Disordered Eating

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Goals

Although disordered eating spans the life continuum, this talk will focus on the most common adolescent and pre-adolescent eating disorders.

1. Remember how to
   - identify disordered eating in primary care
   - Rule out other causes of weight loss
   - Screen for medical comorbidities of eating disorders

2. Understand what management
   - Continues in primary care
   - Needs support with outside resources and how to work together
   - Needs referral to higher level of care

3. Know the evidence base treatments for eating disorders (Hint – all are team-based care)

Medical Evaluation

History –

- Growth
- Food
- Exercise
- Family History – eating disorders, mood disorders, GI/Endocrine/allergy disorders
- Psychiatric/Trauma

Do symptoms suggest

Inflammation, infection, malabsorption, endocrine, neoplastic process

Signs (not in DSM criteria)

Secrecy around eating, social isolation

Increased interest in food preparation for others, cooking shows and magazines.

Irritability, poor concentration

Reporting fatigue, dizziness, headaches, disrupted sleep, early satiety, abdominal discomfort, constipation

Restrictive Eating Signs

Restricting types of food, calories

Healthy Eating

Rituals around food consumption

Report of decreased hypothalamic-pituitary-gonadal function

Females – range of menstrual abnormalities including cessation

Males – loss of morning erection/nocturnal emissions, decreased libido

Frequent Prolonged Exercise

Binge-Eating/Purging Signs

- Hiding or stealing food, food disappearing
- Frequent use of bathroom after meals
- Evidence of vomiting, laxative or diuretic use
- Compulsive Exercise
- Rapid weight fluctuations
- GERD, increased dental caries, muscle cramping

Physical Findings

RESTRICTIVE EATING/MALNUTRITION

- Muscle wasting, temporal wasting
- Lanugo, thinning/loss of scalp hair
- Hypercarotenemia, dry skin
- Bradycardia, prolonged QTc

VOMITING

- Enamel erosion, palatal petechiae
- Hypertrophy of parotid glands
- Calluses of fingers (Russell's Sign)

Laboratory Abnormalities

RESTRICTIVE EATING

CBC – Anemia, leukopenia, thrombocytopenia

LFTs – may have increased AST/ALT

Hormone studies – decreased FSH, LH, estradiol, testosterone

Vitamin D – decreased

ESR – typically low

VOMITING

Decreased potassium

Increased CO2

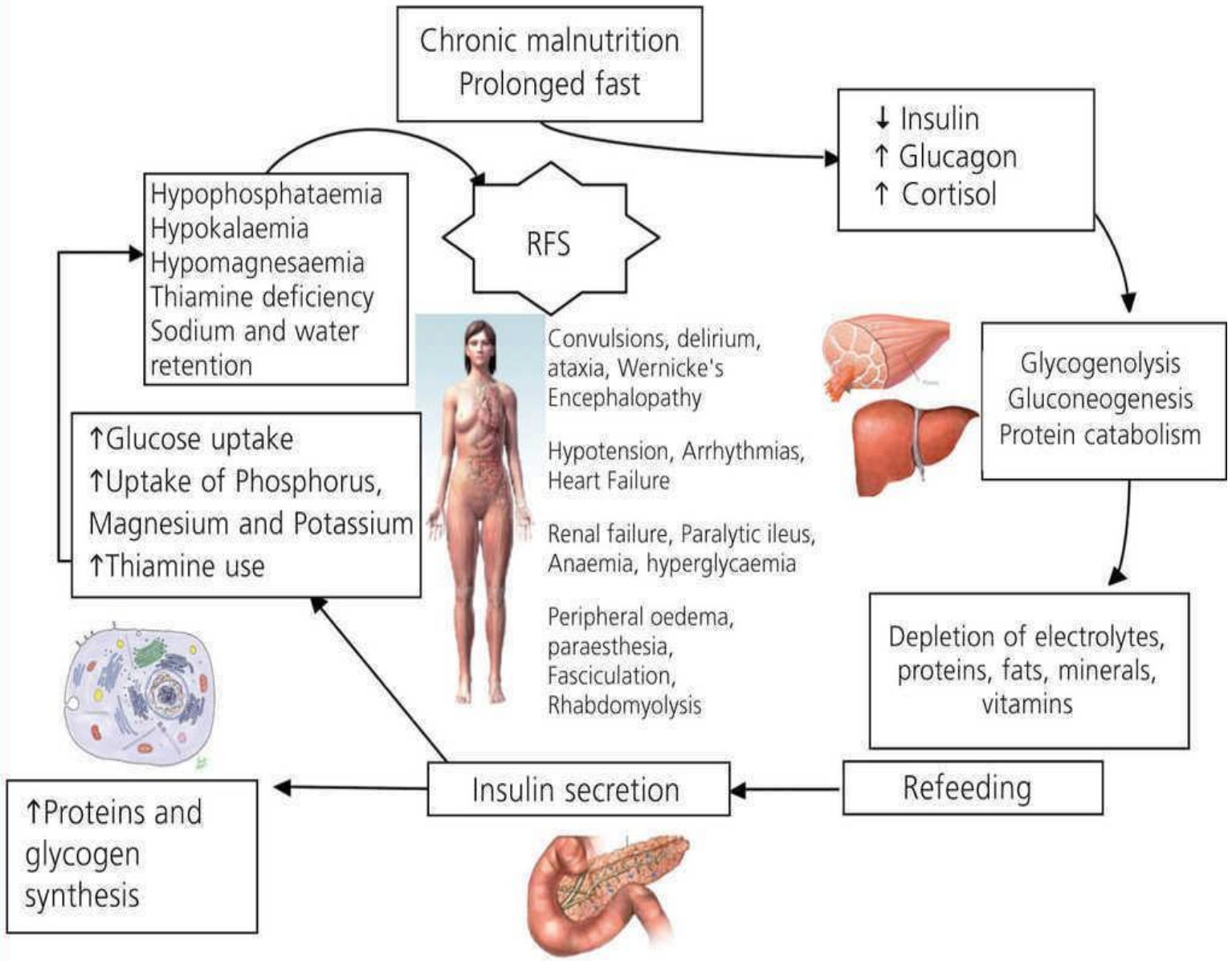
BOTH

- Abnormal thyroid studies (sick-euthyroid syndrome)

Admission Criteria (SAHM)

- Heart Rate <50 bpm
- Blood Pressure <90/45 mmHg
- Pulse change >20 bpm increase
- Blood pressure change >20 mmHg systolic, >10 mmHg diastolic decrease
- Hypokalemia
- Hyponatremia
- hypophosphatemia

Refeeding Syndrome



Goal weight is reached when

- Previously “healthy” growth trends resume
- Hormonal function normalized
- Vital signs stable

Outpatient Medical Care

Activity Management

Nutrition plan – working with an EDO skilled RD

- Be aware recovery from malnutrition can lead to a hypermetabolic state
  - Restricting patients may need very high caloric intake

Weight Gain if needed – 1-2#/week

Symptom management

- Constipation, lack of hunger cues, GERD

Regular Monitoring

Position Paper for the Society for Adolescent Health and Medicine: Medical Management of Restrictive Eating Disorders in Adolescents and Youth Adults

Modified from presentation given at AACAP 2019 – “An Overview of the Medical Management of Eating Disorders” Jennifer Carlson, MD Stanford University

Reference