UCSF Health
Eating Disorders Program

Eating Disorders in Primary Care

Amanda Downey, MD
Assistant Professor
Departments of Pediatrics and Psychiatry & Behavioral Sciences

Erin C. Accurso, PhD
Associate Professor
Department of Psychiatry & Behavioral Sciences

No one involved in the planning or presentation of this activity has any relevant financial relationships with a commercial interest to disclose.

Compared to other patients I see in my practice, I generally enjoy working with patients with eating disorders.

Strongly Disagree ……. Neither Agree nor Disagree ……. Strongly Agree

Currently, how comfortable are you with treating eating disorders?

Extremely Uncomfortable …….. Neither Comfortable nor Uncomfortable …….. Extremely Comfortable

How confident are you in treating eating disorders?

Extremely Unconfident ……. Neither Confident nor Unconfident ……. Extremely Confident

Eating disorders lead to severe medical consequences, including death

Mortality in Anorexia Nervosa

- Individuals with EDs have significantly elevated mortality rates (6-8%)
- AN has one of the highest mortality rates of the psychiatric disorders
  - More than double that of schizophrenia and almost triple that of bipolar or major depressive disorder
- About one-third of deaths in AN are due to heart problems and one-fifth to suicide

Arcelus et al., 2011; Osby et al., 2000; Deter et al., 2005

Psychological eating disorder symptoms are heavily influenced by **malnutrition**

Evolving Diagnoses

- Anorexia Nervosa
- Atypical Anorexia Nervosa (OSFED)
- Bulimia Nervosa
- ARFID
- Binge Eating Disorder
- More!

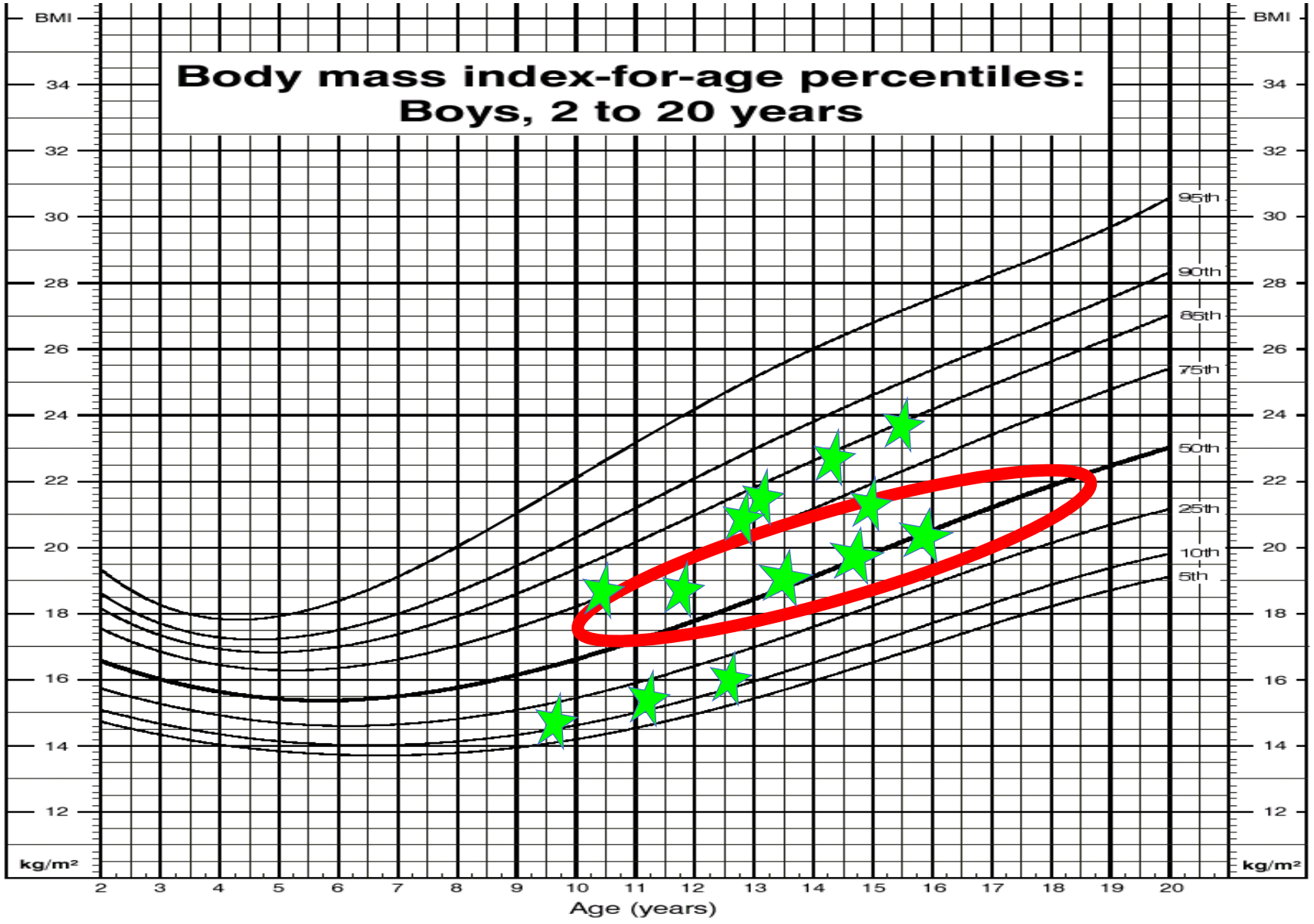
A diagnosis is not necessary!

- Identify concerning growth patterns
- Identify concerning behaviors
- Initial medical management including caregiver involvement
- Facilitate referrals

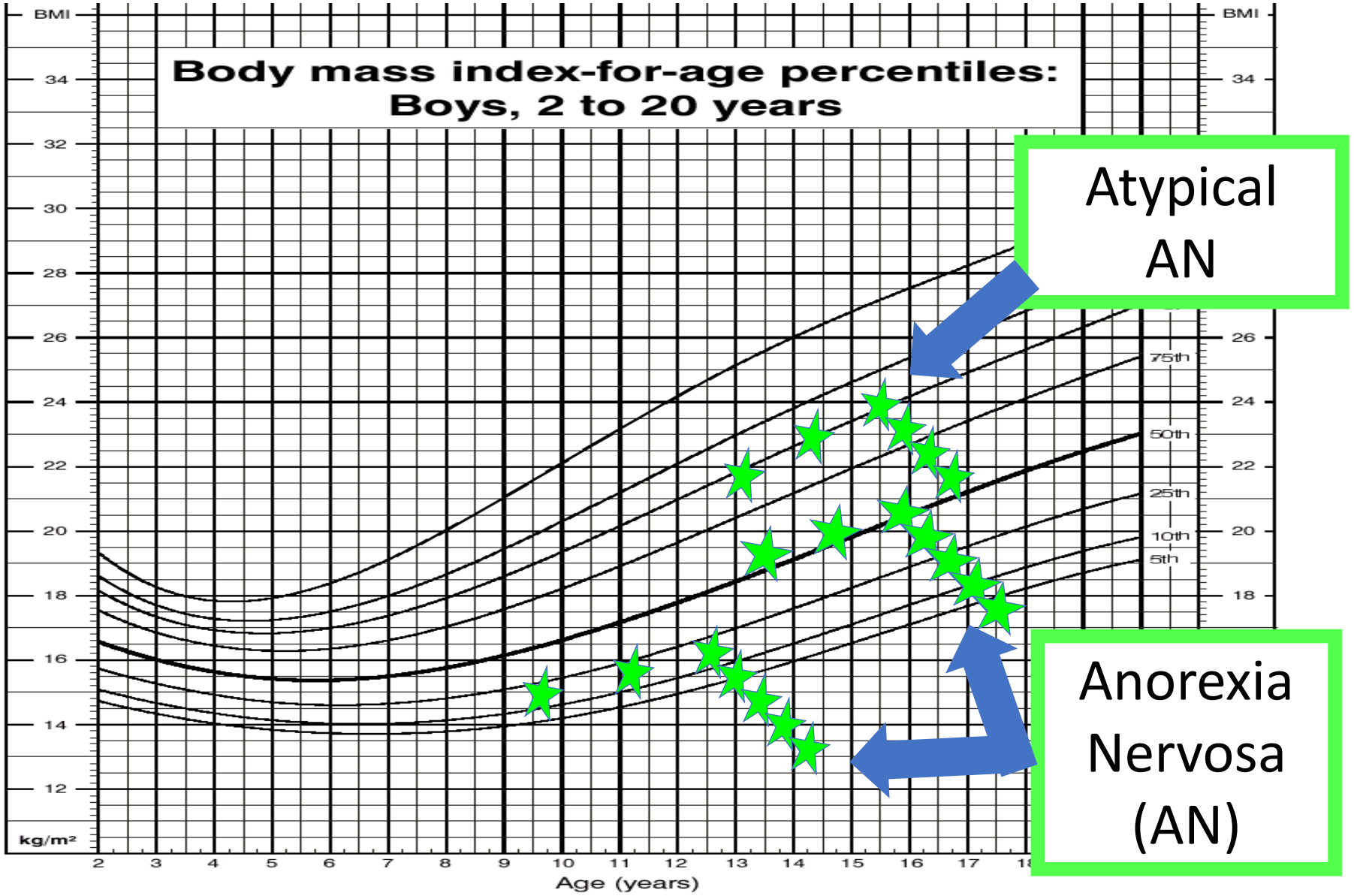
Screening Questions

- How is your eating/nutrition?
- How important to you is what you eat?
- Are you on a diet? Tell me about what led you to start dieting
  - Determine goal (weight loss, health, athletic performance, etc)
- Have you lost any weight recently? How much? With what goal or intent?
- How do you feel about your body? How do you feel about your weight? Any concerns about your weight or shape?

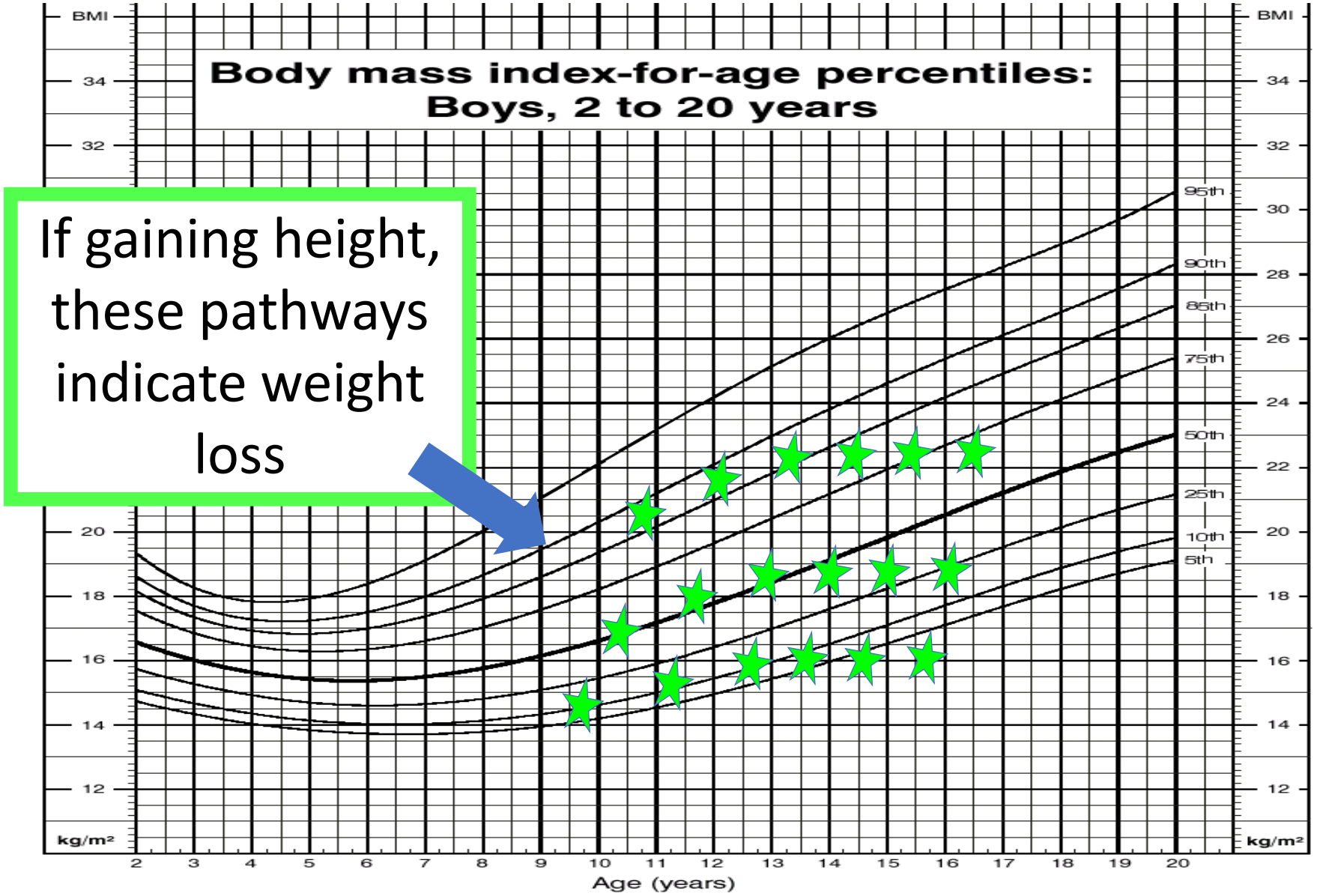
Normal growth takes many shapes



🚩 Concern: Falling off BMI curve



🚩 Concern: Flat BMI curve



If gaining height, these pathways indicate weight loss

Weight loss indicating malnutrition

	Mild	Moderate	Severe
% mBMI*	80-90%	70-79%	<70%
BMI Z-score	-1 to -1.9	-2 to -2.9	-3 or greater
Weight Loss**	>10% body mass loss	>15% body mass loss	> 20% body mass loss

* Percent median BMI

** Rapid weight loss may place a patient at increased risk of medical complications and increase severity of malnutrition

[SAHM Position 2015]

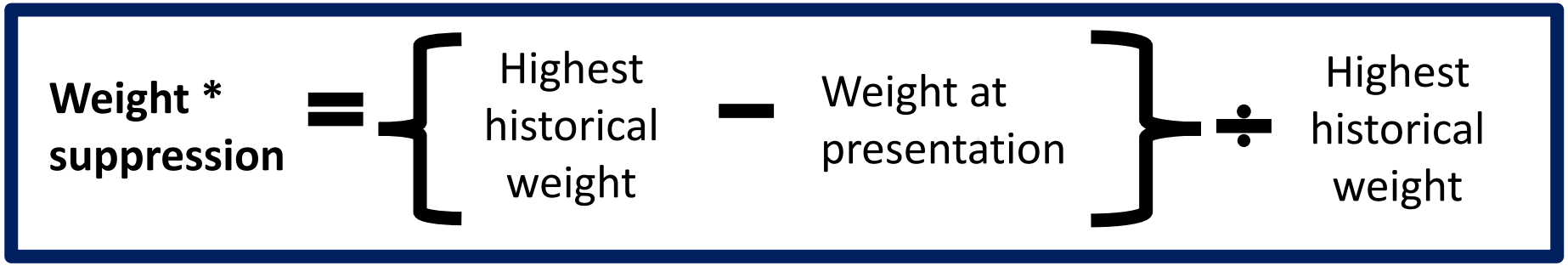
Weight Suppression

Comparing Jill (AN) to Jane (Atypical AN)

- Two girls with weight loss due to ED
- Both are 16 yr. old and 65 inches tall
- Both have lost "significant weight" via restriction, diet pills, purging, and excessive exercise
- **Jill (AN):** 125 → 85#, BMI 14.2 kg/m^2 = 40# loss
- **Jane (AAN):** 260 → 128#, BMI 21.3 kg/m^2 = 132# loss

Are these girls equally malnourished?

Weight Suppression



Jill (AN)

125 ⟶ 85 lbs = 40# loss, **32%** suppressed

Jane (Atypical AN)

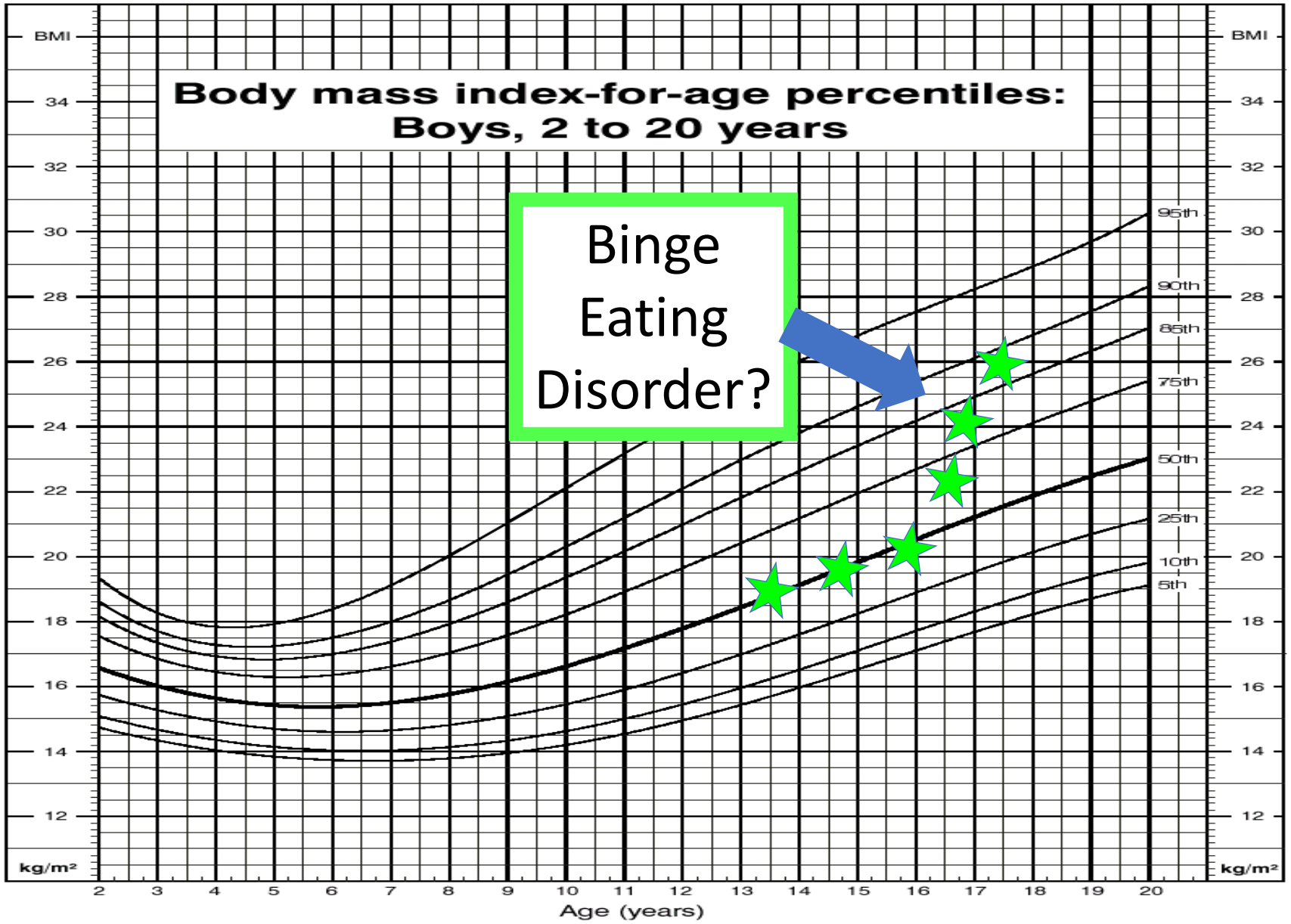
260 ⟶ 128 lbs = 132# loss, **51%** suppressed

Weight suppression predicts illness severity

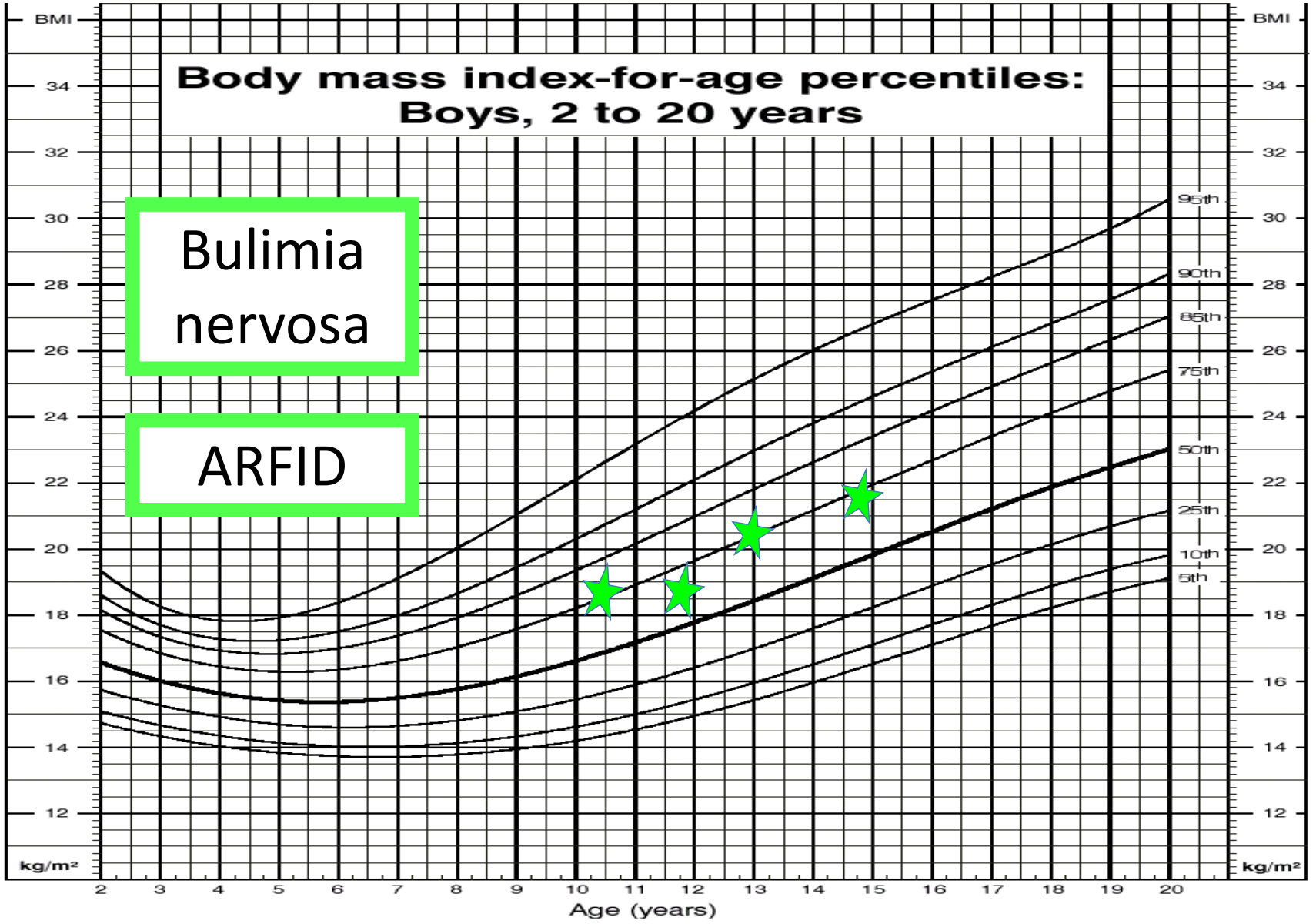
Patients with greater weight suppression have:

- Lower heart rates (weight suppression, not admit %mBMI, associated with lowest 48-hr HR) [Garber 2015]
- Persistent amenorrhea [Seetharaman, Golden et al. 2017]
- Lower T3 [Aschettino-Manevitz 2012]
- Worse ED psychopathology [Lavender 2015; Berner 2013]

Rapid Weight Gain

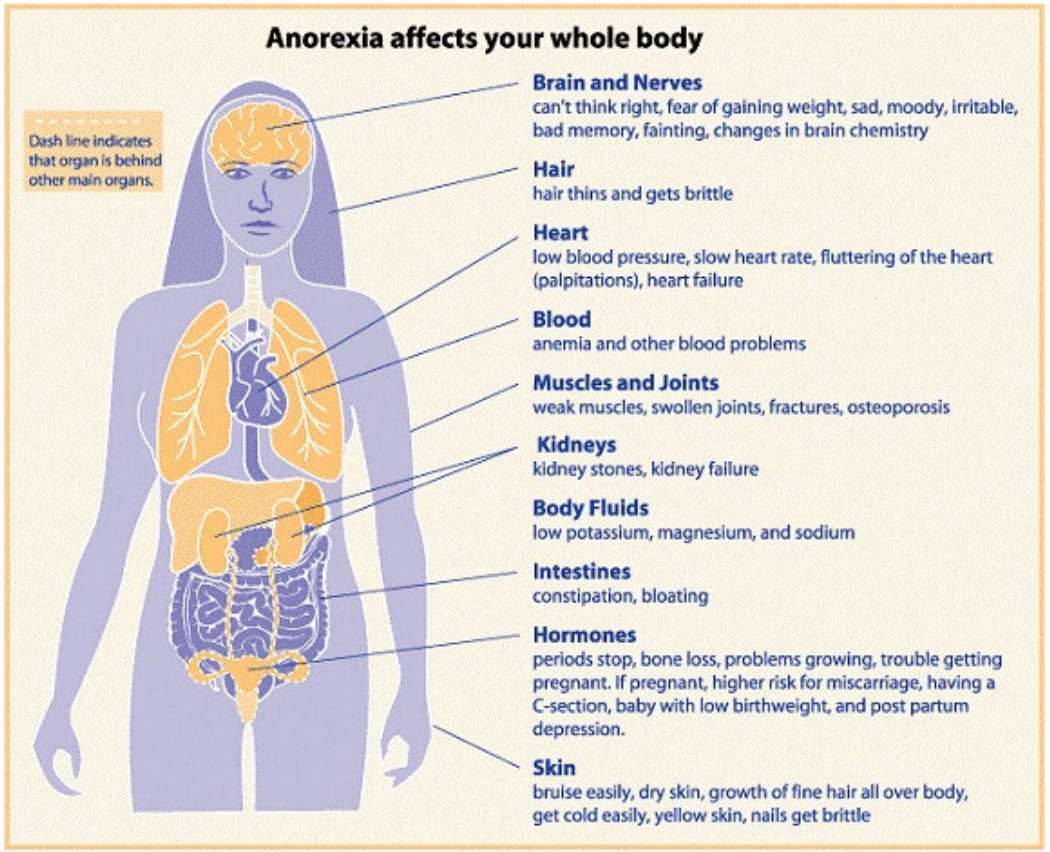


Normal growth does not rule out an eating disorder



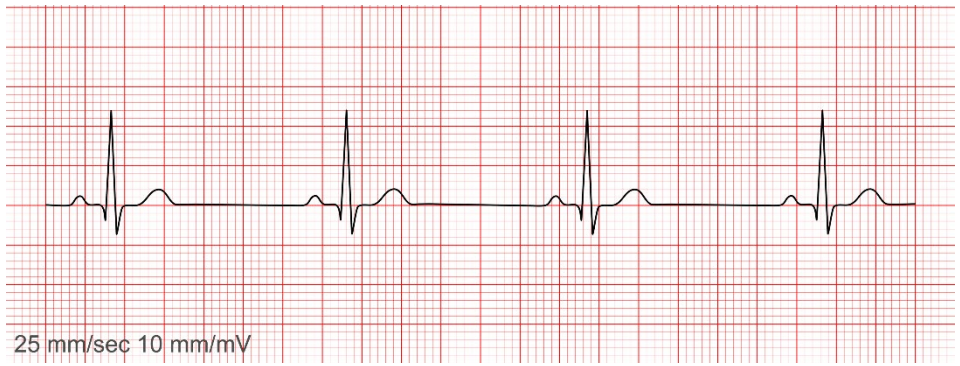
Medical Evaluation

- Height and weight (in a gown)
- Vitals including orthostatics
- History and physical exam
- Careful review of growth charts
- EKG
- Laboratory evaluation
- Referrals and follow up



Medical Tests

- EKG (sinus bradycardia, prolonged QTc, arrhythmia)
- Initial labs (CBC, CMP, Mag, Phos, Lipid Panel, ESR/CRP, TTG/IgA, Zinc, Vitamin D, TSH)
- Urine sample (specific gravity, pH, UDS, hcg)
- Dual-energy X-ray absorptiometry (DXA) scans when amenorrhea is present for at least 6 months



Primary Care Treatment

- Food is the best medicine
- Mobilize caregiver involvement
- Medically stabilize abnormal vital signs and electrolytes
- Carefully monitor growth and development
- Establish clear roles with team members and “stay in your lane”

Treatment Goal Weights

- Treatment goal weight (TGW) is a personalized, estimated target weight range for optimal recovery based on available growth records that takes into account normal expected growth in the next 12 months.
- **Return to historical growth trajectory (BMI) from age 4 on**
- If there is a lot of variation in growth history, consider what eating was like at various points (e.g., disordered eating, food insecurity) or weight at last menses
- If well above the growth curve (e.g., >99th percentile for BMI) and losing weight, minimum goal is no further weight loss

Treatment Goal Weights

Atypical AN

Treatment Cadence

- If under treatment goal weight, frequent follow-up for weight check and vital signs until in TGW range or care established in an eating disorder program
  - Follow-ups every 1-2 weeks
- May space out visits once gaining weight steadily, in TGW range, or established with multidisciplinary team
- Touchpoint with family to empower caregivers with seriousness of illness and their critical role in recovery

Supporting Weight Gain

- For weight gain, **aim for at least 1-2 lbs of weight gain per week**.
  - Some reputable eating disorders outpatient programs aim for 3-4 lbs per week.
  - Many individuals **require ≈2500-5000 kcal/day** to achieve this goal due to metabolic changes during nutritional rehabilitation!
- Recommend **3 meals per day and 3 snacks**
  - Each meal/snack should include a caloric beverage (e.g., milk, juice)
  - Snacks should be like small meals and contain more than one food group
  - No diet foods (i.e., no sugar-free, low-carb, low-fat, or non-fat foods)
  - Favor calorically dense foods (fats, proteins, carbs)

Nutrition Tips

- Increase caloric density (when weight gain is needed)
  - Increase fats (oil/butter/cream, mayo, avocado, whole milk products like cheese/sour cream/ice cream)
  - Dense toppings (e.g., dried fruit/nuts/granola, honey/Nutella, etc)
  - Fruit/veggies as garnish or as a “vehicle” for fats (e.g., apples and peanut butter, carrots and dip) to minimize fullness and abdominal discomfort
- Regardless of need for weight gain or maintenance, counsel on regular (3 meals + 2-3 snacks) balanced eating that incorporates all food groups
- Food doesn’t have moral value (not “healthy” vs. “unhealthy”)
- Ultimately work towards food variety

Counseling Caregiver(s)

- **Caregiver(s) are 100% in charge** of preparing and plating meals/snacks, and ideally supervised by caregiver(s) or a trusted adult
- Limit negotiation and discussion around meals and snacks; limit child's presence in kitchen during meal preparation to limit negotiation
- Encourage caregivers to feed their child the foods that their family has always eaten
- Patient should return to all foods eaten prior to eating disorder onset
- Families do not need to eat the same portions as the patient

Counseling on timing and types of foods is often sufficient. If weight gain does not follow, then next steps are to increase amount and/or density.

Psychopharmacology: Evidence Is Minimal

- Difficult to recruit
- Patients are medically fragile
- Nutritional deficiencies may affect medication response
- What are we targeting with medications?

Hospitalization Criteria

- **Bradycardia**: HR <50 daytime, <45 at night
- **Hypotension**: BP <90/45 mmHg
- **Hypothermia**: Temp <96° F
- **Orthostasis**: Increase in pulse (>40 bpm) or decrease in BP (>20 mmHg systolic, >10 mmHg diastolic) and symptomatic
- **Weight**: <75% expected body weight or ongoing weight loss despite intensive management

Hospitalization Criteria

- **Acute food refusal**: severe and/or prolonged food refusal
- **EKG abnormalities**: e.g., prolonged QTc
- **Electrolyte abnormalities**: low potassium, phosphorus, magnesium, sodium, glucose
- **Other acute symptoms**: syncope, esophageal tears, intractable vomiting, hematemesis

Walking the Tightrope in Primary Care

- Adolescents who diet are at higher risk for developing an ED
- Even when not intentional, **weight loss precipitates onset of ED**
- Focus on healthy balanced behaviors vs. weight goals
- Instead of restriction/calorie counting, **focus on regular eating with treats in moderation** (don't cut out entire food groups)

Walking the Tightrope in Primary Care

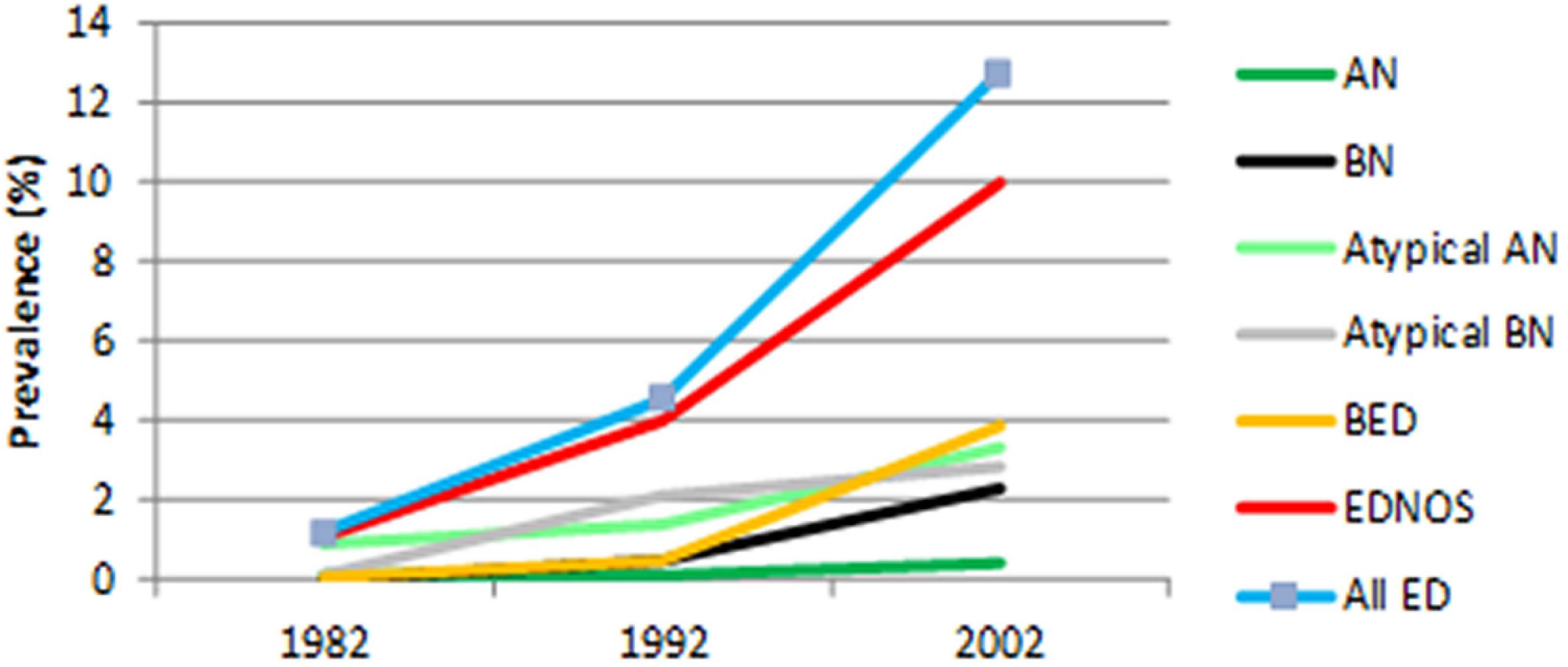
- Eating meals together as a family (mindful eating, social connection, not in front of a screen or with other distractions)
- Incorporating **purposeful joyful movement**
  - Not with the goal of weight loss/body mass change
- Positively **reinforce behavioral change** versus weight loss
- Critical ramifications of weight stigma in medicine

If → Then Scenarios

- Acute weight loss (≥5 lbs in one month) → BMP, Mag, Phos
- Caregivers disempowered or facing barriers → Consider HLOC
- Acute weight gain (≥5 lbs in one week) → BMP, Mag, Phos, spec grav, check for edema
- Abdominal pain/constipation → Non stimulant bowel regimen, metoclopramide
- Intense body dysmorphia interfering → Remove scales, cover mirrors

Eating disorders transcend race, ethnicity, gender identity, sexual orientation, age, socioeconomic status, body shape or size…

Prevalence Rates



Connecting with Mental Health Care

- High patient demand and limited services available since few providers have eating disorders expertise
- Providers with expertise who accept insurance are few and far between
- Caregivers often feel frustrated trying to connect to services
- Medical follow-ups fill a critical gap in “holding the urgency,” checking in on progress, problem-solving, and providing encouragement and support, especially while still connecting to mental health

It's normal for your patient to think that they're doing fine, that everyone is overreacting, and that treatment is not necessary.

That is OK. The treatment plan can move forward regardless…

Behavioral Targets for Adolescents

- Emphasis on **behavioral recovery** rather than insight or cognitive change
- Family-based approaches are best supported by the evidence
  - Indirectly improves family functioning and reduces adolescent eating related cognitive distortions
  - Being firm with the ED and treatment plan can mean less rapport
  - Adolescents (particularly in the initial stages of family-based treatment—FBT) may not like their therapist very much

Treatment Goals

- Weight restoration or stabilization
- Normalization of eating patterns (regular, sufficient amounts, increase variety)
- Cessation of binge eating and compensatory behaviors
- Reduced weight/shape concerns; body acceptance

Weight is just one aspect of recovery, but often coincides with a recovered mind state

Treatment Team

- **Therapist** - individual or family therapy
- **Medical provider** - monitoring and treatment, gown weights, support therapy, hospitalize if necessary
- **Dietitian** - nutrition counseling
- **Caregiver(s)** - hold ultimate responsibility for implementing the treatment plan at home

Family-Based Treatment

- First-line therapy for youth with eating disorders across the diagnostic spectrum
- Places caregivers at the center of treatment
  - Parents are initially charged with renourishment; food as medicine
  - Most evidence-based treatment models for young people have significant caregiver involvement given low adolescent readiness/capacity for change
- Treatment usually takes about one year
- Adolescents may not like their therapist very much

Ways to Partner with the Treatment Team

- Communicate with rest of treatment team to see how medical management can support ongoing treatment goals
- Involve caregivers or loved ones, whenever possible
  - Support caregiver efforts to provide regular meals/snacks (3 meals + 2-3 snacks, depending on need for weight gain or maintenance)
  - Empower caregivers to do what they know is necessary; most caregivers have excellent instincts about their child's nutritional/rest needs
- Provide psychoeducation to families about EDs and convey urgency, if ED behaviors are present and/or weight is below TGW

The treatment model for *other health concerns* often involves engaging with patients and empowering them to take charge of their own health. **This is flipped to caregiver(s) in the context of an eating disorder.**

Indications for Higher Level of Care

- Failure of outpatient treatment (usually trial of at least 3 months, reasonable to continue with outpatient care if patient is not yet progressing but also not deteriorating)
- Lack of sufficient structure to make appropriate progress in outpatient care (e.g., caregivers not available or able to provide level of structure/support needed, and individual treatment is not indicated)
- Severe psychiatric comorbidity that cannot be well-managed in outpatient care (e.g., substance use, suicidality)

Important Truths about Eating Disorders

- Eating disorders can present at any weight across the spectrum
- Eating disorders are not choices, but serious biologically influenced illnesses
- Treatment does not rely on the patient's desire or willingness to recover
- Families are not to blame but rather critical allies in treatment
- **Recovery is possible**

Resources & Referrals (See Guides)

- Access to several guides that include tips on detection, weight gain and nutrition, how to support people with an ED, resources for families, and referrals
  - Quick Reference Sheet on EDs for PCPs
  - Comprehensive Guide on EDs for PCPs
  - Guide on EDs for Caregivers
- Medi-Cal is county-specific for mental health, and ED resources vary by county
- Virtual treatment and higher level of care
  - Equip Health (virtual FBT-informed outpatient care)
  - Within Health (virtual IOP and PHP)
  - Clementine (Residential programs in Southern CA and Portland OR)

We Want Your Input!!!

- We are looking to talk with PCPs who work with young people about their experiences around eating disorders care.
- Participate in a 20-minute interview about your practice and earn $50 for your time! http://tiny.ucsf.edu/providerscreener
- Any questions? Contact Siena Vendlinski at siena.vendlinski@ucsf.edu

Thank you!