Treating Eating Disorders in the Primary Care Setting

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Conflicts of Interest

- None

Outline for Today

- Eating Disorder Models for Outpatient Care
- Anorexia Nervosa
- Bulimia Nervosa
- Binge Eating Disorder
- Avoidant Restrictive Food Intake Disorder (ARFID)
- Case Presentation

Ideal Treatment Team Model

Medical Doctor

Registered Dietician

Family Therapist

Individual Therapist

Psychiatrist

Realistic Treatment Teams

- Finding eating disorder providers is difficult
  - Underserved area of medicine
  - Patients may be limited due to insurance and physical location
  - Increase in diagnosis in recent years

Outpatient Care for Eating Disorders in Primary Care

- Eating Disorders most commonly present in primary care
  - Providers have long standing relationships with family
- Limited resources-family unable to travel to see specialist or no providers in network
- Early detection and treatment improve prognosis
- With tools/training primary care providers can feel comfortable managing medical aspects of ED care or managing until patient is able to see a specialist or for higher level of care
- If unsure-reach out/e-consult specialist

Behaviors likely to escalate and get worse with time; goal is to guide families in right direction while awaiting further care

Screening Tools

SCOFF

- Do you make yourself Sick eating too much?
- Do you worry you have lost Control with eating?
- Have you lost more than One stone (14lbs)?
- Do you believe you are Fat?
- Would you say Food dominates your life?

EATING DISORDER SCREEN FOR PRIMARY CARE

- Are you satisfied with your eating patterns?
- Do you ever eat in secret?
- Does your weight affect the way you feel about yourself?
- Have members of your family had an eating disorder?
- Do you or have you had an eating disorder?

GROWTH CHARTS!

General Work Up for New Diagnosis-Use your judgement

- CMP +Mag +Phos
- CBC
- Ferritin
- TSH
- Vitamin D
- *B12*
- *Urine pregnancy*
- *Estradiol*
- *Prolactin/LH/FSH*
- *Testosterone Level*
- EKG
- *Celiac Panel*
- *Inflammatory Markers*
- *UA*
- *Amylase*

When is outpatient care not appropriate?

TABLE 6 Indications Supporting Hospitalization in an Adolescent With an Eating Disorder

One or More of the Following Justify Hospitalization
1. ≤75% median BMI for age and sex (percent median BMI calculated as patient BMI/50th percentile BMI for age and sex in reference population × 100)
2. Dehydration
3. Electrolyte disturbance (hypokalemia, hyponatremia, hypophosphatemia)
4. ECG abnormalities (eg, prolonged QTc or severe bradycardia)
5. Physiologic instability:
a. Severe bradycardia (HR <50 beats per min daytime; <45 beats per min at night);
b. Hypotension (90/45 mm Hg);
c. Hypothermia (body temperature <96°F, 35.6°C);
d. Orthostatic increase in pulse (>20 beats per min) or decrease in BP (>20 mm Hg systolic or >10 mm Hg diastolic)
6. Arrested growth and development
7. Failure of outpatient treatment
8. Acute food refusal
9. Uncontrollable binge eating and purging
10. Acute medical complications of malnutrition (eg, syncope, seizures, cardiac failure, pancreatitis and so forth)
11. Comorbid psychiatric or medical condition that prohibits or limits appropriate outpatient treatment (eg, severe depression, suicidal ideation, obsessive-compulsive disorder, type 1 diabetes mellitus)

Reprinted with permission from the Society for Adolescent Health and Medicine.[85] ECG, electrocardiogram.

Anorexia Nervosa-DSM V

- Restricted caloric intake relative to energy requirements, leading to significantly low body weight for age, sex, projected growth, and physical health
- Intense fear of gaining weight or behaviors that consistently interfere with weight gain, despite being at a significantly low weight. *Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected (e.g., falling off a previously followed growth curve).*
- Altered perception of one's body weight or shape, excessive influence of body weight or shape on self-value, or persistent lack of acknowledgment of the seriousness of one's low body weight.
- Restricting type
- Binge-eating/purging type

Changes from older criterion

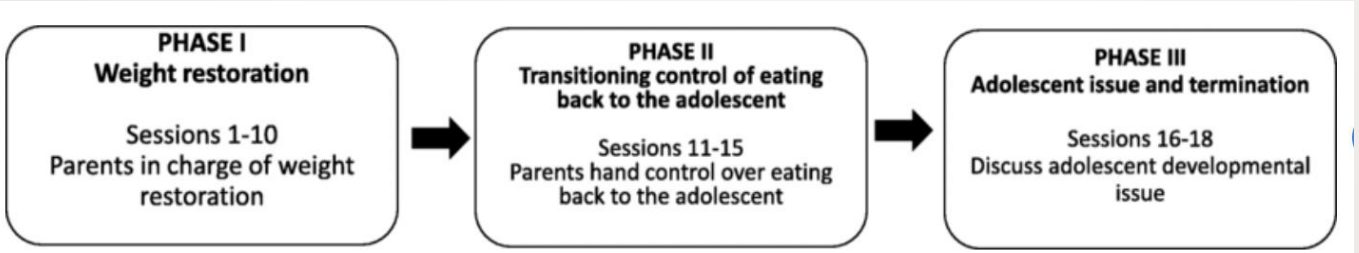
Not present in diagnostic criteria:

- Requirement for amenorrhea,
- No specific weight criterion (i.e. < 85% expected body weight)

Eating Disorders are defined by behaviors, not weight!

Family Based Treatment

- Family Based Therapy (The Maudsley Approach)
  - Has parents take full control of all aspects of their child's eating with guidance of multidisciplinary team
  - The evidence-based treatment for anorexia nervosa



The three phases of family-based treatment

Family Based Treatment in Primary Care

Phase 1: Rapid restoration of physical health, orchestrated by parents

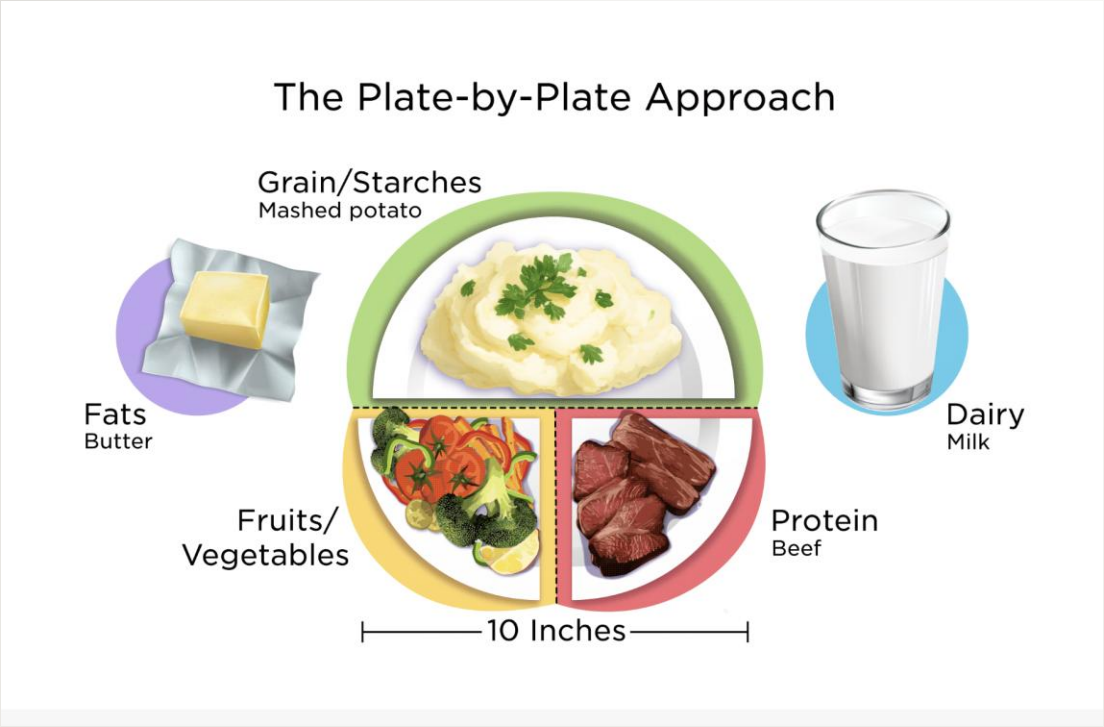
- Decisions about eating are temporarily taken out of patient's hands and given to parents.
- Parents fully in charge of all aspects of eating (menu planning, portioning food, meal/snack time, monitoring ALL food intake)
- Careful calorie counting/measuring is not necessary (follow general meal plan)
- Visits every 1-2 weeks with medical provider
- Treatment Team's Job→ Coach Parents
- Give parents easy nutritional goals while awaiting formal dietician input

Family Based Treatment in Primary Care

- All food is healthy and can be fit into meal plan (it should be flexible)
  - Redefine what "healthy" means for your family
- Re-introduction of fear foods is critical
- Easing into treatment prolongs recovery and decreasing chance of full recovery
- Patient should not be involved in any aspect of food preparation or food shopping
- Do not expect the patient to make good decisions about food
- Eating disorder is externalized from the patient

- Side effects from malnutrition (bloating, constipation, mood disturbances if not present prior to ED) will resolve with food!
  - Symptom management at discretion of provider

Plate by Plate Approach



- ½ starches or grains
- ¼ fruits and vegetables
- ¼ protein
- A caloric beverage such as milk
- Fats such as oils/butter

- Plan for 3 meals and 2 to 3 snacks a day
- No more than 3 to 4 hours without a meal or snack.
- Fill the plate. If there's still room on the plate after adding all food groups, fill it up with more food.
- Aim for variety.

Rule of 3s (and 4s)

- Eat 3 meals and up to 3 snacks every day
- Eat at least every 3 hours
- Eat at least 3-4 food groups per meal

Family Based Treatment in Primary Care

- This will not work if a patient does not have a supportive home environment or caregivers who are willing to intervene
- If no supports available at home-work directly with patient-benefit from structure
- Consider higher level of care where they will have more support in initial refeeding phase

Bulimia Nervosa- Criteria

- Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
  - Eating, in a discrete period of time (e.g., within a two hour period), an amount of food that is definitely larger than what most people would eat during a similar period of time and under similar circumstances.
  - Lack of control over eating during the episode (e.g., a feeling that you cannot stop eating, or control what or how much you are eating).
- Recurrent inappropriate compensatory behavior 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 behaviors both occur, on average, at least once a week for three months.
- Self-evaluation is unduly influenced by body shape and weight.
- Binging or purging does not occur exclusively during episodes of behavior that would be common in those with anorexia nervosa.

Bulimia Nervosa Treatment in Primary Care

- CBT is mainstay of treatment
  - Some use for DBT/FBT-B
- More evidence for medication compared to anorexia
  - Fluoxetine (any SSRI)
  - Topamax
- Need to break cycle of binge/purge/restriction
  - Families often can play a key part in this (adapted FBT)
  - Remove binge trigger foods from house
  - If possible eat meals as family-do not allow food in bedroom
  - Monitoring post meals
- H2 Blocker - evidence?

Binge Eating Disorder-Criteria

- Recurring episodes of binge eating characterized by both of the following:
  - Eating, in a discrete period of time, an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances
  - 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)
- Binge-eating episodes are associated with three (or more) of the following:
  - Eating much more rapidly than normal
  - Eating until feeling uncomfortably full
  - Eating large amounts of food when not feeling physically hungry
  - Eating alone because of being embarrassed by how much one is eating
  - Feeling disgusted with oneself, depressed, or very guilty after overeating
- Binge episodes average at least once a week for three months

Binge Eating Disorder Treatment

- Behavioral Changes:
  - Limit access to binge triggers
  - No food in bedroom
  - Consider locking cabinets overnight
  - Eating regularly throughout the day
- CBT (1st line) & DBT
- Pharmacotherapy-all second line to therapy
  - SSRIs (not likely to cause weight gain in setting of BED)
  - Topiramate
  - Lisdexamfetamine (Vyvanse)

No head-to-head trials have compared SSRIs with topiramate or lisdexamfetamine

Avoidant Restrictive Food Intake Disorder (ARFID)

- An eating or feeding disturbance as manifested by persistent failure to meet appropriate nutritional and/or energy needs associated with one (or more) of the following:
  - Significant weight loss (or failure to achieve expected weight gain or faltering growth in children)
  - Significant nutritional deficiency.
  - Dependence on enteral feeding or oral nutritional supplements.
  - Marked interference with psychosocial functioning.
- The eating disturbance is not attributable to a concurrent medical condition or not better explained by another mental disorder. When the eating disturbance occurs in the context of another mental disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.
- The disturbance is not better explained by lack of available food or by an associated culturally sanctioned practice.
- The eating disturbance does not occur exclusively during the course of anorexia nervosa or bulimia nervosa, **and there is no evidence of a disturbance in the way in which one's body weight or shape is experienced.**

ARFID Treatment

- Initial treatment has similar goals to AN in that first focus is on renourishment
- FBT is used but not as well studied
- In FBT-ARFID: focus of treatment is on helping parents increase the types and variety of food consumed by the patient.
- Allow initial increase in quantity with “safe foods” with gradual planned introduction of new foods (a lot of visit)
- Emphasis on educating the parents about the factors unique to ARFID

South Portland Adolescent Medicine-Eating Disorder Clinic

- 4 Adolescent Medicine Doctors
- 1 Registered Dietician specialized in treatment eating disorders
- Looking for a new behavioral health provider

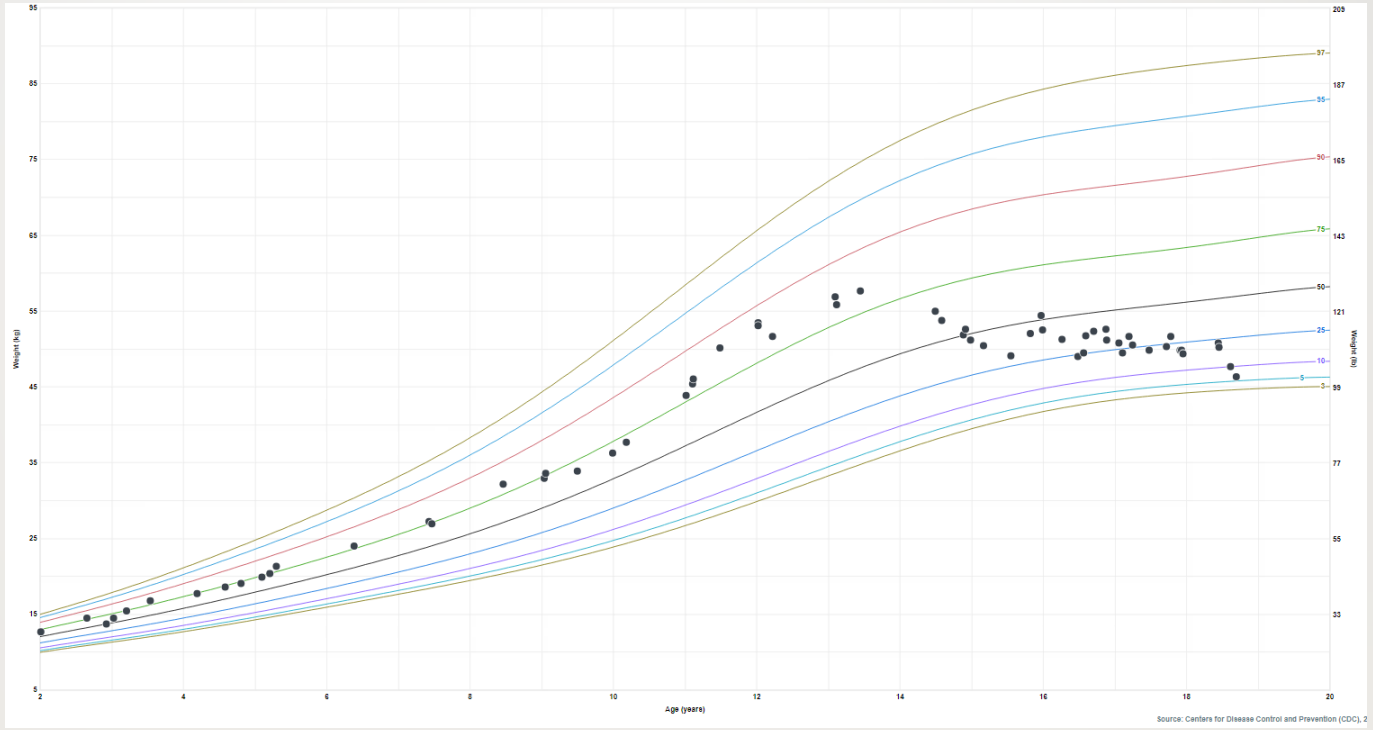
Local Resources

- Multiple mental health providers – virtual or in person
- Kaleidoscope, CV well being - dieticians
- South Portland Adolescent and Young Adult Medicine/Maine Medical Clinic
- EQUIP (nationwide)– virtual PHPs
- Walden Eating Disorder Program – closest residential
- Barbara Bush Children's Hospital – hospitalization for medical stability (can use S Portland Providers for assistance)

Case Presentation

- Patient is a 18 yo female who are seeing in your office for evaluation of weight loss and abdominal pain. She describes epigastric abdominal pain and bloating present over the past 2 months that is associated with nausea and occasional NBNB vomiting
- She has been seen in the ED x2 in past 2 months; work up there included a normal RUQUS, normal LFTs and lipase and normal electrolytes.
- She notably has lost 30 lbs over the past 2 years which she attributes to symptoms of lack of appetite, increased anxiety, and more recently bloating.
- She had been smoking marijuana multiple times a day for the past 3 months but has been cutting back since ED visit 2 weeks ago when she was told it could be making her symptoms worse.
- She finds the weight loss distressing and says she would like help gaining weight.

Growth Chart



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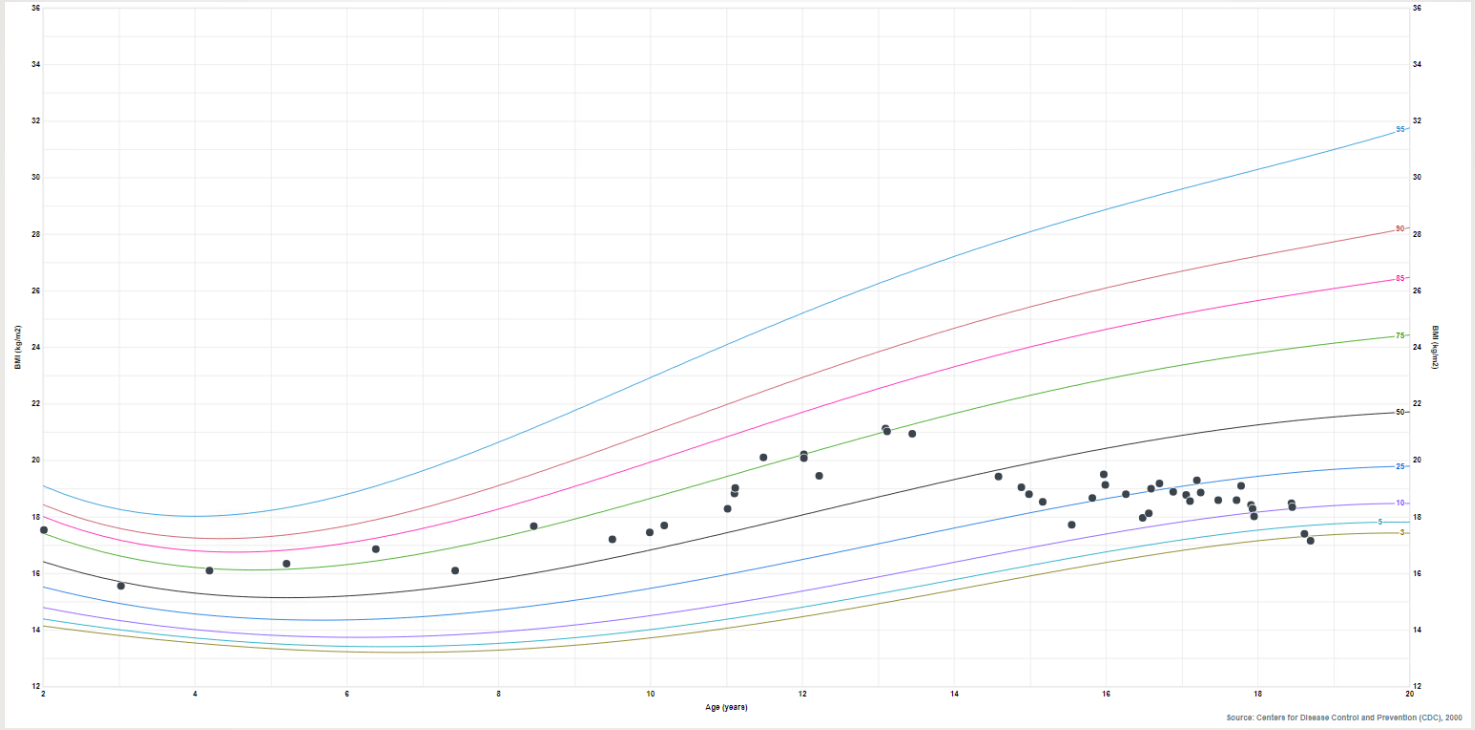

Further Clinical Information

- When asked further about weight loss:
  - She denies counting calories, weighing herself, denies wanting to lose weight in fact says she feels very upset about her body, used to be muscular and strong, would like gain back weight and feels her current weight very upsetting, ideal weight unknown but says she would like to be at least ~130lbs

  24 hr recall:

  - B: Dunkin-egg and cheese wrap, hash browns and donut
  - S: Blackberries, cheesy bread
  - D: Pizza- 3 slices of pepperoni

  Typical day: yes

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