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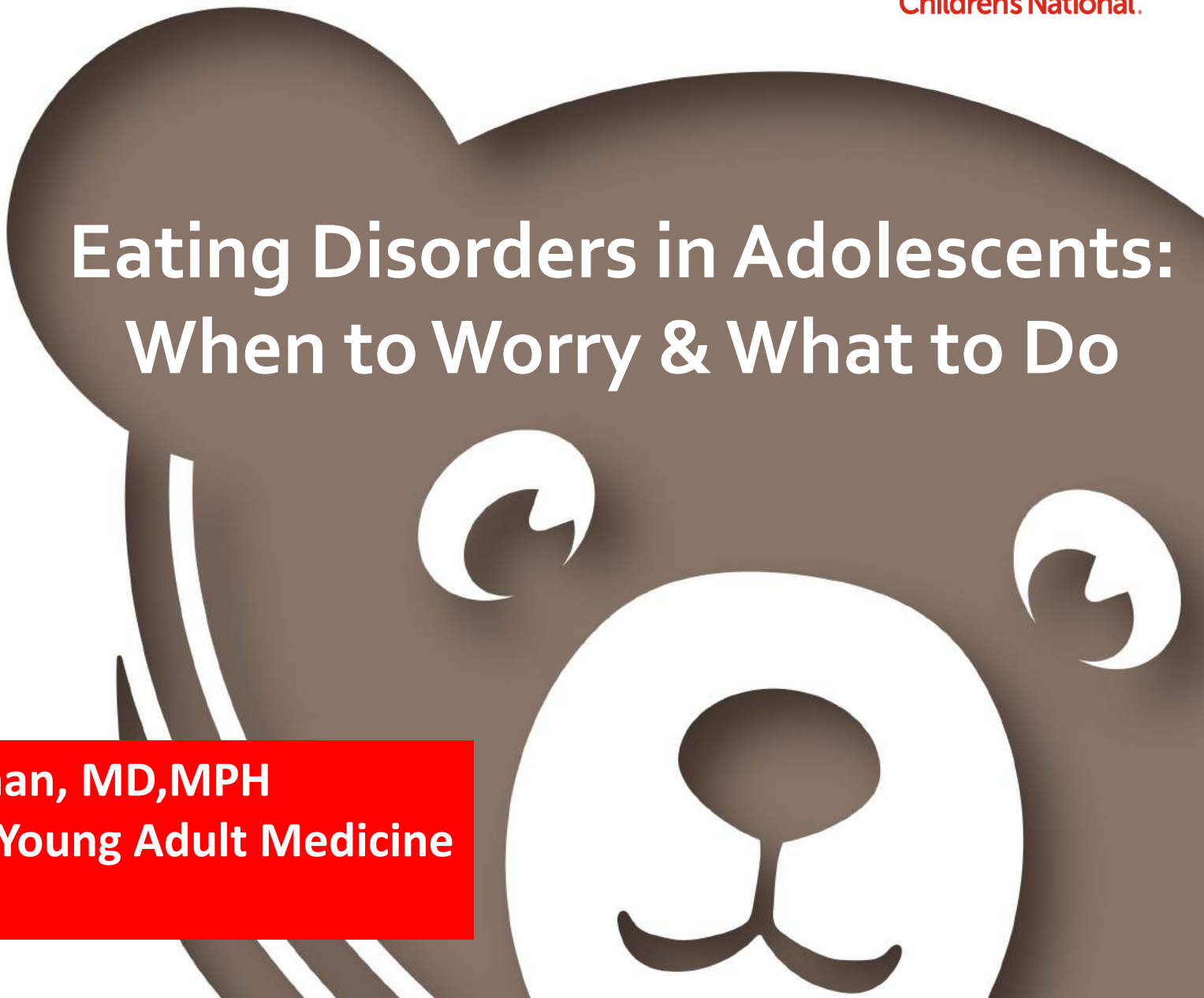
Eating Disorders in Adolescents: When to Worry & What to Do



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Adolescent & Young Adult Medicine
June 19, 2019

Disclosures

I have no conflicts of interest.

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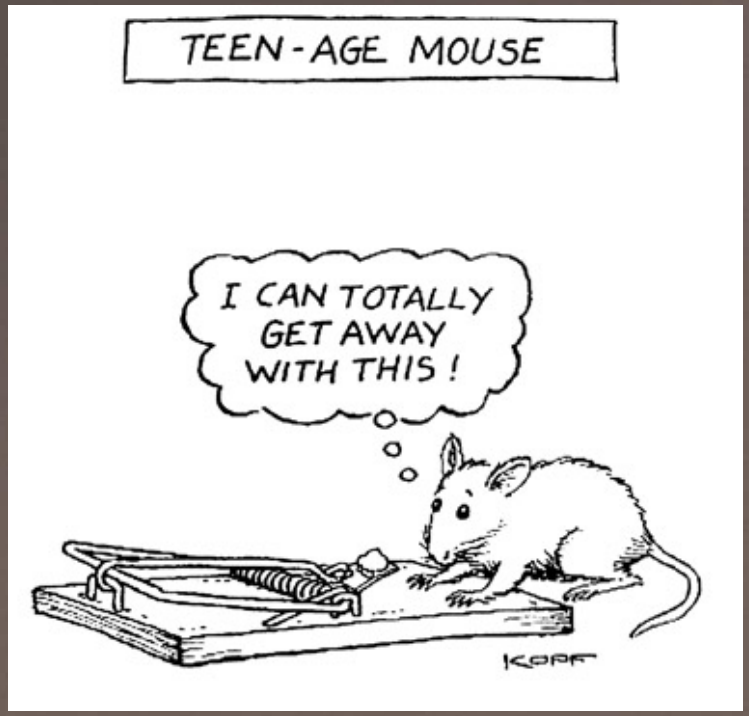
Disclosures



I admit to being an Adolescent Medicine enthusiast.

If you find interacting with teenagers challenging, thank you for participating today.

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Learning Objectives

- Perform a basic initial assessment for a suspected eating disorder
- Describe criteria for urgent medical stabilization, and the spectrum of higher level treatment options
- Implement strategies for prevention , early intervention, and longer term family support
- Describe the role of the parent/family in management of adolescent eating disorders

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Today's Road Map

- Cases 1 & 2
  - Diagnosis
- Cases 3 & 4
  - Admission Criteria
  - Concepts in ED Management
  - Referral & Levels of Care
- Cases 5 & 6
  - Recovery Goals
  - Supporting Families

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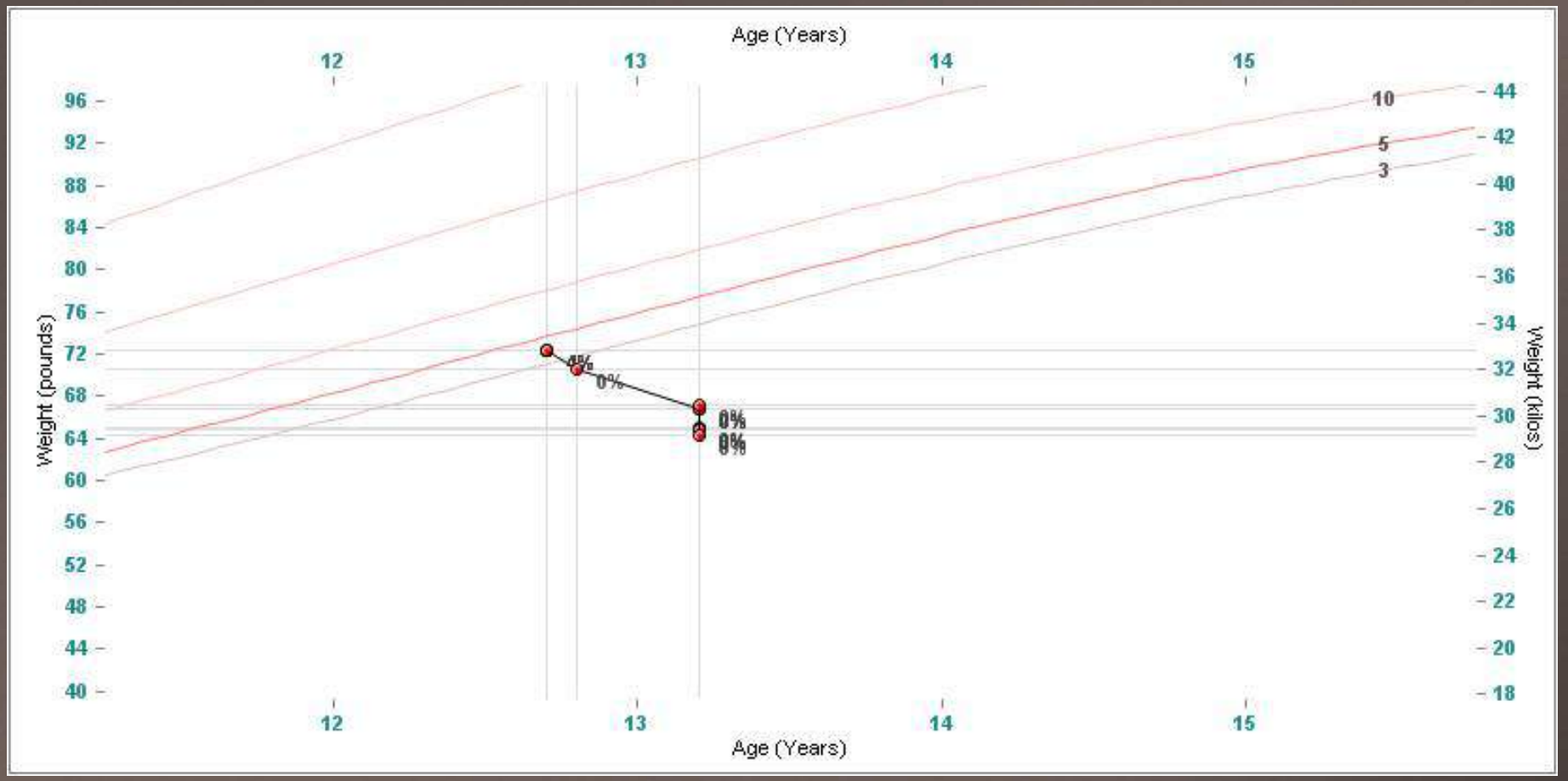
Case 1: Is it an eating disorder?



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DSM-V Criteria for Anorexia Nervosa

- Restriction of energy intake relative to requirements leading to significantly low body weight for age/sex/developmental trajectory or physical health
- Intense fear of gaining weight/becoming fat, or persistent behavior that interferes with weight gain despite significantly low weight
- Disturbance of how body weight/shape is experienced, undue influence on self-evaluation, persistent lack of recognition of low body weight

SUBTYPES – restricting, binge-eating/purging

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Epidemiology & Classification

- Epidemiology*
  - DSM-IV: Lifetime prevalence of 0.5-2% (AN); 0.9-3% (BN); 4.8% (EDNOS)
  - Peak onset 13-18yo (AN), 16-17yo (BN)
  - Mortality rate 5-6% (AN)

- "New" diagnostic entities
  - Atypical Anorexia
  - Avoidant/Restrictive Food Intake Disorder (ARFID)
  - Binge-Eating Disorder
  - Other Specified Feeding/eating Disorder (OSFED)

*Campbell & Peebles (2014). Pediatrics, 134: 582-92.

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When to worry?

Consider ED in patients with:

- Preoccupation with food, body image, restricting and compensatory behaviors

As well as….

- Growth failure
- Pubertal delay
- Overweight/Obesity
- Chronic illness

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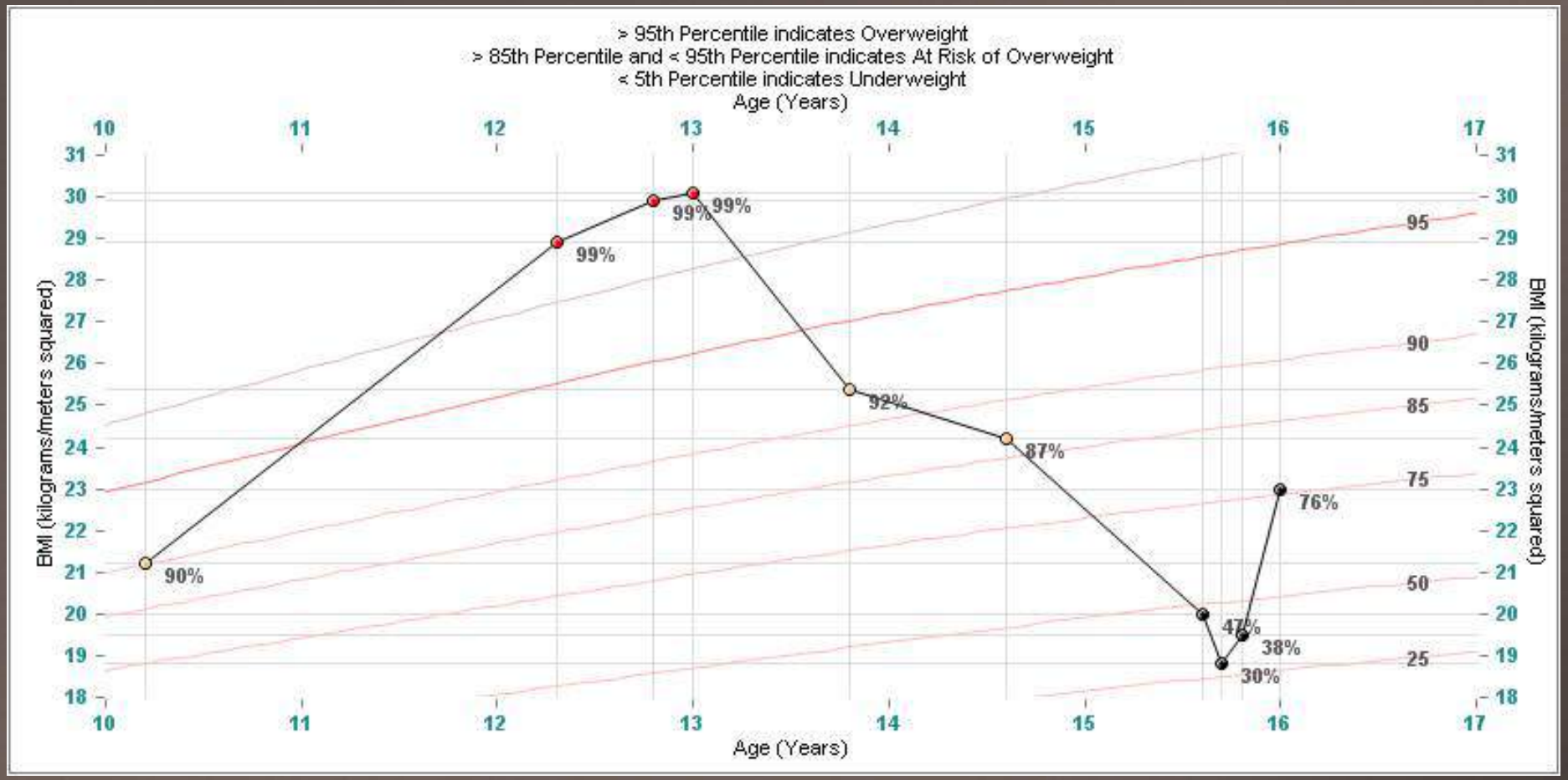
Case 2: When is weight loss a problem?



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Initial Evaluation

- Rule out other medical conditions/comorbidities*
  - Endocrine, GI, Psychiatric or other chronic conditions
- Establish medical stability
  - Gowned weight, PE, Lab evaluation
- Collect an eating behaviors history
  - Don't forget exercise and menstrual history
- Comprehensive psychosocial ROS
  - HEADSS/SSHADESS

* Don't forget to screen for food insecurity

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Sample History Details

- Food-related behaviors
  - Restricting types or amounts, calorie counting or goals, social eating, response to others' efforts to get them to eat more
- Symptoms related to eating
  - Physicals sensations, anxiety, guilt
- Compensatory behaviors
  - Purging by emesis, exercise, medications/laxatives
- Body image concerns/goals
  - Concern/preoccupation about weight/shape/size
  - Goal weight, knowledge of weight history, weight maltreatment
- Nutritional history – 24 hour recall

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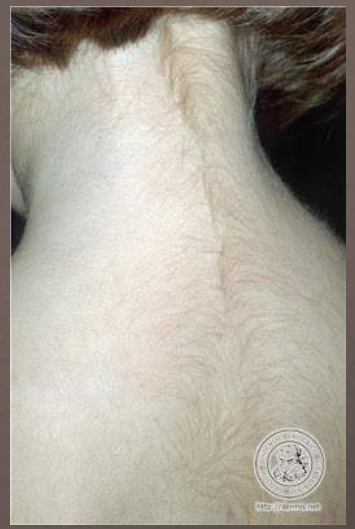
Assessing Medical Stability

- ROS
  - Dizziness, syncope, weakness, fatigue, exercise intolerance
  - Edema, palpitations, chest pain
  - Frequency of purging behaviors
  - Approximate daily intake
  - Self injury/suicidality
- Physical Exam findings
  - Bradycardia, orthostatic hypotension or tachycardia
  - Acrocyanosis
  - Edema

Assessing Medical Stability

- Initial evaluation:
  - Complete metabolic panel, Mg, P, UA, TSH
  - Other labs as indicated clinically
  - EKG for bradycardia, symptoms, abnormal electrolytes



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Formulating a Plan

- Is it an eating disorder?
- Do I need to admit?
- Do I need to elevate care?
- What other supports does this family need?
  - School support, FMLA, public assistance, care coordination
- Initial close follow up is prudent:
  - Simple interim nutrition plan
  - Track weight trajectory
  - Assess coping and resilience

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Levels of Care
(Families need a roadmap too)

- Primary Care
  - Engage nutrition, family or individual therapy, FBT therapist
- Outpatient Specialty Care
  - Medical, Mental Health, Nutrition
- Higher Level Outpatient Care (HLOC)
  - Intensive Outpatient or Partial Hospitalization Programs
- Inpatient/Residential

- Inpatient Medical Stabilization=Urgent nutrition rehabilitation

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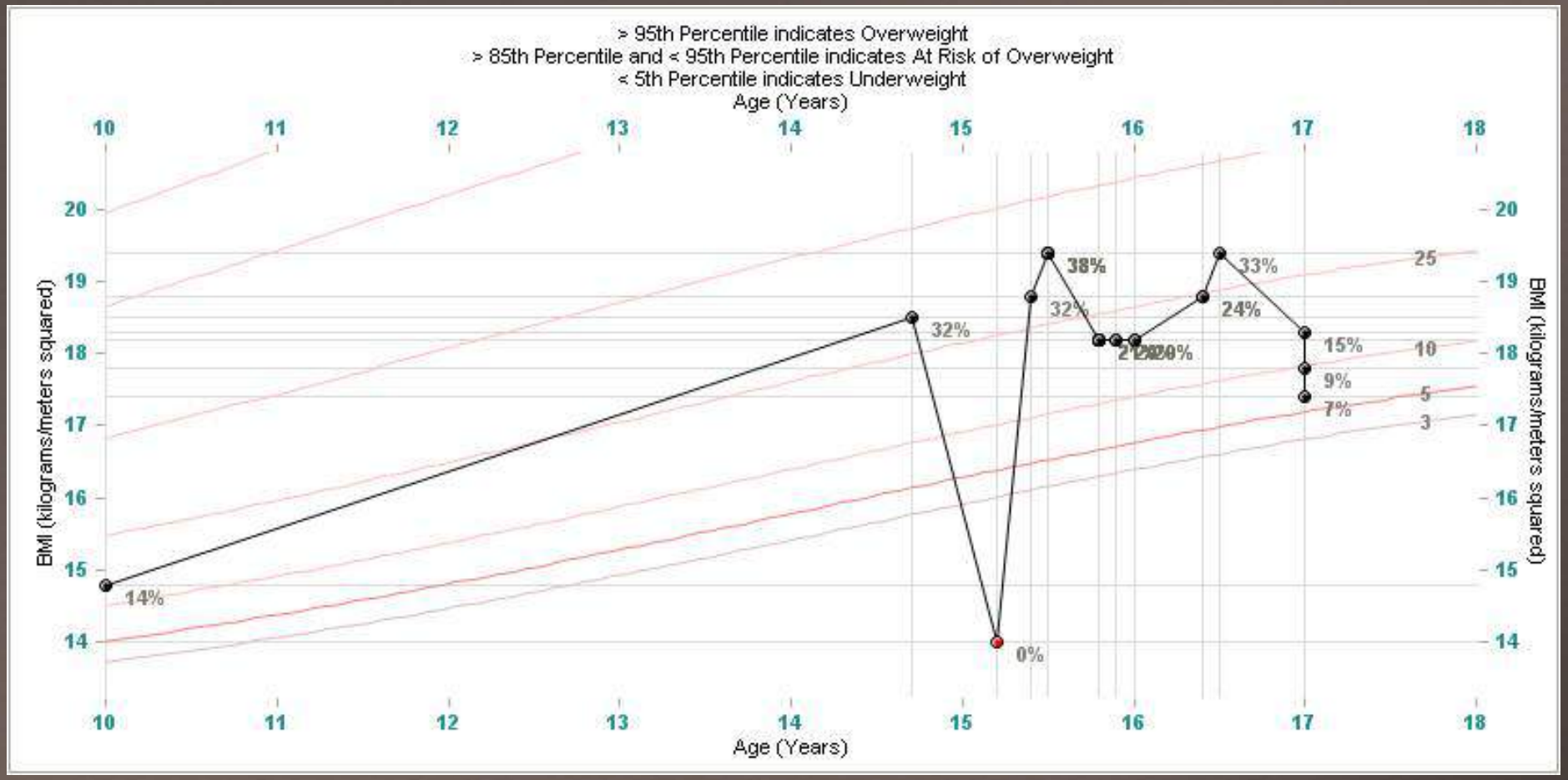
Case 3: When to admit?



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Criteria for Medical Stabilization
Bradycardia: HR<50 awake, <45 asleep
Hypotension: SBP<90 mmHg
Hypothermia: T<96°F (<35.6°C)
Orthostatic tachycardia (>20bpm) or hypotension (>10mmHg), or overt syncope
Prolonged QTc or other arrhythmia
<75% IBW, Body fat <10%
Acute food refusal
Failure to respond to outpatient treatment or weight loss despite intensive management
Intractable vomiting, hematemesis

Rome & Strandjord (2016). *Peds in Review,* 37(8):323-36.

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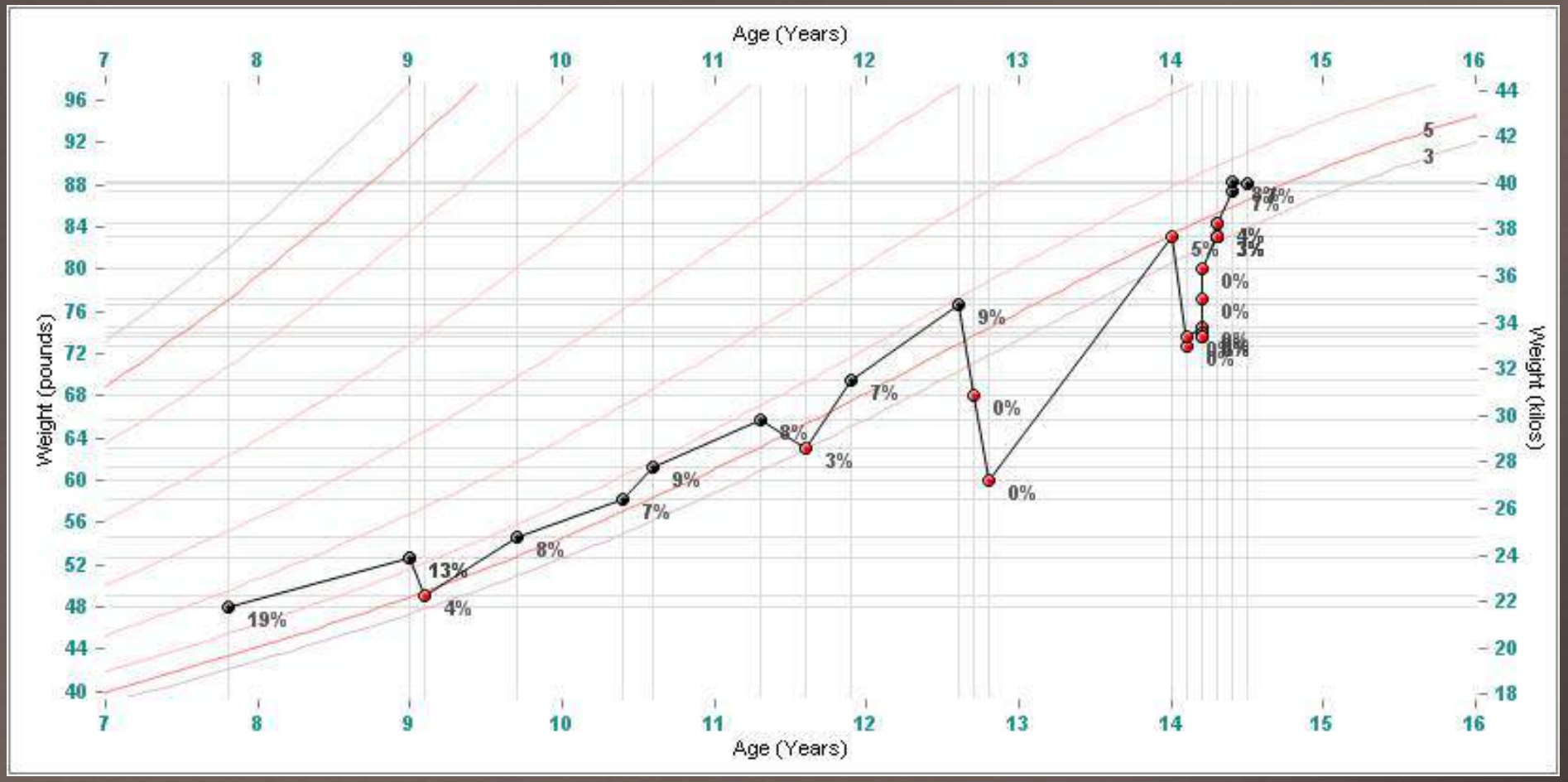
Case 4: "Nutrition before Insight"



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Key Concepts in ED Management

- Nutrition First
  - Nutritional recovery is a precondition for psychological recovery
- Family Based Treatment(FBT) is the current standard
  - Empowers caregivers to guide weight restoration
  - Employs an "agnostic" approach to remove blame, externalize the disorder

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Family Based Treatment: The Maudsley Approach

- Regards parents as the solution, not the problem
- Behavior-focused approach guiding parents to assume an active and primary role in changing maladaptive eating behaviors, and restoring nutritional status at home
- Conducted by a Family Based Treatment (FBT) therapist, over 15-20 sessions (~12 months)
- Not the same as family therapy

*Can you do FBT without an FBT therapist?

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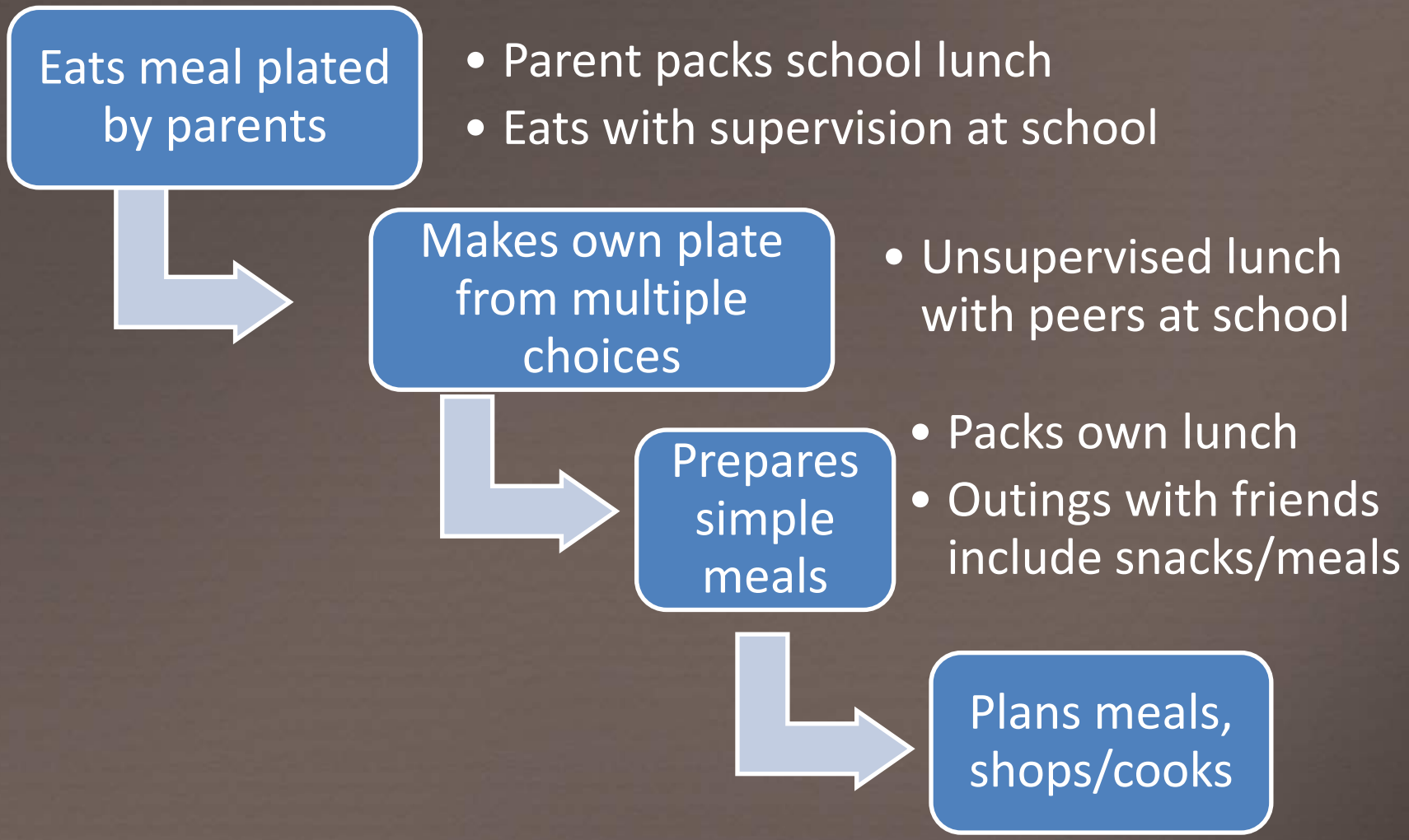
Developmental Continuum of Eating Independence



Adapted with permission from Mulhlheim, L, (2018). *When Your Teen Has an Eating Disorder.* Oakland, CA: New Harbinger.

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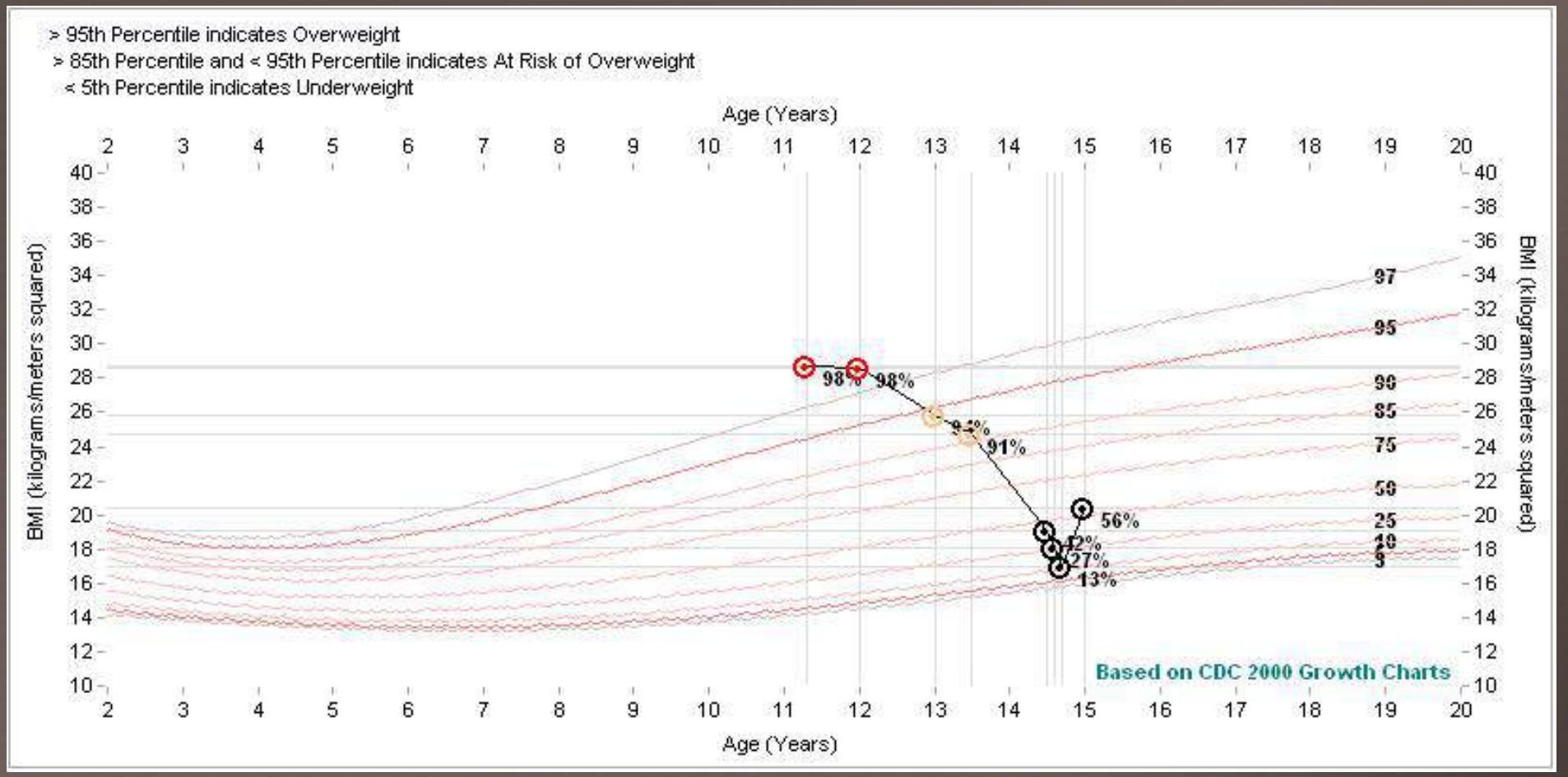
Case 5: What does recovery look like?



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Recovery Goals

Physiologic

- Reversal of target organ damage
- Weight/growth restoration
- Restoration of menses/pubertal development
- Safe return to exercise

Nutritional

- Maintenance weight achieved through balance and variety
- Flexibility and independence in eating

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Recovery Goals

Psychological

- Decreased influence of body image on self esteem/self concept
- Age appropriate functioning
- Improved social function

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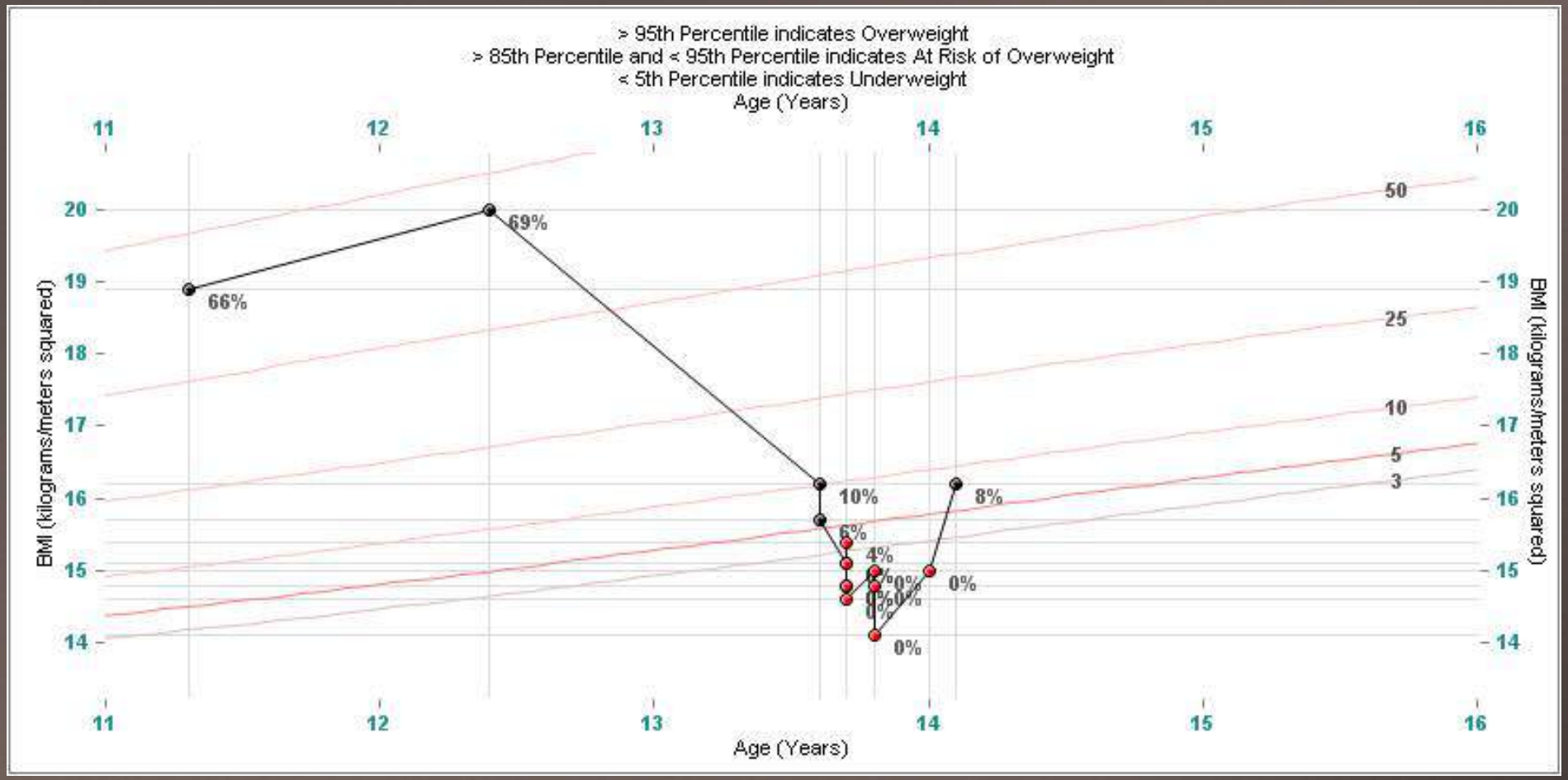
Case 6: What does recovery look like?



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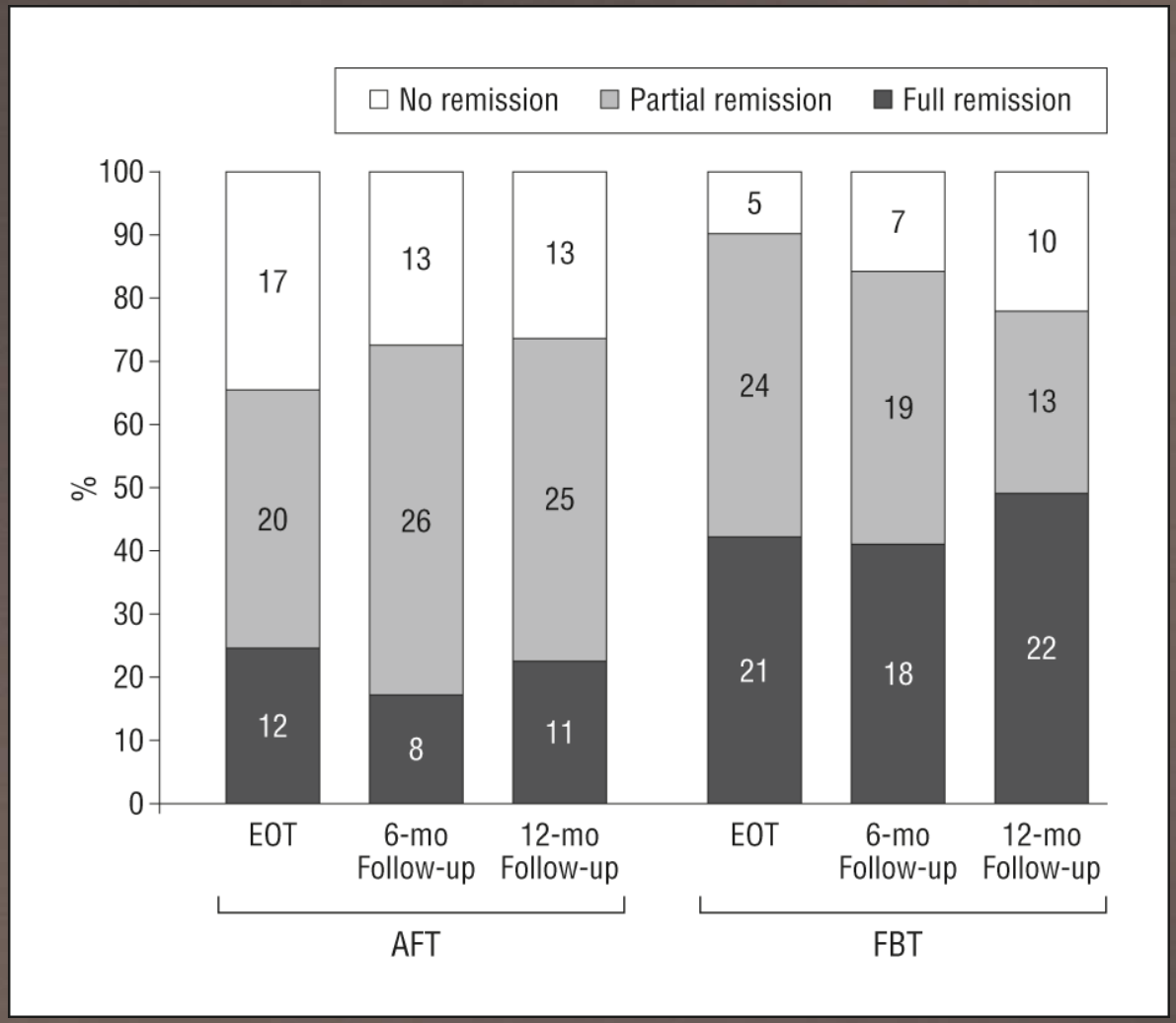
Outcomes



N=121, RCT of FBT vs. AFT, 12-18yo with AN (DSM-IV)

Lock & LaGrange (201). Atch Gen Psychiatry, 67(10):1025-1032

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Tips for Supporting Families

- "It's a marathon not a sprint"
- Caregivers should present a unified front
- Coach parents to model distress tolerance
- Acknowledge parents' distress
- Coach parents to be kind AND firm – appearing confident helps too
- Be aware of treatment fatigue
  - Support parents' self care
  - Support family logistics to optimize engagement in care

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Tips for Supporting Families

Families of Young Adults

- Set clear boundaries for parent involvement for youth who can legally make their own health care decisions
- Support emerging decision makers through informed collaboration
- Plan for supported independence
- Set expectations for independence and ensure follow up/resources at college

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Wrapping it Up

- Primary care providers have a critical role in the identification and management of adolescent eating disorders
- Early case identification & urgent intervention are crucial
- The new standard is more nutrition, less medication, and family-centered, family-driven care
- Admission may be required to address medical stability
- A spectrum of higher level care provides support at the appropriate level

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Wrapping it Up: So what can I do?

- Be vigilant & proactive
  - Identify risk early and intervene quickly
  - A simple nutrition plan may be enough
  - Be thoughtful about sports clearance
  - Refer medically unstable patients for admission
- Know your village
  - What are your options for nutrition and behavioral health support?
  - Where can you refer locally for higher level care?

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Wrapping it Up: So what can I do?

- Refer and collaborate
  - Connect families with the right level of care
  - We are happy to help you determine what level is appropriate!
- Support families
  - Stay involved, validate necessary treatment, provide family-centered support
- Think Prevention
  - discourage fad dieting
  - promote health and family meals
  - address weight maltreatment

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Recommended Reading (ED 101)

Rome, E & Strandjord, SE (2016). Eating Disorders. *Pediatrics in Review*, 37(8):323-336.

Campbell, K & Peebles, R (2014). Eating Disorders in Children and Adolescents: State of the Art Review. *Pediatrics*, 134(3): 582-6.

Gaudiani, JL (2019). Sick Enough: A Guide to the Medical Complications of Eating Disorders. New York, NY: Routledge.

Shaefer, J (2004). Life Without Ed. New York, NY: McGraw Hill.

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Resources for Families: FBT

www.maudsleyparents.org

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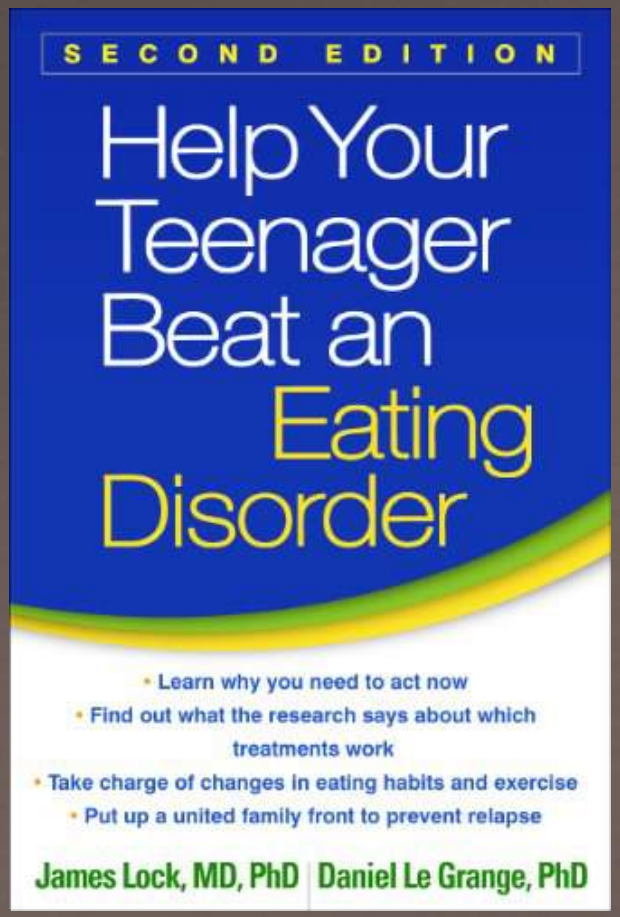
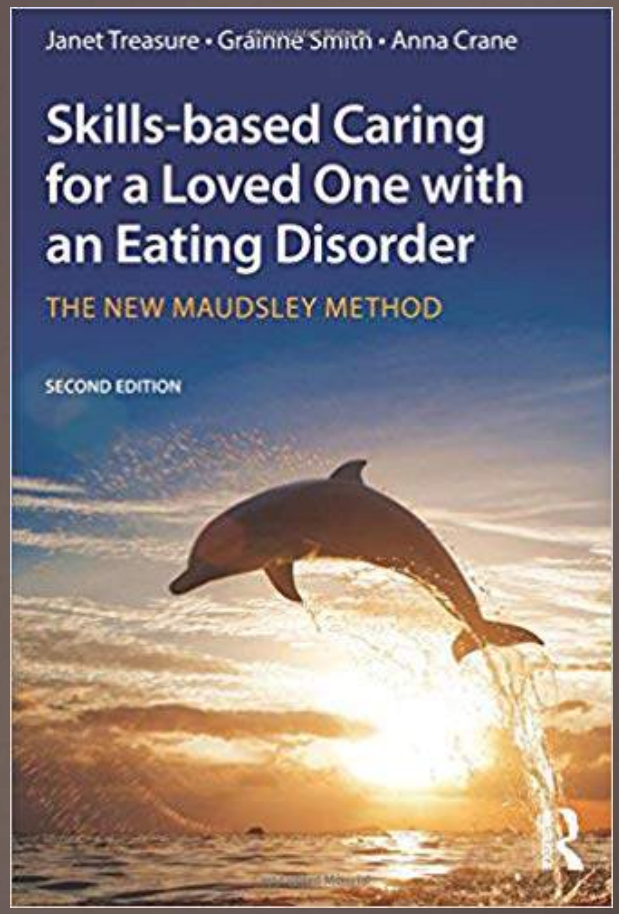
Resources for Families: FBT





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Resources for Families

www.FEAST-ED.org

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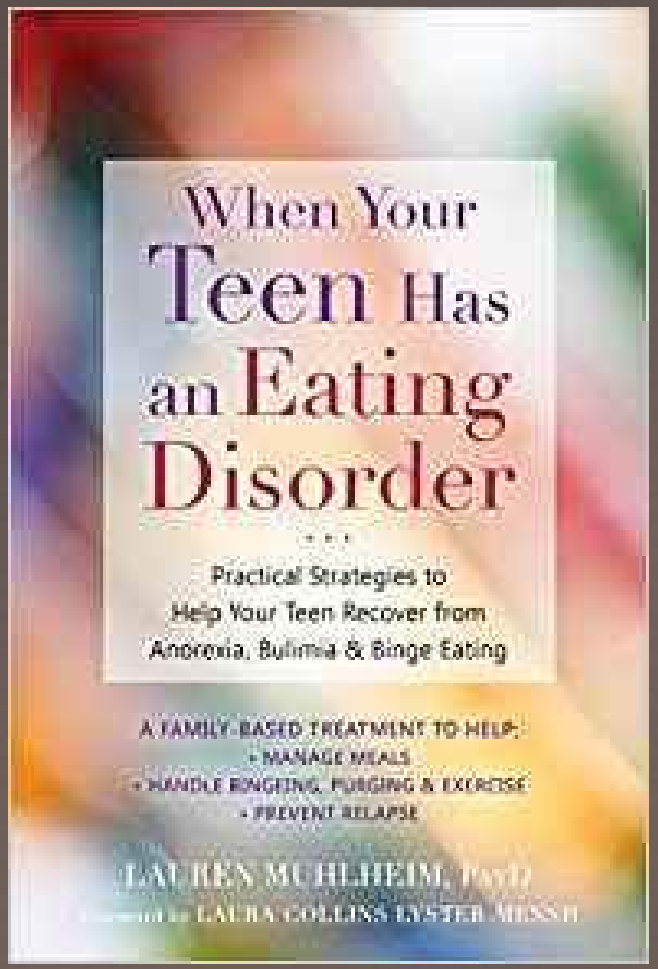
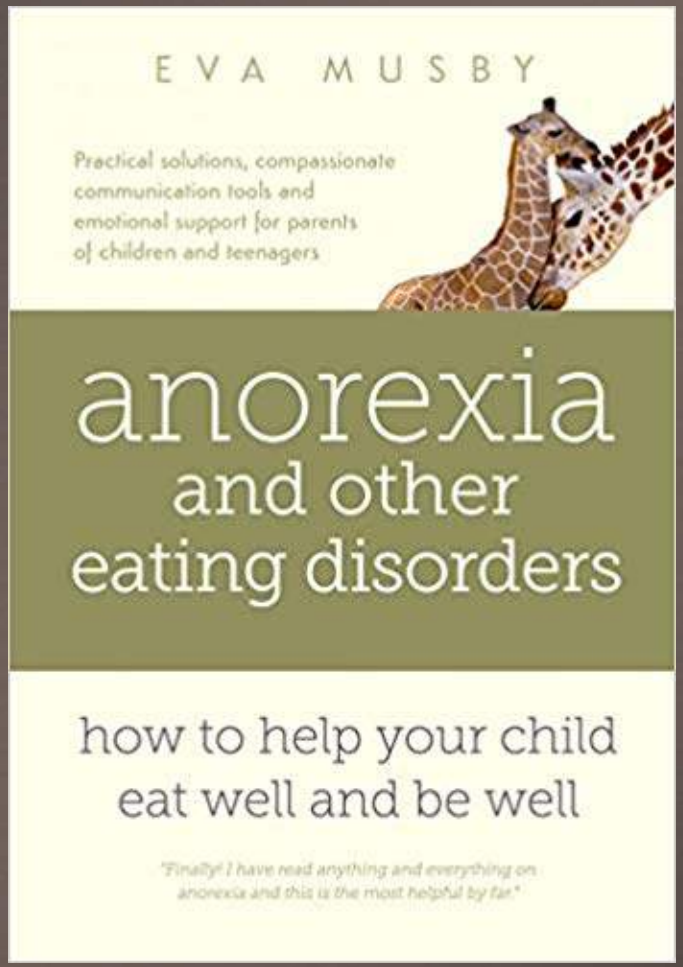
Resources for Families





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Donald Delaney Eating Disorders Clinic at Children's National

- Clinic Director:
  - Darlene Atkins, Ph.D., datkins@cnmc.org
- Clinic Location:
  - CNHS @ Friendship Heights, 5028 Wisconsin Ave
- Multidisciplinary services:
  - Medical, Nutrition, Psychology, Psychiatry
- Coordinated services with CNMC
  - Psychiatry, FBT, Inpatient Medical Stabilization

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Donald Delaney Eating Disorders Clinic at Children's National

- **Making a referral**
  - Email or fax referral information to:
    Petrinia Young, Senior Administrator
    peyoung@childrensnational.org
    Fax: 202-237-0694
- **Phone consultation (Adolescent Medicine)**
  - CNHS Physician Access Line , 202-476-4880
- Emergency Referral for Medical Stabilization
  - CNHS Main Hospital ED, 202-476-LIFE (5433)
  - Hospital operator for Adolescent Med On Call
    202-576-5000

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Dr. Tomas Silber
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Dr. Larry D'Angelo
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Discussion

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