UCSF Health
Eating Disorders Program

Eating Disorders in Primary Care

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Eating disorders lead to severe medical consequences, including death

One of the most common causes of mortality in patients with eating disorders is:

Mortality in Anorexia Nervosa

- Individuals with EDs have significantly elevated mortality rates (6-8%)
- AN has one of the highest mortality rates of the psychiatric disorders
  - More than double that of schizophrenia and almost triple that of bipolar or major depressive disorder
- About one-third of deaths in AN are due to heart problems and one-fifth to suicide

Arcelus et al., 2011; Osby et al., 2000; Deter et al., 2005

Psychological eating disorder symptoms are heavily influenced by malnutrition

Evolving Diagnoses

- Anorexia Nervosa
- Atypical Anorexia Nervosa (OSFED)
- Bulimia Nervosa
- ARFID
- Binge Eating Disorder
- More!

A diagnosis is not necessary!

- Identify concerning growth patterns
- Identify concerning behaviors
- Initial medical management including caregiver involvement
- Facilitate referrals

Screening Questions

- How is your eating/nutrition?
- How important to you is what you eat?
- Are you on a diet? Tell me about what led you to start dieting
  - Determine goal (weight loss, health, athletic performance, etc)
- Have you lost any weight recently? How much? With what goal or intent?
- How do you feel about your body? How do you feel about your weight? Any concerns about your weight or shape?

Early Signs

Cutting back on food intake or skipping meals

Avoiding eating with others/family

Changing food selections (cutting out foods, becoming vegetarian/vegan)

Exercising more

Making comments about body (often brought up by parents)

Reading recipe books, getting involved in cooking

Food going missing

Using bathroom after meals / vomit residue in toilet or shower

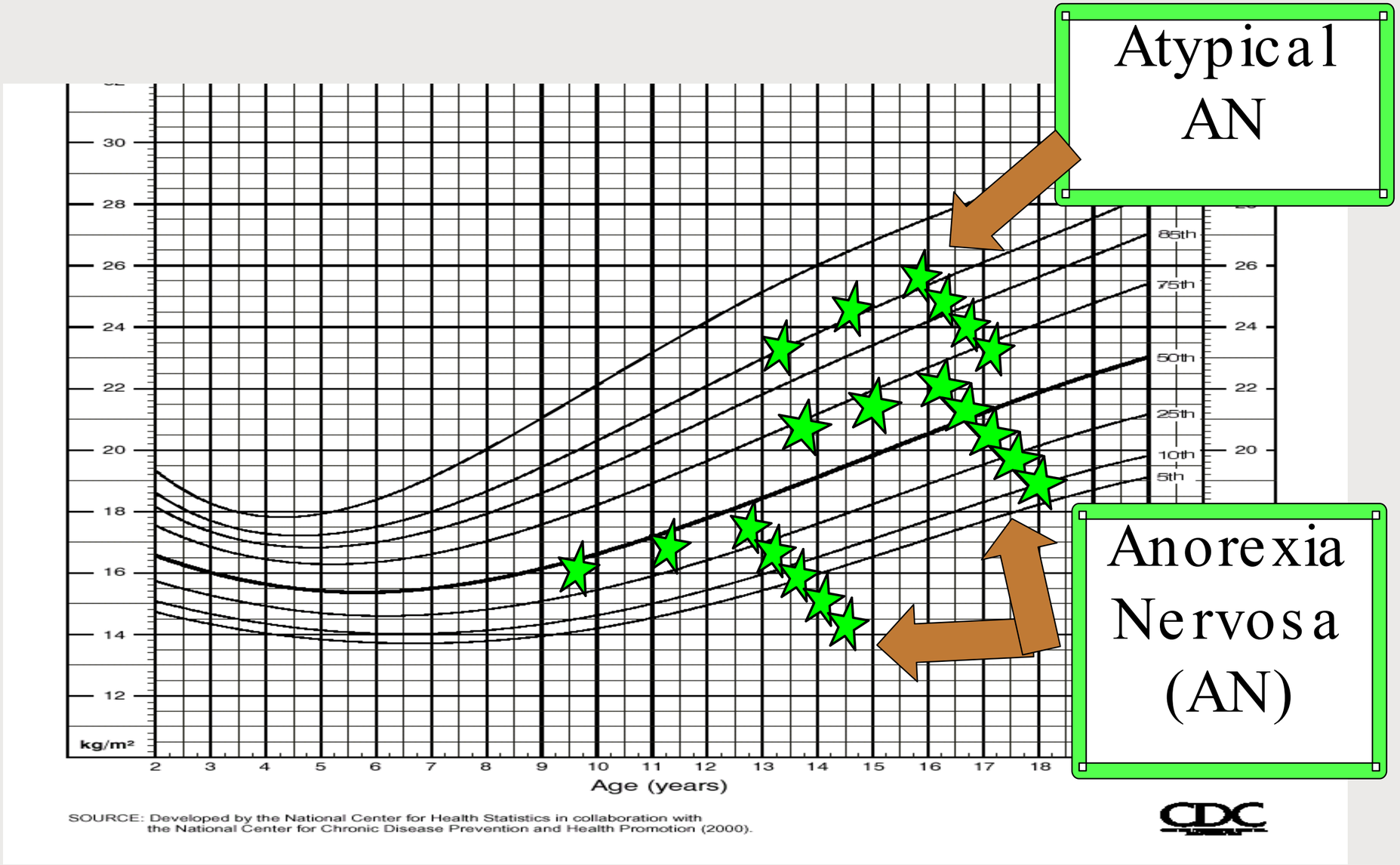
Patient

- I’m not bingeing
- I’m not vomiting
- I’m getting my period regularly
- I’m an athlete. I’m not exercising to lose weight
- I’m fine with my body
- I’m fine with my weight
- I’m not scared of gaining weight

Caregivers

- I found bags of junk food hidden in her room
- They run to the bathroom right after meals, and we find vomit residue on the toilet
- I haven’t bought sanitary products for her in 6 months
- Their coach says they train beyond what their teammates do
- They wear only baggy clothes
- He weighs himself a few times a day
- They won’t eat more than 500 kcal per day

Concern: falling off BMI curve



Weight loss indicating malnutrition

	Mild	Moderate	Severe
% mBMI*	80-90%	70-79%	<70%
BMI Z-score	-1 to -1.9	-2 to -2.9	-3 or greater
Weight Loss**	>10% body mass loss	>15% body mass loss	> 20% body mass loss

*Percent median BMI

**Rapid weight loss may place a patient at increased risk of medical complications and increase severity of malnutrition

[SAHM Position 2015, 2022]

Despite similar amounts of weight loss, a young person with a low BMI is more likely to be medically unstable as compared to a patient with a normal BMI.

Weight Suppression

Comparing Jane to Typical AN

- Two girls with weight loss due to ED
- Both are 16 yr. old and 65 inches tall
- Both have lost “significant weight” via restriction, diet pills, purging, and excessive exercise
- Jill AN: 125 > 85 # , BMI 14.2 kg/m2 = 40 # loss
- Jane AAN: 260 >128 # , BMI 21.3 kg/m2 = 132 # loss

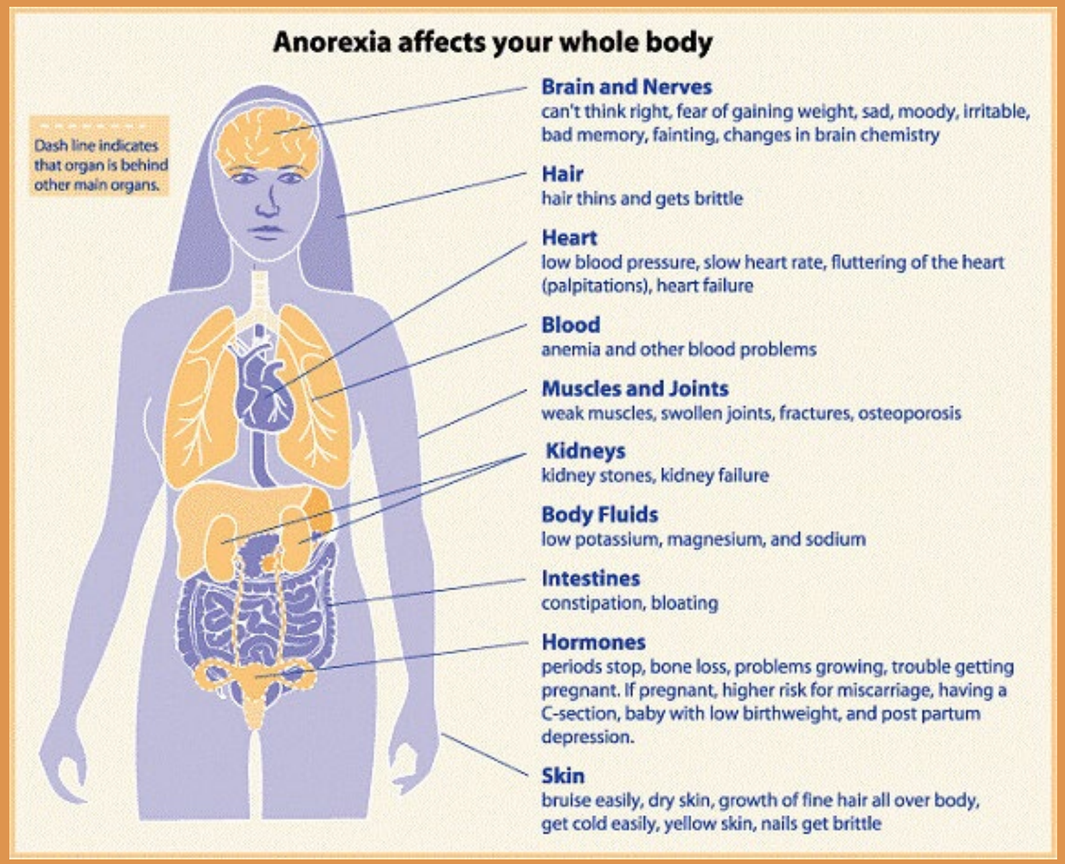
Are these girls equally malnourished?

Weight suppression predicts illness severity

- Weight suppression, not admit %BMI, associated with lowest 48-hr HR (β =0.398, 95% CI -0.833, -0.062, p=0.021) [Garber 2015]
- Persistent amenorrhea [Seetharaman, Golden et al. 2017]
- Lower T3 [Aschettino-Manevitz 2012]
- Worse ED psychopathology [Lavender 2015; Berner 2013]

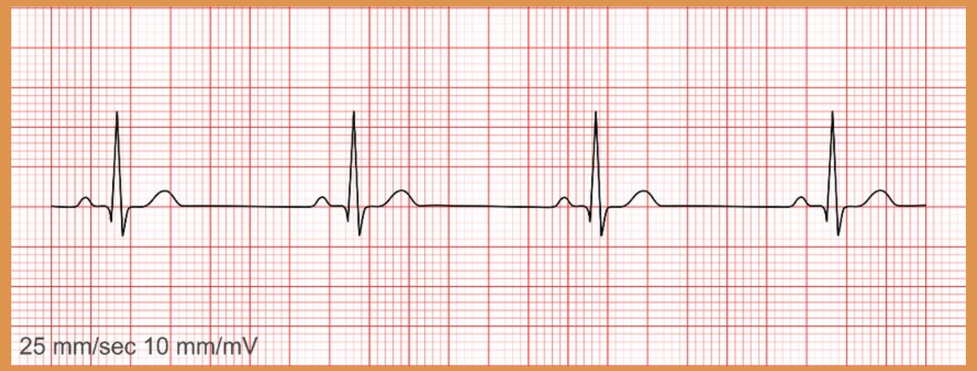
Medical Evaluation

- Height and Weight (in a gown)
- Vitals including orthostatics
- History and Physical Exam
- Careful review of growth charts
- ECG
- Laboratory Evaluation
- Referrals and Follow Up



Workup

- ECG (sinus bradycardia, prolonged QTc, arrhythmia)
- Initial Labs (CBC, CMP, Mag, Phos, Lipid Panel, ESR/CRP, TTG/IgA, Zinc, Vitamin D, TSH)
- Urine sample (specific gravity, pH, UDS, hcg)
- Dual-energy X-ray absorptiometry (DXA) scans when amenorrhea is present for at least 6 months



Primary Care Treatment

- Food is the best medicine
- Mobilize caregiver involvement
- Medically stabilize abnormal vital signs and electrolytes
- Carefully monitor growth and development
- Establish clear roles with team members and “stay in your lane”

Treatment Goal Weights

- Treatment goal weight (TGW) is a personalized, estimated target weight range for optimal recovery based on available growth records that takes into account normal expected growth in the next 12 months.
- Return to historical growth trajectory (BMI) from ~age 4
- If well above the growth curve (e.g., >99th percentile for BMI) and losing weight, minimum goal is no further weight loss

Treatment Cadence

- If under treatment goal weight, frequent follow-up for weight check and vital signs until in TGW range or care established in an eating disorder program
  - Every 1-2 weeks
- May space out visits once gaining weight steadily, in TGW range, or established with multidisciplinary team
- Touchpoint with family to empower caregivers with seriousness of illness and their critical role in recovery

Caregiver and Provider Goals

- For weight gain: Aim for at least 1 -2 lbs of weight gain per week.
- Many individuals require ~2500 -5000 kcal/day to achieve this goal due to metabolic changes during nutritional rehabilitation!
- Recommend 3 meals per day and 3 snacks; each meal/snack should include a caloric beverage (e.g., milk, juice)
- Caregivers are 100% in charge of preparing and plating meals. Limit negotiation and discussion around meals and snacks. Limit child's presence in kitchen during meal preparation to limit negotiation.

Caregiver and Provider Goals

- Encourage caregivers to feed their child the foods that their family has always eaten.
- Families do not all need to eat identical portions to that of the patient.
- Patient should return to eating all foods eaten prior to onset of disordered eating
- No diet foods: no sugar -free, low carb or low/non -fat
- All meals and snacks (ideally) should be supervised by a trusted adult

Psychopharmacology: Evidence Is Minimal

- Difficult to recruit
- Patients are medically fragile
- Nutritional deficiencies may affect medication response
- What are we targeting with medications?

Hospitalization Criteria

- Bradycardia: HR <50 daytime, <45 at night
- Hypotension: BP <90/45 mmHg
- Hypothermia: Temp <96° F
- Orthostasis: Increase in pulse (>40 bpm) or decrease in BP (>20 mmHg systolic, >10 mmHg diastolic) and symptomatic
- Weight: <75% expected body weight or ongoing weight loss despite intensive management

Hospitalization Criteria

- Acute food refusal: severe and/or prolonged food refusal
- EKG abnormalities: e.g., prolonged QTc
- Electrolyte abnormalities: low potassium, phosphorus, magnesium, sodium, glucose
- Other acute symptoms: syncope, esophageal tears, intractable vomiting, hematemesis

For a patient engaging in frequent purging (self-induced vomiting), the urinalysis is likely to reveal which of the following abnormalities?

Walking the Tightrope in Primary Care

- Adolescents who diet are at higher risk for ED development
- Weight loss precipitates onset of ED
- Focus on healthy balanced behaviors vs. weight goals
- Instead of restriction/calorie counting, focus on regular eating with treats in moderation (don't cut out entire food groups)

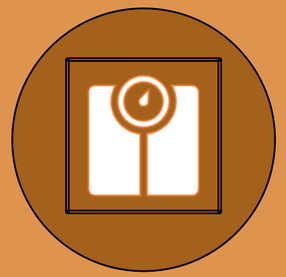
Walking the Tightrope in Primary Care

- Eating meals together as a family (mindful eating, social connection, not in front of a screen or with other distractions)
- Incorporating purposeful joyful movement (not with the goal of weight loss or body mass change)
- Positively reinforce behavioral change versus weight loss
- Critical ramifications of weight stigma in medicine

If ⟶ Then

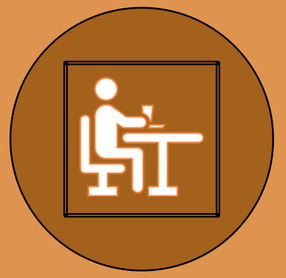
- Acute weight loss (≥5 lbs in one month) ⟶ BMP, Mag, Phos
- Caregivers disempowered or facing barriers ⟶ Consider HLOC
- Acute weight gain (≥5 lbs in one week) ⟶ BMP, Mag, Phos, spec grav, check for edema
- Abdominal Pain/Constipation ⟶ Non stimulant bowel regimen, metoclopramide
- Intense body dysmorphia interfering ⟶ Remove scales, cover mirrors

Treatment Goals

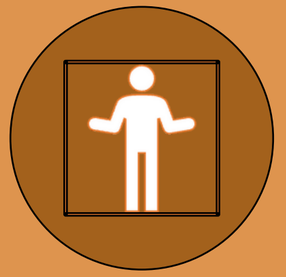


Weight restoration or stabilization

Cessation of binge eating and compensatory behaviors



Normalization of eating patterns (regular, sufficient amount, increase variety)



Later: Reduced weight/shape concerns; body acceptance

Body image concerns typically do not improve until weight is restored and eating patterns are normalized

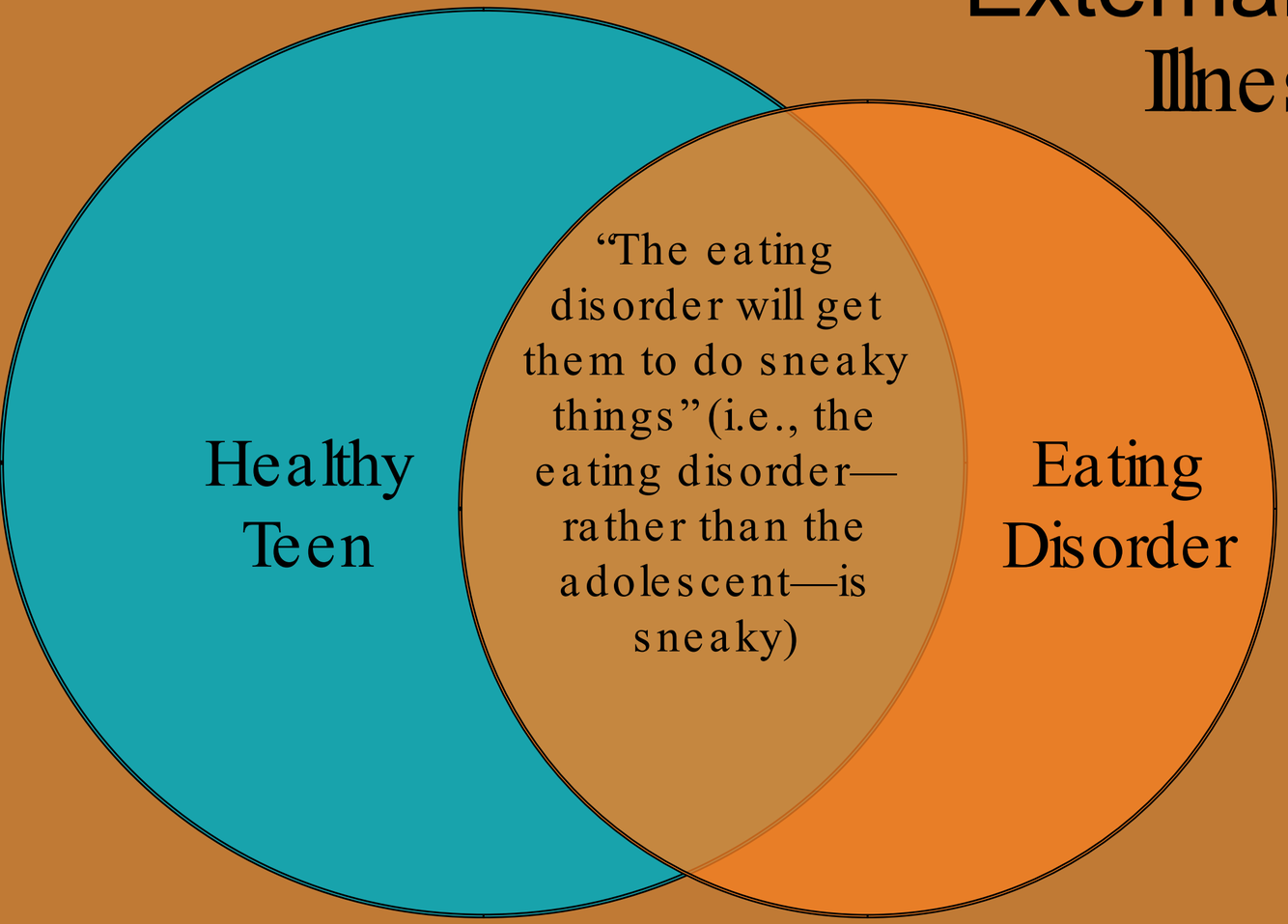
Evidence-Based Treatment for Youth EDs

- **Family-Based Treatment** (initially puts caregivers in charge of nutrition)
- **Cognitive-Behavioral Therapy** (with family involvement when appropriate)
- Less evidence for youth but sometimes used: **Dialectical Behavior Therapy**
- Estimate **6-12 months** of outpatient therapy
- Higher levels of care (**IOP, PHP, Residential**) sometimes needed, but not generally evidence-based
- **Family** involvement best supported by the evidence

How do I support the family when specialty care is not available?

- Psychoeducation
- Illness externalization
- Early goal: increased and/or regular eating, decrease compensatory bxs
  - If wt gain needed: prescribe 3 meals and 3 snacks daily
  - If wt gain not needed, prescribe 3 meals and ≥1 snack daily, not going for more than 3-4 hrs w/o eating
    - Note: regular eating decreases binge episodes

Externalizing the Illness



How do I support the family when specialty care is not available?

- Involving caregivers or loved ones when possible
  - Empowerment – in most cases, caregivers have excellent instincts about their child's nutritional/rest needs, and the ED is trying to convince them otherwise
  - Meal/snack support
    - When appropriate, ask caregivers to decide what, when, and how much the patient will eat, and monitor for completion
  - Protect against compensatory behaviors (e.g., use bathroom before meals, monitor afterward 30-60 min)

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How do I support the patient when specialty care is not available?

- General coping to address distress before/during/after meals, when having urges to engage in compensatory bxs, with wt checks, etc
  - Focus on active coping (eg distraction, deep breathing) rather than introspective or passive techniques (eg quiet mindfulness, reading, noticing body sensations)
- Motivational interviewing about how the ED is getting in the way
  - "How is the constant thinking about calories making it hard to do the things you like to do?"
- Reinforce any small changes
  - "I'm so glad that you were restful this week instead of going for a run"

Caregiver-led nutritional rehabilitation is NOT:

- Force feeding
- Punitive

Caregiver-led nutritional rehabilitation IS:

- An act of LOVE
  - Most caregivers love their kids, and want to support them to fight an illness that they typically cannot fight consistently on their own
- A balance of warmth (toward the child) and firmness (against the ED)
  - "I see that the eating disorder is giving you a really hard time right now, and I need you take another bite. I will sit here next to you while you finish."

Provider Tips

- Avoid commenting on appearance
- Do not collude with eating disorder
- Avoid shame
- Adolescents may not like their therapist

Benign comments can be loaded:

- "You look so healthy" = "Whoa, you've gained a ton of weight"
- "You look fantastic" = "Wow, you're so fat"
- "You're made so much progress" = "You're failing, you shouldn't be going along with this plan to eat so much food"

Eating disorders transcend race, ethnicity, gender identity, sexual orientation, age, socioeconomic status, body shape or size…

THANK YOU!