

Eating Disorders

A Review and Case Discussion

TiPS Conference
Friday March 22, 2019
Nicole Brynes, DNP
Anderson Still, MD

Objectives

- To provide a brief overview of the 2 most common eating disorder diagnoses.
- To discuss initial work up, evaluation, and differential diagnosis in the setting of concern for disordered eating.
- To discuss how to refer to local resources for eating disorder treatment.



Part One: A Quick Review

Most Common Disorders

Anorexia Nervosa

- Distorted body image
- Excessive dieting or exercising
- Severe weight loss
- Fear of weight gain or becoming fat

Bulimia Nervosa

- Frequent episodes of binge eating
- Compensatory behaviors
- Engaging in compensatory behaviors at least 1x/wk for 3mos

What DSM-5 Did: Anorexia Nervosa

- Criteria now accommodates broader picture
- **Removed amenorrhea**
 - Allows inclusion of males, premenarchal females, postmenopausal women
- Weight criterion allows **assessment based on individual's growth trajectory**
- **Attempt at decreasing stigma**
 - “Refusal to maintain weight” → “Persistent behavior that interferes with weight gain”

Anorexia Nervosa: The Numbers

- Prevalence: ~1% for females
- Females > Males (1:3 – 1:12 male-to-female ratio)
- Complications – mostly due to malnutrition
 - Electrolyte abnormalities
 - Arrhythmias
 - Bone mineral density reduction
 - Growth retardation
- Prognosis: 33% recover by 5 years with traditional tx
 - *Teens have better outcomes than adults (Est. 50-60% recover, 30% improved)*
 - **Recovery**: Normal weight (>95% expected for age, sex, height) (Lock, et al)
- **Highest mortality rate of any mental health diagnosis**
 - 5 times more likely to die prematurely
 - 20% of deaths due to suicide

What DSM-5 Did: Bulimia Nervosa

- The Basics
 - Recurrent episodes of binge eating and compensatory behaviors
 - Compensatory behaviors: self-induced vomiting, laxative abuse
 - Typically have normal or above-normal body weight
- The Changes
 - **Reduced frequency of binge-purge episodes**
 - 2x/week → 1x/week for 3 months

Bulimia Nervosa: The Numbers

- Prevalence: ~3%
 - Peaks in late adolescence and young adulthood
- Far less common in males (1:3 – 1:18 male-to-female ratio)
- Complications mostly secondary to purging behaviors
 - Electrolyte abnormalities
 - Mallory-Weiss esophageal tears
 - Dental issues
- Prognosis: 33-66% achieve full recovery by 5 years
 - Good short term success but high relapse rates
- Mortality less common than in AN
- High rates of suicide (vs. general population)

Other Notable Eating Disorders

- Avoidant/Restrictive Food Intake Disorder
- Binge-Eating Disorder
- Other Specified Feeding and Eating Disorder
- Unspecified Feeding and Eating Disorder

Part Two: The Interview and Initial Evaluation



Case: A

- A is a 15 year old female who is new to your clinic and comes in for a WCC. The chart shows that she is 65 inches tall and weighs 95 pounds. She denies any problems or concerns.
- How do you screen A for an eating disorder?

Screening Tools

- Screening Tools:
 - SCOFF
 - Do you make yourself **Sick** because you feel uncomfortably full?
 - Do you worry that you have lost **Control** over how much you eat?
 - Have you recently lost **15lbs (One stone)** or more in a three-month period?
 - Do you believe yourself to be **Fat** when others say you are too thin?
 - Would you say that **Food** dominates your life?
 - *Answering “yes” to 2 or more questions is considered a positive screen*
 - Eating Disorders Examination-Questionnaire (EDE-Q)
 - Female Athlete Screening Tool (FAST)

A's Responses to Screening Questions

1. Do you make yourself **vomit** because you feel uncomfortably full?

- A's response "No."

2. Do you worry that you have lost **control** over how much you eat?

- A's response "No."

3. Have you recently lost **15lbs** or more in a three month period?

- A's response "No."
- Mom's response "No, but she has gotten taller and hasn't gained any weight in a while."

4. Do you believe yourself to be **fat** when others say you are too thin?

- A's response "No., not fat exactly"
- Mom's response "She often says she hates how her clothes look on her."

5. Would you say that **food** dominates your life?

- A's response "No."
- Mom's response "She is very particular about what she eats. Lots of salads and she cut out sweets and desserts last year."

What do you want to do next?

Eating Disorders: The History

- Question categories:
 - Weight history
 - Diet history
 - Exercise history
 - Body image
 - Binging/Purging
 - Reproductive health
 - Substance use
 - Psychiatric history
 - Family history
 - Review of systems
 - HEADSS questions



Weight History

- What was your highest weight?*
- What was your lowest weight?*
- What do you think your weight should be?



Diet History

- 24-hour diet history
- Do you ever feel guilty about eating?
- Do you count calories/fat/carbohydrates?
- Do you avoid any foods?



Exercise History

- Do you exercise? What kind of exercise do you do?
- How often do you exercise? How intensely?
- How stressed do you feel when you are unable to exercise?



Binging/Purging

- Do you ever binge? How often? Triggers?
- Do you vomit? How often? How soon after eating?
- Do you use laxatives/diuretics/diet pills/caffeine? How many? How often?



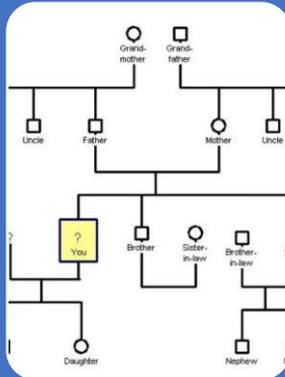
Body Image

- How much of your day is spent thinking about your body?
- How much of your day is spent thinking about food/eating?
- Are there body areas that cause you stress? Do you do any body checking?



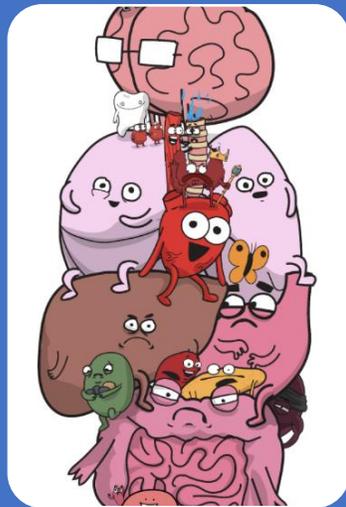
Reproductive Health: Females

- When was your first period?
- Are your periods regular?
- When was your last period? How much did you weight?



Family History

- Family history of eating disorder, obesity or dieting?
- Anyone with history of depression, anxiety, bipolar disorder, OCD, substance abuse or other psychiatric diagnosis?



Review of Systems

- Dizziness, syncope, fatigue, weakness?
- Pallor, easy bruising/bleeding, cold intolerance?
- Hair loss, lanugo, dry skin?
- Constipation, diarrhea, early satiety, bloating, abdominal pain, heartburn?
- Palpitations, chest pain?
- Muscle cramps, joint pains?
- Excessive thirst and voiding?

Common Red Flags

- Significant weight loss* and/or plateauing on growth curve
- For females → primary or secondary amenorrhea
- Bradycardia, dizziness, or syncope
- GI complaints:
 - Loss of appetite
 - Reflux
 - Recurrent abdominal pain

Case: A

- A is a 15 year old female who is new to your clinic and comes in for a WCC. The chart shows that she is 65 inches tall and weighs 95 pounds. She denies any problems or concerns.
- Her mother does express some concern that A has not gotten her menstrual cycle for a while.
- A began having menses at age 12 and reports it was regular until about 8 months ago when it stopped.

Case: A (cont.)

- Review of systems is negative except for a few things. She is often cold but it's winter so she figured everyone was. She doesn't get much sleep at night, which she attributes to staying up late doing school work. She is in 10th grade and does well in school. She wants to go to college to study neuroscience. She sometimes wakes up through the night and has trouble falling back asleep, which she suspects is due to worrying about school. She has also had a couple of episodes when she felt lightheaded but denies passing out. These episodes happened back in the summer during soccer practices. It was hot and she thinks she wasn't drinking enough water.

What do you want to do next?

The Evaluation: Lab Studies

- Comprehensive Metabolic Profile
- Calcium, Magnesium, Phosphorus
- CBC
- Urinalysis
- TSH, free T4
- hCG
- EKG
- Consider urine drug screen
- Consider celiac panel, ESR, CRP

The Differential

Binge-Eating

- Obesity
- Major Depressive Disorder
- Prader Willi Syndrome
- Kleine-Levin Syndrome

Vomiting

- Migraine
- Pseudotumor cerebri
- Hydrocephalus
- CNS malignancy
- GI disease
- Cyclic vomiting

Weight Loss

- Celiac disease
- IBD
- Malabsorption
- Hyperthyroidism
- Addison's disease
- Occult malignancies
- MDD
- HIV

The Evaluation: Determine Medical Instability

- Noting any of the following suggests medical instability:
 - **IBW < 75%**
 - **Inability to gain weight/significant weight loss** despite treatment if IBW > 75%
 - **Vital sign instability**
 - HR < 50bpm awake OR < 45bpm asleep
 - Hypotension (<80/50mmHg)
 - Symptomatic orthostatic changes
 - Hypothermia (T < 36C)
 - **Electrolyte abnormality**
 - Hypokalemia
 - Hyponatremia
 - Hypophosphatemia
 - Symptomatic hypoglycemia

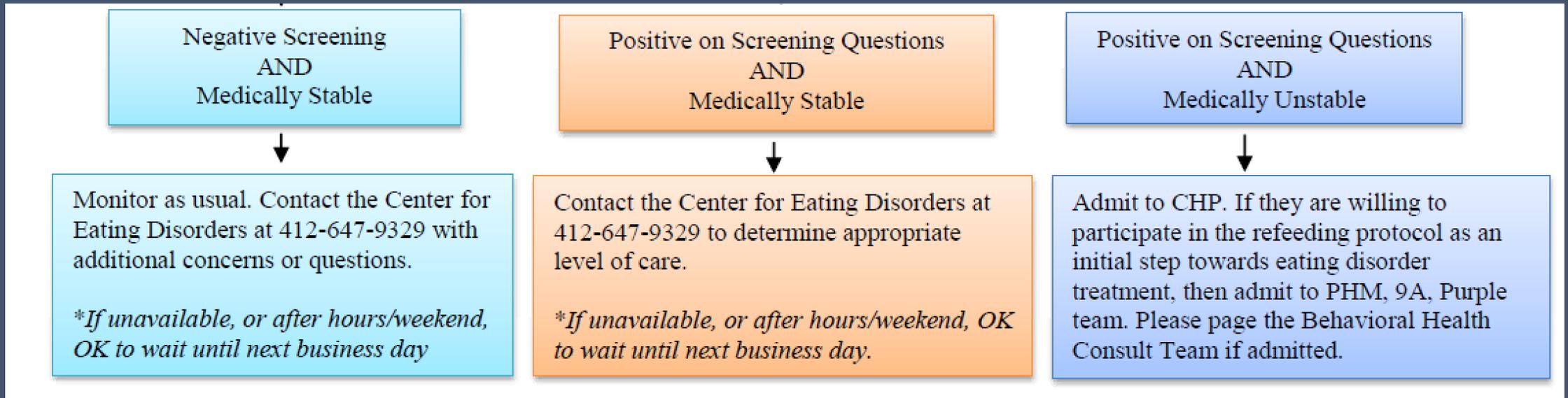
The Evaluation: Determine Medical Instability

- Noting any of the following, suggests medical instability:
 - **Dehydration**
 - **Arrhythmia or prolonged QTc**
 - **Eating disorder behaviors** interfering with functioning or leading to medical instability
 - Food refusal
 - Vomiting
 - Severe laxative abuse
 - Lack of improvement or rapid worsening while in outpatient treatment

The Evaluation: Determine Medical Instability

- Noting any of the following suggests medical instability:
 - Other **medical complications** related to eating disorder or malnutrition
 - Esophageal tear
 - Syncope
 - Seizure
 - **Comorbidities** that interfere with treatment of eating disorder outside of hospital

The Decision Tree



What to say to patients with eating disorders?

- **Health: Physical and Mental**

- "Food is your medicine."
- "Your health is non-negotiable."
- "Your attention/ concentration seems better today."
- "Your body needs energy to rebuild."
- Ask about any improvement in mood, sleep, or energy.

- **Nutritional stabilization/ weight gain:**

- "Your treatment progress is on target."
- Provide encouragement to eat 100%

What to say to patients with eating disorders?

Acknowledge/validate struggle while still encouraging change

- Egosyntonic nature of the illness
- Acknowledge that change is hard
- Recognize the desperation that drives symptoms
“choice”
- Patients aren't trying to be difficult
- “Eating is simple, but not easy. I'm here to help you through this and to help you eat 100%.”
- “Refeeding is painful AND the only way to get back to your life is by doing what you need to do to get yourself healthier.”

What to avoid saying to patients with eating disorders?

- **Negotiating with the eating disorder:**
 - Adjusting target weight based on their anxiety
- **Focusing on body shape/size/appearance:**
 - "You look good / healthy."
 - "You're gaining weight really well."
 - "You look like you're normal (healthy) weight."
- **Drawing attention to the amount or type of food they are eating (unless it is medically concerning)**
 - "You should eat a cheeseburger!"
- **Discussing your own weight, eating habits, or exercise routines**
- **Minimizing how difficult it is to eat**
 - "Just eat, what's the big deal?"

Pause: Refeeding Syndrome

- Results from failure to make adequate ATP
- Prolonged undernutrition:
 - Decreased glucose
 - Fat/protein catabolism
 - Depletion of intracellular electrolytes (Phos!)
- Refeeding:
 - Increased glucose
 - Insulin production
 - Phos moves into cells
 - Insufficient production if Phos already low
 - Multisystem organ dysfunction

Who is at risk for Refeeding Syndrome?

Patient has one or more of the following

- **BMI <16** kg/m²
- Unintentional weight loss of **>15%** in the previous 3–6 months
- Little or no nutritional intake for **>10 days**
- **Low levels** of potassium, phosphorus, or magnesium before refeeding

Patient has two or more of the following

- **BMI <18.5** kg/m²
- Unintentional weight loss of **>10%** in the previous 3–6 months
- Little or no nutritional intake for **>5 days**
- **History** of alcohol misuse or drugs, including insulin, chemotherapy, antacids, or diuretics

Part Three: The Referral

Some Definitions: Treatment Types

Type	Hours/Frequency	Examples
Outpatient (OP)	1-2hrs per week	Ex. Center for Eating Disorders The Emily Program
Intensive Outpatient Program (IOP)	3hrs/day for 3 days/week	Ex. Center for Eating Disorders IOP Renfrew Center IOP (female)
Partial Hospitalization Program (PHP)	5-6hrs/day for 5days/week	Ex. Center for Eating Disorders PHP Renfrew Center PHP (female)
Inpatient Hospitalization (for Medical Stabilization)	24hrs/day until medically stable	Ex. Refeeding protocol at CHP
Inpatient Hospitalization (for Behavioral Health Stabilization)	24hrs/day	Ex. Center for Eating Disorders Unit at Western Psychiatric Institute & Clinic (WPIC)
Residential Treatment Facility (RTF)	24hrs/day, typically weeks to months	Ex. Sheppard Pratt Hospital Brandywine Hospital Renfrew Center

Treatment Programs at UPMC

Center for Eating Disorders: Inpatient Treatment at Western Psychiatric Hospital (WPH)

The Basics	The Criteria
<ul style="list-style-type: none">• Inpatient psychiatric stabilization• Locked unit• 24/7 monitoring	<ul style="list-style-type: none">• < 75% IBW• Acute psychiatric emergencies (ex. SI, acute psychosis, etc.)• Comorbid psychiatric illnesses that interfere with treatment of the eating disorder in other settings/levels of care• Consider for eating disorder behaviors that interfere with treatment in OP, IOP or PHP level of care (ex. restricting, purging, exercising while at CHP)

Center for Eating Disorders: Partial Hospitalization Program

The Basics	The Criteria
<ul style="list-style-type: none">• 5 days/week (Monday-Friday)• 8:30am – 2:30pm• Locations:<ul style="list-style-type: none">• Wexford: Ages 11-18y• Oakland: Ages 18* and up <p>*14-17 under special circumstances</p>	<ul style="list-style-type: none">• IBW > 75% (ideally 80-85%)• Medically stable, though requires some monitoring most days of the week• Step down from inpatient• Failure to respond to lower level of care (IOP or OP)• Age 11 and up for Wexford CED PHP• Actively participating in treatment – eating 100% of meal plan, minimal eating disorder behaviors, gaining weight as expected

Center for Eating Disorders: Intensive Outpatient Program

The Basics	The Criteria
<ul style="list-style-type: none">• 3 evenings per week• 4:00pm – 7:00pm• Locations:<ul style="list-style-type: none">• Wexford: Ages 11-18y• Oakland: Ages 18* and up <p>*14-17 under special circumstances</p>	<ul style="list-style-type: none">• IBW > 88%• Medically stable with little need for medical monitoring• Step down from PHP• Failure to respond to OP• Must be 11y or older for CED IOP• Able to engage in regular daily activities

A's Results:

- A is 82% of ideal body weight. Vital signs are stable, but she is orthostatic. Denies any dizziness upon standing.
- On physical exam she is clearly underweight. There is slight lanugo on her arms, back, and face.
- Electrolytes are normal. TSH and liver function tests are slightly elevated.
- EKG shows normal sinus rhythm with bradycardia (heart rate = 56 bpm).

What level of care does she need?

- A. Inpatient
- B. Residential
- C. Partial Hospital Program
- D. Intensive Outpatient Program
- E. Outpatient Treatment

Case A Follow up

- A completed treatment in PHP and IOP last week and just started weekly outpatient therapy this week.
- She is now 92% of IBW and menses have returned. She is no longer cold all the time. Sleep and energy level have improved.
- She reports continued struggles with body image and some urges to restrict what she's eating. She is able to ask her family for help when she gets these urges and that has helped her to continue eating everything she's supposed to.
- She still feels down at times, mostly when she thinks about the weight she has gained.
- She is doing more things with friends though and enjoys that.
- Her parents give the same report.

How to Refer

- UPMC Center for Eating Disorders
 - Intake Coordinator -> 412-647-9329
- Emily Program
 - 1-866-673-8652
- Renfrew
 - 1-800-RENFREW

Online Resources

- National Eating Disorders Association
 - www.nationaleatingdisorders.org
- Families Empowered and Supporting Treatment of Eating Disorders (FEAST-ED)
 - www.feast-ed.org
- Maudsley
 - www.maudsleyparents.org
- NEDIC (National Eating Disorder Information Centre)
 - <http://nedic.ca/>

Questions?

