Management of Eating Disorders in Children / Adolescents

Medicare Local Forum
June 2015
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Talk Overview

- Overview of Eating Disorders
- GCUH – Eating Disorder Management
  - Medical Stabilisation
  - CYMHS
  - Family based therapy – Maudsley
  - PEDAT – Paediatric Eating Disorder Assessment Team
- GP Role
  - Early recognition of Eating Disorder
  - Medical management
Overview of Eating Disorders
Eating Disorders

- ED are serious mental health illnesses - they are not a lifestyle choice or a diet gone “too far”
- ED are associated with significant physical complications and mortality
- In Australia approximately 0.5-1% of girls aged 12-19 years develop Anorexia nervosa.
- Those that develop *anorexia nervosa* have a *mortality rate of almost 20% over 20 years*, which is the highest mortality rate of any medical and psychiatric disorder in adolescence.
Epidemiology

- Peak age of onset for AN is 15-19 years of age (accounts for $\frac{1}{2}$ of all presentations)

- Individuals between 10 to 14 years account for approximately 1 in 5 new presentations of AN

- The incidence of AN in children and adolescents is increasing, whilst age of onset is decreasing
DSM-5

- Anorexia Nervosa (AN)
- Bulimia Nervosa (BN)
- Binge Eating disorder (BED)
- Avoidant restrictive food intake disorder (ARFID)
- Other Specified Feeding and Eating Disorder (OSFED)
  - Atypical AN / Atypical BN
- Unspecified Feeding or Eating Disorder (UFED)
- Pica
- Rumination Disorder
DSM-5 Changes

Aim to give majority of patients an appropriate diagnosis
- reduce ED-NOS category

- ARFID (Avoidance Restrictive food intake disorder) without weight focus

- Binge Eating disorder – own category

- For Bulimia Nervosa
  - Compensatory behaviours can included exercise and restrictive diet
  - Reduced frequency of binge eating and compensatory behaviour to once per week (from twice weekly)
DSM-5 Changes

- For Anorexia Nervosa
  - Amenorrhea not a requirement
  - Subtypes removed i.e. restrictive vs. exercise vs. purging – as changes over time
  - removal of “refusal” as implies intention on part of patient – which can be difficult to assess
  - Atypical AN – reflecting the concern for those children whose weight was still within normal range but decreasing with abnormal cognitions / behavioural thoughts
Approach to Eating Disorder

Initial Assessment:
History / Examination / Investigations
Initial Assessment

History
Eating Behaviours

- Food preparation
- What does the food look like on the plate
- Portion sizes, food choices, restrictions, unusual food behaviours
- Binge / Purge
- How has family responded to the different behaviours
- Eating at school – what is the culture of friends re eating at school
- Ask parents do they think – what the child is eating is enough
Weight controlling behaviours

- Do you do anything else to help lose the weight?

- Do you know of what other people do to lose weight - has anything like that ever happened to you?

Vomiting / Exercise / Laxatives / Alternative

*Assume that secret exercise is happening: e.g. Alarms going off at night*
Eating disorder cognition / belief

- Abnormal body image
- Undue influence of weight / shape on self evaluation
- Denial of illness severity
- Intense fear of gaining weight / becoming fat

“If I said to you – you are unhealthy and you need to gain weight do you think you would be able to do that”
Medical

- Maximum- Minimum weight
- Rapid weight loss
- Menstrual history
- Symptoms suggestive of alternative diagnosis:
  - IBD / Coeliac / Thyroid / DM / Hypercortisolaemia / Adrenal Insufficiency / Pregnancy / Malignancy

*Be aware of Dual Diagnosis – AN with IBD*
Symptoms suggestive of malnutrition:

- Hair thinning or loss / fatigue / dizziness / skin changes / cold intolerance / headache / nausea / bloating / fullness after eating / constipation

**GI symptoms are real: delayed gastric emptying in malnutrition: acknowledge it: it will get better when better nourished**

*Do need to manage constipation if a symptom – acknowledge and treat.*
Co-morbid Conditions

- Mood / Anxiety / OCD / Self-harm
  Depression / Suicide

- Sleep Disturbances
  - Very common in adolescents
  - Raised due to anxiety / personality types
    – perfectionist late nights finishing homeworks
  - Depression / anxiety difficult to tease out
    from exercise / purging secretly at night
    from poor sleep hygiene
  - Melatonin can be used
Initial Assessment

Physical Examination
Examination

- General Inspection: Cachexia / Muscle / subcut. fat stores
- Weight / Height Percentiles & BMI –
  - Calculate expected body weight for height
- Previous Weight History
  - Weight may be in normal range but still medically unstable - *be aware of the significant weight loss from 99% to 50%*
- Previous Growth velocity
Vital Signs

- HR and volume: HR < 60 / or low HR in context of fever or dehydration - *Don’t assume low HR is because child is very fit*
- Temp < 35.5
- BP < 80/50
- Postural changes: Decreased BP / Increased HR on standing
- Hydration status
- Peripheral perfusion: hold hands – cold / acrocyanosis
- Urinalysis: SG, pH, Ketones
Physical Examination

- Hands – Russel sign excoriation
- Skin: Dry / Lanugo / Bruising of spine / Pallor / Orange discolouration / chill blains
- Self- harm – easily missed: upper anterior thighs
- Thyroid – can be associated with weight loss / or co-existing autoimmune
- Salivary glands – enlarged parotid: frequent vomiting
- Oral examination: dental enamel erosion / hygiene / petechial on palate
Physical Examination

- Cardiac: AN can be associated with significant cardiac changes: particularly decreased LV Volume and wall thickness, silent pericarditis, MVP prolapse – *if abnormal cardiac examination – take it seriously.*
- Abdominal examination: Palpable bladder – excess water loading, abnormal musculature, constipation
- Neurological – slow mentation
- Oedema
- Pubertal assessment
Initial Assessment
Investigations
ECG: Bradycardia / Prolonged QT / T wave changes (low amplitude, U wave, ventricle abnormalities)
FBC – often see low WCC, anaemia not as common (amenorrhoea)
UEC: low K, low Cl (metabolic alkalosis), low Na, low Cr:
HCO3 (>30 Vomiting, <18 laxative abuse)
LFT
Ca PO4 Mg – low Phosphate increased risk re-feeding
Ferritin – Iron studies — iron deficiency risk occurs when menstruation returns
B12 / folate
LH, FSH, Oestradiol: low or low normal
ESR / CRP / Coeliac / TFT (excluding other causes)
Vit D (maximising bone health)
Bone Density or DEXA Scan
Eating Disorders -GCUH

Gold Coast University Hospital Services
Multi-disciplinary Team Approach
PEDAT = Paediatric Eating Disorders Advisory Team
Initial Intake

- CYMHS Access – if concern about possible Eating Disorder
  - Ph. (07) 5635 6392
- Intake will normally be conducted by Eating Disorder Program Specialist
  - Decision for ongoing therapy: EDP or CYMHS

*If Medically unstable – contact GCUH 1300744284 (Paediatric Registrar)*
Hospital Admission

- Medical Stabilisation
- Psychological safety – risk to self harm – or significant distress
- Progressing in outpatient slow

*Children <16 years of age or if attending high school up to 18 years*

*Admission to ward often 2-6 weeks (dependent on child / family factors)*
GCUH Criteria for Admission

- Dehydration
- Postural hypotension drop > 10mmHg
- Postural tachycardia with elevated HR of greater than 30% resting hear rate
- Bradycardia < 60pbm
- Hypothermia < 35.5
- Electrolyte disturbances
- Prolonged QTc interval on ECG
- BMI less than 3%ile for age
- Severe rapid weight loss (need to plot previous weights and heights)
Medical Stabilisation

- Commencement of NG feeding – not optional
- Vitamin Supplementation: IMI Thiamine / Oral Phosphate, Magnesium and multivitamin
- Monitoring for re-feeding syndrome
- Strict Bed Rest – increase mobilisation as physiologically stable
- Cardiac Monitoring
- Initiate Investigations
- Very black and white protocol

*Highlighting to parents- Serious Medical Condition*
Dietitian

- Commence Nutrison Standard 30ml/hr
- Increase & monitor NG feeding (min. 150% of RDI for Energy) and monitor bloods
- Child Encouraged to eat normal diet = 3 meals / 3 snacks
- When medically stable – aim to transition over to full oral feeds
- NG feeds often continued for longer to ensure Nutritional Gains
- Adjunct Supplements - Fortisips

*Aim for >0.5kg weight gain per week*

- *Initial Weight gain greater due to fluid (may see > 2 kg in first week)*
CYMHS – During Admission

- Introduction to CYMHS team and Eating Disorder Program Psychologist / Nurse
  - Assist with hospitalisation
  - Promote oral refeeding
  - Address anxiety: Relaxation / Distraction / Mindfulness
- Prepare child and family for outpatient therapy and goals
Role of Psychiatric Medication

- Co-morbid diagnosis: Anxiety / Mood
- Poor response to psychological intervention
- Nutrition usually improves anxiety and mood—don’t rush
- Medication doesn’t work well if underweight
  - Need tryptophan amino acid to increase 5HT

- Common medications used
  - SSRI – Depression / Anxiety / OCD
  - Olanzepine – Decrease stress associated with eating
Discharge

- Medically Stable
- At time of Discharge
  - Robina CYMHS Inpatient unit
  - CYMHS Outpatients
  - Eating Disorder Service

*Hospitalisation does not cure ED – in fact ED Cognitions can be stronger during and following admission*

*Better outcomes if brief admission then outpatients management*
PEDAT – Paediatric Eating Disorder Advisory Team

EDP Psychologist & Senior Nurse / CYMHS Psychiatrist / CYMHS Case-worker / Dietician / Paediatrician

- All child / adolescents post admission GCUH or Robina Inpatients
- Children / Adolescents known to CYMHS with ED requiring Paediatric or Dietician input / advice
- Forum for team to discuss ongoing service planning and development
Eating Disorder Program
Family Based Therapy
Enhanced - CBT
Eating Disorder Programme

Family Based Therapy (FBT) - Maudsley
- Gold Standard + Most researched for patients <19 years
- 30-50% full remission at 12 months:
  - EDE* in normal range / 95% EBW
- 75-90% remain weight restored 5 years post
- ED cognitions may persist

* Eating Disorder Examination Interview – Rating of ED Symptoms
Key concepts of FBT

- AN is a life threatening family crisis
- Focus on symptoms (not cognitions) - Weight restoration / eating
- Agnostic view
- Family is the key resource in helping child to recover
  - Family not to blame but responsible for weight restoration
  - How are family going to mobilise resources
- Separation of child and illness
- Therapist Guides family - Non-Authoritarian
FBT Phases

1) Intense Re-feeding

- 3 months 10 sessions
- Aim weight restoration 90-95% EBW
- Parents manage AN behaviours
- Full family involvement
- Food is the issue
- Create Anxiety in family – Life-threatening disease
2) Transition to adolescent control
   - Gradual return to adolescent independence
   - Maintain weight 90-100%

3) Adolescent Issues
   - Address co-morbidities
   - Helping patient become a competent teenager
   - Often have disclosure of serious abuse / trauma / family issues
Enhanced-CBT

- Role for alternative therapy - FBT doesn’t work or adjunct

- e-CBT
  - Used in Adults with AN – 66% for completers
  - Specific form of cognitive behaviour
    - Core low self esteem
    - Perfectionism (Achieving in other domains)
    - Life: interpersonal problems – difficult relationships or other factors that lead to restricted diet / purging.
    - Mood intolerance (Emotional deregulation)
DYSFUNCTIONAL SCHEME FOR SELF-EVALUATION

Over-evaluation of eating, shape and weight and their control

Over-evaluation of achieving "PERFECTIONISM"

CORE LOW SELF-ESTEEM

Strict dieting and other weight-control behaviour

(Achieving in other domains)

Binge eating

Compensatory vomiting/laxative misuse

L I F E

MOOD INTOLERANCE
GP Role in Eating Disorder
As a GP you are likely to be one of the first health professionals a person with an eating disorder will come in contact with.

GP role in the treatment can encompass
- Prevention
- Identification
- Medical management in a primary care setting
- Referral
Early Detection

- Early Detection of an Eating Disorder is the best indicator of a swift and complete recovery.

- Many people with eating disorders and their families have been turned away from medical intervention and support because they have been told they or their child is “not sick enough”.

- Identifying an Eating Disorder before a patient is medically compromised – don’t wait until meet DSM-5 criteria

Refer early – contact CYMHS Access

Duration of therapy, evidence of FBT, and need for Multi-disciplinary Team involvement means private options not ideal
Avoid a “rule-out” approach to

- Extensive series of tests to rule out all possible medical causes of symptomatology (e.g., amenorrhoea) before considering an eating disorder delays access to appropriate treatment.

“Generally, clinicians should assume that anyone who is underweight or exhibits rapid weight loss has a dieting disorder unless proven otherwise”

- While there are many organic conditions that cause weight loss, the most common cause of substantial weight loss in adolescent females in the developed world is undoubtedly anorexia nervosa.
Common Presentation of ED

- Changed attitude to food and cooking
- Avoiding meals
- Slow eating/picking at food
- Eating in secret
- Cooking for family not for self
- Eating low calorie foods
- Changing food choices (e.g., vegetarian or vegan diet)
- Medical problems
- Weight fluctuations with possible denial of diet or deliberate weight loss
- Fractures from minimal force
- Menstrual irregularities
- Gastrointestinal problems (bloating, constipation, generalised abdominal pain, changing bowel habit)

- Hypoglycaemia – may present as ‘dizzy spells’
- Behavioural and psychological presentations
- Raiding the fridge
- Social phobia with regard to eating
- Excessive work or training
- Low mood or mood instability
- Poor concentration
- Self diagnosis
- New food intolerance (e.g., lactose intolerance)
- Suddenly developing ‘allergies’ to foods
The SCOFF reliably identifies people who are likely to have an eating disorder.

The SCOFF five-question screening tool:

- **S** – Do you make yourself **Sick** because you feel uncomfortably full?
- **C** – Do you worry you have lost **Control** over how much you eat?
- **O** – Have you recently lost more than **One** stone (6.35kgs) in a three-month period?
- **F** – Do you believe yourself to be **Fat** when others say you are too thin?
- **F** – Would you say **Food** dominates your life?
If the person raises the eating disorder

- Acknowledge
  - how difficult it must have been to disclose such personal information
  - that they may feel shame and isolation over the disorder
  - patients’ experience as they describe it
  - symptoms may be experienced as involuntary and that there is often an enormous sense of powerlessness and hopelessness accompanying the lack of resolution

- Provide information about
  - The negative consequences of an eating disorder
  - Options for treatment in a non-threatening way.
  - Encourage the patient to seek specialist help if necessary
  - These problems are not uncommon, other people also suffer from them and resolve them successfully, though it may take time
Resources

- Eating Disorder Information Kit

- Queensland Health Statewide Mental Health Network – Child and Youth Eating Disorder Working Party – Access Pathway and Quick Reference for Management of Eating Disorders in Queensland
Questions?
DSM-5 Anorexia Nervosa

- Persistent restriction of energy intake leading to significantly low body weight (in context of what is minimally expected for age, sex, developmental trajectory, and physical health).

- Either an intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain (even though significantly low weight).

- Disturbance in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Subtypes: Restricting type / Binge-eating/purging type
DSM-5 Bulimia

- Recurrent episodes of binge eating. An episode of binge eating is characterised by both of the following:
  - 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 during a similar period of time and under similar circumstances.
  - A 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).

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

- The binge eating and inappropriate compensatory behaviours both occur, on average, at least once a week for three months.

- Self-evaluation is unduly influenced by body shape and weight.

- The disturbance does not occur exclusively during episodes of Anorexia Nervosa.