Eating Disorders

Presenting Problem:

A participating PCP emailed a consultation request to the WI CPCP about a 14-year-old female patient recently seen for the second time. At the first well-child visit one year previously, the patient was 5'3" and weighed 105 pounds. Today, the patient is 5'4" and weighs 98 pounds. The patient was irritable and guarded, refusing to allow physical examination or any lab work. Her mother appeared anxious. The PCP did not detect imminently dangerous symptoms when taking vital signs, and the patient denied suicidal thoughts. The patient reluctantly agrees to return to clinic in one week for follow-up. The PCP is concerned about anorexia nervosa.

Consultant's Response:

- Clarify the cause of the patient's weight loss, starting with a full physical exam and lab tests.
- Consider both **psychological** and **non-psychological** causes, with non-psychological causes being diagnoses of exclusion.
    - **Non-psychological causes** of weight loss:
        - A variety of medical conditions can masquerade as eating disorders: hyperthyroidism, malignancy, inflammatory bowel disease, immunodeficiency, malabsorption, chronic infections, Addison's disease, and diabetes.
            - Most patients with a medical condition that leads to eating problems express concern over their weight loss.
        - Common **psychological causes** of weight loss:
            - Clinical depression with decreased appetite/interest
                - Request the patient complete a **PHQ-9 rating scale**
                    - PHQ-9* Questionnaire for Depression Scoring and Interpretation Guide
            - Eating disorders, such as anorexia nervosa or bulimia nervosa
                - Request the patient complete an **EAT-26 rating scale.**
                    - **Note** that patients may deny or minimize symptoms in effort to avoid intervention.
                - Click on the links below for full diagnostic criteria:
                    - ANOREXIA NERVOSA
                    - BULIMIA NERVOSA
- If the patient refuses to allow adequate workup and there is concern for imminent danger, consider the process for a chapter 51:15 involuntary hold. Many counties have a mental health crisis team who complete an initial evaluation.
- When diagnosing an eating disorder, the next step would be determination of **level of placement for treatment**, depending on severity of symptoms. Assistance with this determination is available in Identification and Management of Eating Disorders in Children and Adolescents published by the American Academy of Pediatrics and the Society of Adolescent

Health and Medicine. Indications for **medical hospitalization** of children and adolescents with eating disorders:

- **Note:** Check weight in a gown and check *urine specific gravity* at the same time you check the weight, as acute water-loading is a common way patients try to appear heavier than they are.

- Indications for ***voluntary*** psychiatric hospitalization:
  - This varies based on the specific hospital, but needs to involve imminent risk of danger towards self or others in a patient who *agrees* to inpatient admission and for whom lower-acuity settings/placements are not considered adequate.
- Indications for ***involuntary*** psychiatric hospitalization:
  - If the patient appears to be at imminent risk of danger towards self (or others) but the patient and/or guardian refuses inpatient, you may need to start the process for a chapter 51:15 involuntary hold, as discussed above.
- If not meeting the above criteria, proceed with referral for Intensive Outpatient treatment or Partial Hospital Program treatment, if available, or outpatient treatment.

Teaching Points:

- Diagnostic criteria for **Anorexia Nervosa** (DSM-5):
  - Restriction of energy intake compared 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 though underweight.
  - Disturbance in the belief of one's body weight or shape, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.
  - Prognosis is directly tied to the patient's insight and willingness to engage in treatment.
    - **Without treatment**:
      - Up to 20% of people with serious eating disorders die.
    - **With treatment:**
      - Close to 3% of people with anorexia die.
    - Twenty percent stay dangerously underweight and are seen often in emergency rooms, mental health clinics, inpatient hospital units, and eating disorder treatment programs.
    - About 20% make a partial recovery, meaning that they may be able to hold a job and keep some superficial relationships but remain extremely focused on food and weight. They may also remain underweight in the longer term which can give rise to other health complications.
    - **Only 60% make a full recovery** in which they live a life free from any eating disorder-related thoughts or behaviors.
      - Parents sometimes feel desperate and, wanting to please their child, will agree to continue doctor/treatment facility/therapist 'shopping', which can delay progress, entrench symptoms, and worsen the patient's chances of making it into the 60% category of patients who show significant and long-lasting recovery.