Eating disorder screening and initial management in primary care

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Disclosure Statement

I have no conflicts of interest.

Learning Objectives

1. Distinguish between the most common eating disorder diagnoses
2. Identify indications for screening for eating disorders in the primary care setting
3. Describe strategies for supporting patients and their families before a treatment team is established

Why do eating disorders matter?

Global prevalence of eating disorders (EDs) in adolescence has grown from 3.5% to 6.9% between 2000 to 2018

- 9% of the US population or 28.8 million Americans will have an eating disorder in their lifetime
- ED prevalence in adolescent females ranges from 0.3 to 2.3%; 0.3 to 1.3% in adolescent males

Why do eating disorders matter?

High risk of mortality

- **EDs have the 2nd highest fatality rate of any mental illness behind substance use**
- Approximately 31% of individuals with anorexia nervosa, 23% of individuals with bulimia nervosa, and 23% of individuals diagnosed with binge eating disorder have attempted suicide
- Suicide is one of the leading causes of death for those diagnosed with an eating disorder

Why do eating disorders matter?

Medical complications impact all body systems

- AN: secondary to weight loss and malnutrition
- BN: related to purging
- BED: high rates of obesity and metabolic disorders

Why do eating disorders matter?

Impairs psychological well being and quality of life

- Individuals with eating disorders frequently experience mental health comorbidities including anxiety, depression, substance use, OCD and PTSD
- 46% (roughly half) of individuals with BED reported some degree of impairment across the domains of work, home management, social life, and close relationships and **13% reported severe impairment**

Why do eating disorders matter?

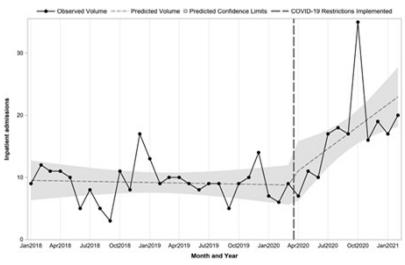
Public health concern

- Treatment is costly, and often only available in major metropolitan areas
  - $4.6 billion are spent annually on ED treatment
- Significant productivity losses due to illness and/or caregivers taking time off of work to care for a loved one or a child
- Only 20-57% of individuals receive treatment, less so in marginalized areas
  - Delay in care leads to poorer prognosis and higher morbidity, which results in higher use of health care services
- **In total, eating disorders cost the US economy roughly $64 billion in a single year**

Impact of the pandemic

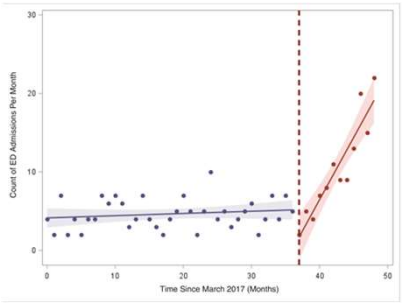
Pandemic has had a lasting effect on eating disorders, particularly for children and adolescents:

- Number of patients seeking care and requiring admission significantly increased
- Numbers have not continued to increase but numbers have not come back down either, so overall volume of eating disorders has increased



Monthly inpatient admissions pre- and post pandemic.

Journal of Adolescent Health, Volume 69, Issue 4, 2021, Pages 660-663. ISSN 1054-139X. https://doi.org/10.1016/j.jadohealth.2021.05.019.



Interrupted time series analysis of monthly counts of ED-related admissions, March 1, 2017, through March 31, 2021.

Pediatrics October 2021; 148 (4): e2021052201. 10.1542/peds.2021-052201

Eating Disorder Diagnoses

- Other Specified Feeding and Eating Disorder (OSFED)
- Anorexia Nervosa (AN)
- Bulimia Nervosa (BN)
- Binge Eating Disorder (BED)
- Avoidant/Restrictive Food Intake Disorder (ARFID)

Other Specified Feeding and Eating Disorder

OSFED DSM 5 criteria:

- Category that applies to individuals who experience significant distress from symptoms similar to AN, BN, BED, but do not meet the full criteria for those diagnoses

Most common eating disorder diagnosis

- OSFED represents 39.5% of eating disorder cases among males, and 44.2% of cases among females in the US in 2018-19.

Anorexia Nervosa

DSM-5 diagnostic criteria for anorexia includes:

- **Restriction of energy intake relative to requirements,** leading to a significantly low body weight in the context of age, sex, developmental trajectory and physical health
- **Intense fear of gaining weight or becoming fat,** even when significantly underweight
- **Altered perception of one's body weight or shape,** excessive influence of body weight or shape on self-value, or persistent lack of acknowledgment of the seriousness of one's low body weight

Subtypes:

- Restricting type
  - Weight loss achieved primarily through restricting intake or excessive exercise
- Binge-eating/purge type
  - Weight loss achieved through restriction with episodes of binging/purging

Atypical Anorexia

- Diagnosis of anorexia nervosa for those who are not low weight and/or individuals who live in a larger body
- Falls within the OSFED category

Binge Eating Disorder

Binge Eating Disorder DSM 5 criteria:

Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:

a. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances
b. **The sense of lack of control over eating during the episode** (e.g., a feeling that one cannot stop eating or control what or how much one is eating)

Bulimia Nervosa

Bulimia Nervosa DSM 5 criteria:

A. **Recurrent episodes of binge eating,** as characterized by both:

1. Eating, within any 2-hour period, an amount of food that is definitively larger than what most individuals would eat in a similar period of time under similar circumstances.
2. **A feeling that one cannot stop eating or control what or how much one is eating.**

B. **Recurrent inappropriate compensatory behaviors** in order to prevent weight gain such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting or excessive exercise.

Avoidant Restrictive Food Intake Disorder

According to the DSM-5 ARFID is diagnosed when:

- **An eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food; concern about aversive consequences of eating)** as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:
  - Significant weight loss (or failure to achieve expected weight gain or faltering growth in children).
  - Significant nutritional deficiency.
  - Dependence on enteral feeding or oral nutritional supplements.
  - Marked interference with psychosocial functioning.

*****Behavior is not driven by a desire to lose weight or to change something about their body**

What can I do as a primary care provider?

- 60-87% of people with eating disorders go unrecognized or untreated
- We know that early detection is important because it leads to early intervention, improved outcomes, and a better prognosis

What can I do as a primary care provider?

Understand the impact of implicit weight bias on your own practice

- Create a weight inclusive environment
- Avoid weight shaming
- Model and encourage positive self talk about patient's own bodies

Avoid stigmatizing language

- Use inclusive language and avoid stigmatizing words such as "normal" "fat" "obese" "skinny"
- Use person centered language
  - Person with a higher weight or individual who lives in a larger body

What can I do as a primary care provider?

Eating disorders do not discriminate

- ED's affect individuals of all shapes, sizes, genders, and socioeconomic status

High Risk Groups

Groups that often go undiagnosed:

- Males
  - Diagnosis often delayed because symptoms are not always recognized as an eating disorder
- Individuals in larger bodies
  - 2.45 times greater chance of engaging in eating disordered behaviors as patients with an average weight, they are diagnosed half as frequently
- Low-income settings
  - Fewer resources

High Risk Groups

LGBTQ+ folks, especially trangender and gender-diverse youth are at extremely high risk for eating disorders

- LGBTQ adults and adoelescents experience greater incidences of ED and eating disordered behaviors than their heterosexual and cisgender peers
- Nearly nine in ten (87%) LGBTQ youth reported being dissatisfied with their body

High Risk Groups

- Adolescent and young adults
- Athletes
- Family history of eating disorder
- Individuals with comorbid psychiatric conditions - depression, OCD, substance use disorders, anxiety disorders
- Individuals with chronic health conditions (PCOS, diabetes)

Screening

Is there a role for screening asymptomatic individuals?

- USPSTF determined that there is not enough evidence to suggest screening asymptomatic individuals. (March 15, 2022)
- But! Clinicians should be aware of the risk factors, signs, and symptoms of eating disorders and listen to any patient's concerns about eating
  - Screening for eating disorders has the potential to improve health outcomes, such as quality of life or function if it can lead to early detection and early treatment
- Ultimately … the decision to screen should be based on an individual's risk factors and circumstances

Screening

In practice in pediatrics,

- AAP recommends screening for eating disorders at annual visits and sports physicals through weight and height monitoring, and looking for signs of eating disorders
  - All preteens and adolescents should be screened about eating patterns and body image issues

Warning signs/ Red flags

Symptoms of an eating disorder:

- Rapid weight loss or weight gain
- Pronounced deviation from growth trajectory
- Bradycardia
- Pubertal delay
- Menstrual changes, such as oligomenorrhea and amenorrhea

Review of systems:

- Dizziness, fainting, bruising, hair loss, brittle hair, diarrhea, constipation, abdominal pain after meals, dental problems, low energy, trouble focusing/concentrating at school, fatigue, cold intolerance

Warning signs/ Red flags

- Frequently talking about food, weight, and/or body shape
- Change in diet
- Rapid or persistent decline or increase in food intake
- Excessive or compulsive exercise patterns
- Self induced vomiting, dietary restriction, binge eating, or compulsive eating
- Abuse or misuse or diet pills, laxatives, diuretics, or emetics
- Denial of food and eating problems, despite concerns of others
- Eating in secret, hiding food, disrupting meals, feeling out of control with food

Barriers to detection

- Stereotypes about eating disorders
- Patients often downplay mental health symptoms and instead focus on the physical symptoms (present with constipation, syncope/dizziness, fatigue, GI distress, trouble with sleeping)
- Conditions that thrive in secrecy - many folks are reluctant to disclose they are struggling with binge-eating or some other eating disordered pattern
- Lack of insight or awareness is common

What now?

Eating disorder has been diagnosed. What are the next steps?

Indications for Hospital Admission

- At CHaD
  - HR <50 daytime, <45 nighttime
    - EKG abnormalities
  - Hypotension, hypothermia, orthostatic tachycardia or hypotension
  - Refusal to eat, dehydration
  - Electrolyte disturbance
  - Acute medical complications of malnutrition
- At Boston Children's Hospital
  - HR <40 supine (<45 if premenarchal)
  - Presyncope or syncope with standing or systolic <80
  - Abnormal electrolytes
  - Acute food refusal x 24hrs
  - Weight <75% expected body weight
  - Weight loss >10% in <6 months

Management

Multidisciplinary Team:

- Medical provider
- Nutritionist/dietician
- **Mental health provider**

Levels of care

Treatment setting depends on severity of mental health impairment and presence or absence of medical complications

- Inpatient
  - 24 hrs/day in medical hospital
- Residential
  - 24 hrs/day in eating disorder treatment facility
- Partial hospitalization
  - 10-11 hrs/day at eating disorder treatment facility, sleep at home
- Intensive outpatient
  - 4-6 hrs/day at eating disorder treatment facility
- Outpatient
  - 1 or more hrs/week (at discretion of therapist) with therapist
  - Frequent visits with medical provider and dietician

Treatment

For children and adolescents:

- **Family based therapy** (AN, BN)

For young adults:

- **Cognitive behavioral therapy for eating disorders (AN, BN, BED)**
- Maudsley model of anorexia for adults (AN)
- Specialist supportive clinical management (AN)
- Focal psychodynamic therapy (AN)
- Guided Self-Help (AN, BN, BED)

Treatment

Medications should be used as adjuncts to psychological therapy

- Antidepressants are discouraged in anorexia nervosa, except for treatment of comorbid psychiatric conditions
- Fluoxetine - BN
- Lisdexamfetamine - BED

*Buproprion is contraindicated in patients with EDs increased seizure risk in individuals who purge

What can you do today?

So you've evaluated the patient, they do not need to be admitted to the hospital, you've provided them with referrals …

How do you manage these patients while they wait for a more established treatment team?

Disclaimers

- These tips are NOT a long term plan
- However, these tips help me feel like I am actually doing something in situations where the team is not yet fully established
- I want to **validate and acknowledge** the difficulty of taking care of eating disorder patients, especially before team is together
- The goal of this talk is to empower you to help patients stay safe or even slowly improve

Case 1

- In your office you see a 14 year old soccer player with a 17 pound weight loss in the past few months. They are medically stable and do not require hospitalization. Referral for treatment program has been placed but appointment isn't for two months. **How do you support this patient while waiting for their intake with an eating disorder treatment program?**

Initial Discussion

With the family:

- Discuss the multidisciplinary team approach and start **getting the team together** (nutrition and psych).
- Have patient **stop all exercise** to reduce calorie output.
- Discuss indications for ER and have them share with patient (chest pain, syncope, mental status changes, failure to eat or drink for 24 hours, dehydration, etc.)
- Have the parent(s) **hide scales** in the home.
- **Weekly follow up** if youth is starting to become bradycardic (i.e. in the 50s), vomiting, and/or actively losing, **every other week if/when youth has stabilized** as long as they are not bradycardic and are not vomiting.
- Discuss **blind weights and the "thumbs" plan** = thumbs up (appropriate weight gain), thumbs down (weight loss), thumbs sideways (no or very small gain) plan for weights.

Case 2

- 16 yo who was recently diagnosed with anorexia. The patient has expressed anxiety about the diagnosis and possible treatment at home. **What are some behavioral tips you can give this patient to help them adjust to their diagnosis while waiting for establishment with a therapist?**

Behavioral tips for outpatient setting

- Talk to patient about how right now the ED has control over youth but the goal will be to flip it and **give youth control over the ED**.

- Coach youth to mentally **separate themselves from ED,** and name it.
- Foreshadow to both youth and parent that **eating disorders have a natural up and down, waxing and waning course**.
- Introduce the concept that **food is the medicine for an eating disorder** and for some people it is helpful to think of it as a job/treatment, like antibiotics are for an infection.

Behavioral tips for outpatient setting

- Explain **escalation-de-escalation cycle** as it pertains to anxiety at meal times.
- Family should talk to patient about what would work as **distraction** during and after meals – such as conversation about a favorite topic, music or tv, crafting, playing video games. Encourage patient to work with therapist to develop a distraction plan.

"Managing the Cycle of Acting-Out Behavior In the Classroom" by Geoff Colvin, 2004

Behavioral tips for outpatient setting

- Coach parents **to avoid triggering phrases and words** until the youth has psych support (saying good job or praising for finishing a meal, calories, weight gain) and to **discuss non-triggering words with youth** (praise effort/work, say nothing).
- Help patient/family/team assess who are **helpful meal support persons** – parent? nurse? or no one? **Disclaimer:** the last one can be the eating disorder talking.
- Recognize and **normalize parental guilt** as something that almost always occurs with new diagnosis of eating disorder.

Case 3

15 year old with past hx anxiety and depression who presents to your clinic with a 15 pound weight loss over the past 6 months, no bradycardia, normal labs and EKG. Exercising regularly. Skipping breakfast, eating fruit for lunch, having a "normal sized" dinner.

She has therapist with some comfort with eating disorder but no nutritionist. You place a nutrition referral but appointment isn't for 3 weeks. **Mom asks you about what to do with her nutrition until she gets in with nutritionist. What do you say?**

ED nutrition starter guide

- Resume regular meals – start with **SOMETHING at each meal** even if small. Work up to 3 meals and 2-3 snacks. Encourage patient and mother to do **a little more every day**.
- Encourage family to **avoid discussion about calories and weight; hide scales**.
- **Family should be present at as many meals as possible**. Talk to parent alone about lunch at school and whether the youth is skipping. If they are, work on ideas for which adult at school could sit with youth during lunch.
- Talk about "jobs" with patient and family in the same room. **Parent job = prepare and plate the food; youth job = eat the food.** Explain to the youth that this may seem scary but can actually be easier because they won't have to fight with eating disorder about what to eat. Elicit a verbal agreement from both patient and parent that this will occur with both in the same room at the same time.
- Family should **not criticize but gentle prompting is ok** IF it is helpful to the youth.

ED nutrition starter guide

- **Boost/nutrition shakes are totally fine** to start, especially if they are already using them. Nutritionist can work on switching that over to regular food once they are engaged.
- For younger (11-12 yo) stable youth, especially if family is significantly distressed and engaged, you can try the FBT method where the expectation is that they will **eat before they leave the table or do anything fun/rewarding** for each meal/snack. Takes a lot of buy in, and need to foreshadow that the first few weeks will be hellish, but many younger kids will eventually relent and start eating.
- At each visit, if **weight loss add 2 items to 2 meals** (or 3-4 items across the day), if **no or very small gain add 2 items to a meal** (or 2 items across the day) until youth is gaining. Give item examples: handful of nuts, a yogurt, a cheese stick, an apple and milk, half a sandwich, etc.
- Don't miss opportunities for **praise** – hard work family/youth has done already, willingness to come to the visit.

Resources

Virtual eating disorder treatment programs

- EQUIP
- Within
- Renfrew@Home

Local treatment programs

- Walden Residential Program - MA
- Cambridge Eating Disorder Recovery Center - Concord, NH and Cambridge, MA
- Monte Nido Eating Disorder Center of Boston
- Reflections Eating Disorders Treatment Center - Salem, NH

Resources

- National Center of Excellence for Eating Disorders (NCEED)
  - Education and training for healthcare providers about eating disorders
- FEAST
  - Resources and support groups for caregivers and families
- National Eating Disorders Association (NEDA)
  - Parent toolkit, other resources for families and providers
- The Emily Program
  - Eating disorder treatment center with educational materials and resources for families
- National Alliance for Eating Disorders
  - Support groups
- WithAll
  - Empowers parents/caregivers to help young people develop a positive body image and relationship with food
- Project HEAL
  - Meal support, clinical assessments, help with insurance navigation, community/peer support groups, crisis hotline

Take Home Points

1. Eating disorders are common and they don't discriminate
2. Important to screen all adolescents and young adults
3. At the first visit emphasize to patient and family:
   a. Importance of a multidisciplinary treatment team
   b. Importance of increasing nutrition slowly over time
   c. Encouraged them to start externalizing the eating disorder as the first step in giving control back to the youth
   d. Normalize the prolonged recovery and the impact the disorder has on the whole family, not just the kid
   e. Acknowledge how hard it is! Praise when possible

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Questions?

https://toledocenter.com/resources/7-hidden-signs-of-eating-disorders/