for refeeding syndrome
  - Eating < 500 calories per day for 3 days
  - Severe malnutrition
- Greatest risk for refeeding syndrome occurs days 2 to 4 after feeding starts

Refeeding syndrome

- With increased food intake:
  - ↑Glucose → ↑insulin
  - Insulin → ↑cellular uptake of phosphate → hypophosphatemia
  - Hypophosphatemia → tissue hypoxia, myocardial dysfunction, respiratory failure
- Insulin → ↑ cellular uptake of potassium and magnesium

Refeeding patients with eating disorders

- Metabolic rate increases when they start to eat again
- Caloric requirements can be as high as 5,000 per day
- Calories = Resting Energy Expenditure (REE) multiplied by an activity factor
  - REE x 2.5 to 3.5 for age ≥ 12
  - REE x 2 to 3 for age < 12

  *Typical healthy person: REE X 1.3

Meals and snacks at home

- Require 3 meals and 2 snacks
- Each meal should have 3 food groups and snacks should have 2.
- Uneaten food replaced with supplement:
  - 50 to 90%: 1 to 2 cans
  - < 50%: 2 to 4 cans
- No bathroom for 60 minutes after a meal
- No exercise

Determining weight goal

- Weight goal:
  - Previous growth trajectory
  - Pubertal stage
  - Growth potential

Multidisciplinary approach to treatment

- Medical
- Nutritional
- Psychological

Family Based Treatment (FBT)

- Current gold standard of treatment
  - Highly focused, staged treatment (12-x18 months)
  - Shorter course than most other treatments
  - Fewer relapses
  - Fewer hospitalization.
  - Supports the families during the refeeding or nutritional rehab process.
  - This is in place of residential , IOP or PHP.

FBT Tenets

- Neither parents nor adolescents are to blame
- Empower parents – they are responsible for weight restoration
- Food as medicine
- Emphasis on behavioral recovery rather than improving insight or understanding
- All Foods Fit.
- Be mindful of the language

How can we help prevent eating disorders?

- Eradicating weight stigma
- Emphasizing health and “health promotion” rather than “weight” and “obesity prevention”
- Discouraging dieting
- Avoid praising weight loss
- Focus on treating underlying causes of the eating behaviors:
  - Anxiety and depression
- Encouraging intuitive eating and meaningful movement

Helping parents prevent eating disorders in their children

- Discourage “weight talk” and teasing
- Avoid labeling foods as “good” or “bad”
- Instead of taking “unhealthy” foods away, focus on adding a variety of foods
- Encourage family meals