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A guide to the community management of paediatric eating disorders

Developed by Sahaj Puri for PedsCases.com.
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Introduction:

Hi everyone and welcome to this PedsCases podcast reviewing the CPS position statement on "A guide to the community management of paediatric eating disorders". My name is Sahaj Puri and I'm a first year resident in Pediatrics at McMaster University. This podcast was developed in collaboration with Dr. Christina Grant, who works in Adolescent Medicine at McMaster University.

Eating disorders are a serious group of illnesses that are typically seen within the adolescent population.[1] They can have severe life-threatening physical and mental health implications within this patient group, and as such, it is important to have an approach to tackling these conditions. The purpose of this podcast is to highlight the Canadian Pediatric Society's recommendations regarding screening and management of pediatric eating disorders, primarily within community settings.

Learning Objectives:

By the end of this podcast, the listener should be able to:

1. Define what an eating disorder is and list examples of restrictive eating disorders.
2. Recognize that eating disorders can present in any patient regardless of their age, gender, sexual orientation, ethnic identity or socioeconomic background.
3. Describe an approach to the workup of an eating disorder in a pediatric patient (including an approach to a history, physical exam, and laboratory investigations).
4. List medical complications that may arise secondary to a pediatric eating disorder and recognize criteria for hospitalization.
5. Describe the principles of the family-based-treatment (FBT) approach for management of pediatric eating disorders.
6. Understand the CPS recommendations which aim to facilitate effective community management of pediatric eating disorders.

Clinical Case:

Janice is a 16 year old female presenting to your office for follow up regarding menstrual concerns. Menarche was at 12 years of age and her cycles became regular

at 28-day intervals around age 13. For the last 6 months, she has not had her period. When you spoke to her alone during previous appointments, she shared that she is not sexually active. Your medical workup so far has been negative for any cause of amenorrhea. However, you note that her weight has been falling off of the growth curve over the last year. At today's visit, she is far below the 5th percentile.

You wonder whether Janice's weight loss may be contributing to her amenorrhea. Recognizing that this may be a sensitive subject for Janice, you think of how to approach a conversation about her dietary intake and how you may screen for an eating disorder.

Keep this case in mind as we go through the rest of this podcast and we will return to Janice at the end of our discussion.

Background on Eating Disorders

Eating disorders can be seen in pediatric patients regardless of their age, gender, sexual orientation, ethnic identity or socioeconomic background.[1] This group of disorders is noted to cause an increased risk of morbidity and mortality.[2] Around 5% of Canadian adolescents are thought to have an eating disorder.[3] However, only a fraction of this group receives timely care. Factors that may play a role in delayed diagnosis include identifying as male, being a sexual or racial minority, a pre-pubertal child, or an individual who is thought to be of average or above average weight.[4]

Anorexia nervosa has the highest rate of mortality among any psychiatric disorder.[5,6] It is important to recognize that some adolescents may present with atypical anorexia nervosa, where they experience a drastic weight loss but maintain a normal or above average BMI.[1] Though practitioners may overlook or miss a case of an eating disorder in patients who present in this manner, these patients are still at an elevated risk of mental and physical health concerns.[1]

While eating disorders may typically be perceived as conditions related to body image, some patients may present with restrictive eating patterns that are unrelated to concerns about their weight. For example, avoidant/restrictive food intake disorder (ARFID) is associated with a reduced intake that may be due to a lack of interest in eating or due to sensory sensitivities.[1] Some children with ARFID dislike eating because they worry about choking or vomiting.[5, 7]

The Role of Community Healthcare Providers

The incidence of eating disorders within the adolescent population has continued to increase over the last decade.[8] Not all children with eating disorders can access care in tertiary centers, highlighting the need for community providers to feel comfortable caring for patients with these concerns.[1, 9]

Community providers can play a key role in early identification of patients presenting with eating disorders. A child's symptoms may be vague such as fatigue, menstrual abnormalities or abdominal pain.[10] Therefore, preventative healthcare visits can be used to screen for disordered eating behaviours.[9]

Barriers to screening and early detection of eating disorders in the community include fewer resources, time constraints and inconsistent physician knowledge and comfort regarding management principles.[11] Additionally, adolescents with eating disorders may deny their symptoms or avoid seeking care.[12] Despite these challenges, community providers are in a unique position to provide counselling that may lead to changes early in the illness course.

Screening Tools

All adolescents should be screened for eating disorders at yearly visits with their primary care physician using structured psychosocial history-taking tools.[2]

HEEADSSS / SSHADESS

An example of one approach to an adolescent history is the HEEADSSS or SSHADESS history.[13] Drawing from this approach, providers may ask their patients questions such as, "Does your weight or body shape cause you stress?" or "Have there been any recent changes in your weight or any desire to change your weight?".[13]

SCOFF Questionnaire

There are other eating-disorder-specific screening tools as well, such as the SCOFF questionnaire.[14] In this approach, the following questions are asked:

- Do you make yourself vomit (**S**ick) because you feel uncomfortably full?
- Do you worry you have lost **C**ontrol over how much you eat?
- Have you recently lost more than 15 pounds (**O**ne stone) in a three-month period?
- Do you believe you are **F**at when others say you are too thin?
- Would you say that **F**ood dominates your life?

1 point is assigned every time a patient answers yes to a question, and 0 points are assigned when they say no.[14] A total score that is equal to or greater than 2 points indicates that the patient is at a higher risk of anorexia nervosa or bulimia.[14]

The Eating Disorder Screen for Primary Care

The Eating Disorder Screen for Primary Care is another questionnaire that can be used among the adolescent population.[15] It asks questions such as "Are you satisfied with your eating patterns?", "Do you ever eat in secret?" and "Does your weight affect the way you feel about yourself?".[15]

Workup for a Suspected Eating Disorder

Focused History

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If screening tools identify behaviours that may indicate an underlying eating disorder, a detailed history should follow for further investigation. Behaviours to monitor for include body image concerns, a significant desire for weight loss, a fear of gaining weight, restrictive or binging eating habits, purging behaviours, excessive exercise and the use of pharmacological therapies to lose weight.[1]

When taking a focused history, it is important to establish whether the patient has encountered issues with eating in the past, or if there is a family history of similar concerns. Understanding the timeline of the patient's eating habits is also important, including the pattern of their weight gain or weight loss.[1] Providers should then obtain a dietary history to uncover what a typical day of eating may look like for the patient.[1] It is also important to ask the patient about how they *feel* regarding their eating patterns, and whether they have any associated fears.[1] Providers should also inquire about binging or purging behaviours and the patient's exercise habits.[1]

Outside of eating-disorder-specific questions, practitioners should screen for common comorbidities such as mood or substance use disorders, suicidal ideation, and a history of abuse or trauma.[1] Obtaining a collateral history from a caregiver can be useful, especially in cases where patients may lack insight.[12]

Focused Physical

As part of a complete physical exam, weight, height and BMI should be plotted at each patient visit.[1] This allows for further workup in patients with unexpected changes in their weight, those who have not reached weight or height milestones, or those with signs of bradycardia, hypotension or pubertal delay.[16]

Orthostatic vitals can also be useful to assess for medical stability. Changes that may indicate malnutrition include bradycardia, hypotension, or hypothermia.[17] Orthostatic variations are also concerning findings.[17]

Labs

Initial laboratory investigations should be ordered for those with a suspected eating disorder to rule out organic etiologies and assess for complications. Other conditions that may present similarly to eating disorders include celiac disease, inflammatory bowel disease, hyperthyroidism, type 1 diabetes, adrenal insufficiency, lupus, chronic infection and neoplastic conditions.[18]

Initial labs to consider include a CBC, creatinine, urea, electrolytes, glucose, liver function tests, CRP or ESR, TTG IgA, TSH and iron studies.[1] A urinalysis, beta hCG and ECG may also be useful.[1] In specific cases, such as if there is a history of amenorrhea or pubertal delay, serum estradiol, LH and FSH, and testosterone levels may be ordered.[1] Depending on the clinical presentation, bone age imaging or bone mineral density scans can be considered.[1]

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Classifying Degree of Malnutrition

Once a patient has been diagnosed with an eating disorder, consistent follow up is vital. Understanding the degree of the patient's malnutrition can be useful for care.

Malnutrition can be classified based on percent median BMI (which is the current BMI divided by the BMI at the 50th percentile), or with BMI Z-scores.[1] These scores can help categorize the degree of malnutrition as mild, moderate or severe. Generally, a percent median BMI of under 70% is considered severe.[1] Further details regarding the classification of malnutrition is outlined in Table 4 of the CPS statement.

Given that percent median BMI or BMI Z-scores may not reflect the severity of the illness, providers may prefer to monitor the rate and magnitude of weight loss.[17] The magnitude of weight loss is the percentage of body weight lost.[1] A weight loss of greater than 10% is considered severe for malnutrition.[1]

Patients with severe malnutrition require closer follow up to monitor for medical complications and may benefit from referral to an eating disorder clinic or multidisciplinary care team.[19]

Complications Related to Eating Disorders

The list of medical complications that may arise from an eating disorder is exhaustive. For the purposes of this podcast, we'll touch on some of the high yield, system-based complications to think about when caring for a patient with an eating disorder.

From a cardiovascular perspective, we must monitor for bradycardia, hypotension, presyncope and syncope. In extreme cases, there is the risk for cardiac arrest.[1]

Respiratory complications include acute respiratory failure, pneumomediastinum or aspiration pneumonitis.[1]

From a gastrointestinal perspective, patients may present with slowed gastric emptying and motility, constipation, gastritis, and esophagitis.[1]

Patients may also develop a decreased bone mineral density, putting them at an increased risk of fractures.[1]

Regarding hematological complications, patients may present with leukopenia, anemia, thrombocytopenia and elevated ferritin.[1]

Patients may also present with amenorrhea, pubertal delay, arrested or delayed growth, or short stature.[1]

From a metabolic perspective, patients may develop hypoglycemia, impaired glucose tolerance, refeeding syndrome and electrolyte disturbances.[1]

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Other neurological and psychological complications, such as emotional dysregulation, depressed mood, anxiety and suicidality are common as well.[1]

Ongoing Care for Patients with Eating Disorders

Providers following patients with eating disorders should document their vitals, changes in weight, and evaluate for the medical complications previously discussed. A daily multivitamin, elemental calcium and vitamin D supplementation is recommended for all adolescents with restrictive eating disorders to target bone health and micronutrient deficiencies.[20]

Since weight checks can be emotionally difficult for some patients, discussing whether or not your patient would be interested in knowing their weight is an important consideration.[1] The patient's perception and knowledge of their weight can be discussed with their family and may change depending on the stage of their illness.[1] Of note, changes in weight are only one portion of recovery and providers should maintain a holistic view of their patient's progression.

Indications for Hospitalization

If the patient presents with symptoms indicating medical instability, they may require hospitalization. Admission criteria may differ based on local hospital guidelines, however, certain factors should be considered for all patients. Severe malnutrition may warrant admission.[1] Additionally, physiologic instability may present with bradycardia, hypotension, hypothermia or orthostatic changes.[1] Severe dehydration or electrolyte disturbances, ECG abnormalities or acute medical complications such as syncope, seizures, or cardiac failure often require hospitalization.[1] Acute psychiatric concerns such as suicidal ideation or psychosis may also prompt referral to the nearest emergency department.[1]

Family Based Treatment

Several treatment options are available for patients with eating disorders. The first line for restrictive eating disorders is family-based treatment (FBT), which is often led by specialized family-based treatment providers.[21, 22] This type of therapy occurs in an outpatient setting where families are taught to identify eating disorder behaviours and regain a sense of control over nutritional intake.

There are 3 phases of family-based treatment. Phase 1 encourages parents to lead and supervise meals, focusing on restoring the patient's weight.[23] Caregivers should control meals, which may include supervision in the preparation, plating and ingestion of meals, including arranging for supervision at school, until the patient reaches a healthy weight. For patients who engage in purging behaviours, parents should monitor youth after meals for 30 to 60 minutes.[19] Phase 2 returns the control over eating back to the patient in a stepwise manner.[23] Phase 3 works to address other factors that may have been impacted by the patient's eating disorder.[23]

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It is important to recognize that while family-based treatment is recognized as a standard therapy, it may not be well-suited for all family structures.[22] In families where there is a history of abuse, external demands of care or emotional dysfunction, alternative treatment strategies may be more fitting.[22]

Nutritional Guidance and Activity Restrictions

Identifying a treatment goal weight (TGW) for patients with restrictive eating disorders can be a useful guide to monitor progression. This weight is one at which the youth is able to engage in healthy eating patterns, achieve pubertal and growth milestones, participate in physical activity and function well psychosocially.[24] The treatment goal weight can be estimated by assessing the patient's weights prior to development of the eating disorder to determine the total weight that was lost over a specific time period.[1] While we may attempt to determine treatment goal weights through calculations, the true goal weight is the one at which the body is functioning normally again - such as when menses return. As treatment goal weights are only estimates, they should be reassessed at 3 to 6 month intervals and as the patient matures.[24]

In outpatient settings, nutritional rehabilitation should prioritize a regular intake of healthy meals. This typically includes 3 meals and 3 snacks per day.[1] Within the family-based-treatment model, specific goals regarding caloric intake and tracking of calories is not recommended.[20, 23] Instead, parents are coached to consider how their youth used to eat and are encouraged to try to nourish them back to health. Of note, certain diets that emerged during disordered eating, such as vegetarian or vegan diets, may be a symptom of the eating disorder and may pose a challenge when reaching nutritional goals.[1]

Typically, a weight gain of 250-500g per week is thought to be appropriate for outpatient weight restoration.[1] An intake of 2000 to 3000 kcal/day is often required to meet these goals.[19] As physiologic processes resume with increased oral intake, caloric demands may also rise.[1] If a patient's weight is not increasing, the health care provider and families may need to reassess where management may be optimized.

Those in an acute medically compromised condition should avoid physical activity.[1] Even if vitals are normal, patients may benefit from restriction from activities that may disrupt their ability to gain weight, such as a temporary break from the gym or engagement in sports teams.[1] Physical activity should be gradually re-introduced when appropriate, with monitoring of weight and vital signs.

Providing Family Support and Guidance

In addition to prioritizing the patient's wellbeing, it is crucial to educate and support families as they navigate their child's eating-disorder. Health care providers are encouraged to outline the seriousness of an eating disorder to families, to prompt parents to engage actively in their child's recovery.[1] Families may report conflict during

mealtimes, and providers should encourage them to avoid giving into the patient's demands.[1] It may be helpful for families to adopt a "food as medicine" approach, whereby the prescription of food is not seen as an option to the patient.[1] Having families share common meals together and using distraction through conversations about other topics, may be helpful for the patient.[1] Traditional approaches to modifying behaviours, such as rewarding desirable behaviours and outlining consequences for undesirable behaviours, can also encourage the patient to follow through with management plans.[19]

Generally, adolescents have a recovery rate of around 70% from eating disorders.[25] However, this process can be lengthy and may not follow a linear path.[1] As a result, validating the emotions of the family during this time is important to maintain a positive therapeutic alliance.[1]

CPS Recommendations

The CPS has made the following recommendations regarding the community management of pediatric eating disorders:

1. Adolescents should be screened for eating disorders (EDs) as part of any routine or health supervision visit.
2. All children and adolescents, regardless of their body mass index, presenting with significant unexplained weight change, failure to reach an expected weight or height, bradycardia, hypotension, or pubertal delay, should be assessed for a possible underlying ED.
3. Individuals presenting with positive findings on screening should have a detailed history, physical exam, and laboratory investigations to clarify the diagnosis and assess for medical complications.
4. Patients diagnosed with EDs should be routinely assessed for vital sign changes, medical complications, and consideration for hospital admission.
5. When available, referral to a specialized family-based treatment provider should be initiated for restrictive adolescent EDs.
6. Providers should familiarize themselves with the core concepts of FBT and are encouraged to initiate elements of this intervention in their clinical encounters.
7. During treatment, nutritional rehabilitation should focus on the regular intake of meals and snacks with supervision by parents or caregivers. HCPs should assist with adjusting portion size and energy density based on weight progress.
8. When medically appropriate to return to physical activity, HCPs should assist with promoting activities that are social, time-limited, and emotionally positive.
9. HCPs should understand how treatment and recovery processes impact quality of life for all family members, and assist or refer them for therapeutic services or supports as needed.

Back to Clinical Case

Let's go back to our clinical case. You speak to Janice privately and go through a SSHADESS history, which reveals concerns that Janice has regarding her body

image. Throu gh the SCOFF questionnaire, you recognize that Janice may be meeting criteria for an eating disorder. Further history leads to the diagnosis of anorexia nervosa. You do a thorough physical exam and note that Janice is quite hypotensive. She admits to feeling more lightheaded recently and believes she had a fainting episode last week that she did not tell anyone about. You speak to Janice about your worries, sharing that you believe she would benefit from hospitalization for nutritional rehabilitation and medical stabilization.

You see Janice in follow up 1 week after she was discharged from hospital. She is accompanied by her mother, who shares that Janice has been doing much better since returning home. They have engaged in family-based-treatment and Janice's mother has been monitoring for regular intake of all nutrition. Janice was provided outpatient counselling support and referred to an outpatient eating disorder clinic upon discharge from the hospital. She has her first appointment for both resources in the coming week. You plan to follow up with her again to see how she is doing and track the return of her menstrual cycle.

Conclusion

Thank you for listening to this podcast about the community management of pediatric eating disorders! Stay tuned for more podcasts from PedsCases.

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