Our Patients Deserve Better:
Understanding eating disorders and targeting ways to improve

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PRISMA HEALTH®

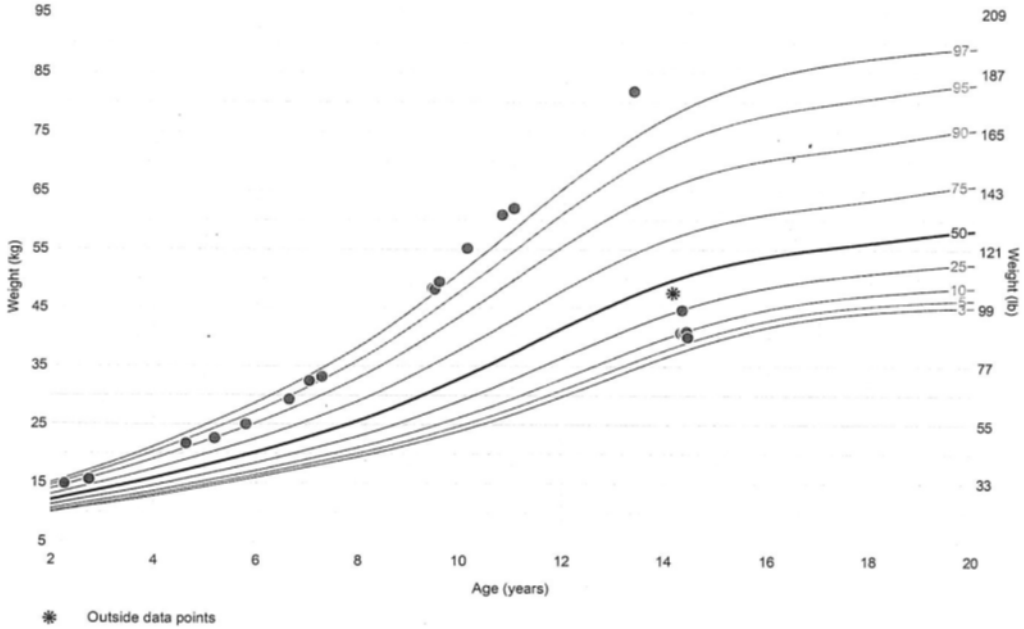
Disclosures

- Non-Financial Relationships
  - Board Member for Just Say Something
  - President of Pridefest Collaborative (non-profit)
- Financial Relationships
  - Contracted MD with the Girlology/Guyology Program
  - Contracted Nexplanon Trainer with Organon
  - Full Time Employee with Prisma Health Upstate

None of these relationships have an influence or impact on the information presented in today's presentation

Objectives

- Understand the extent of the current eating disorder crisis in South Carolina
- Digest practical ways navigate patients struggling with eating disorders
- Discover and implement solutions to improve the care of those struggling with eating disorders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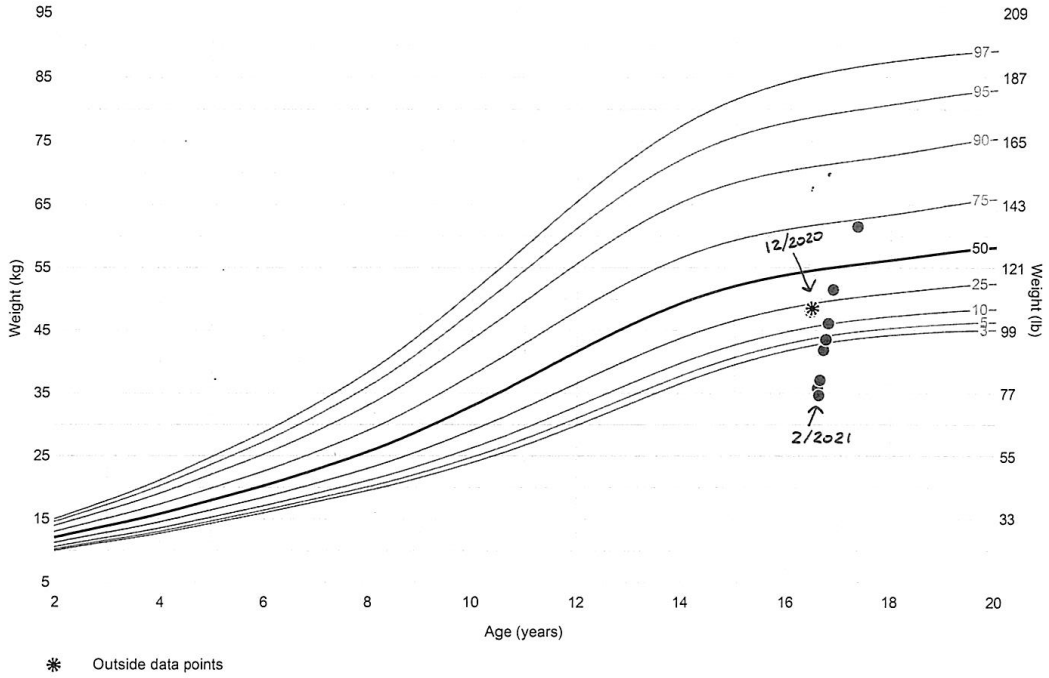
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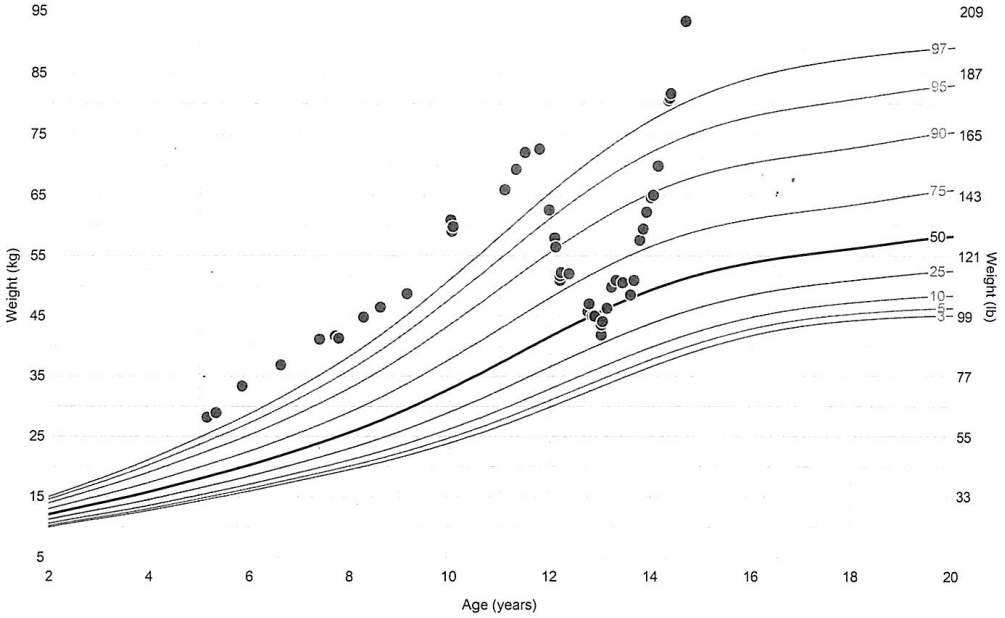
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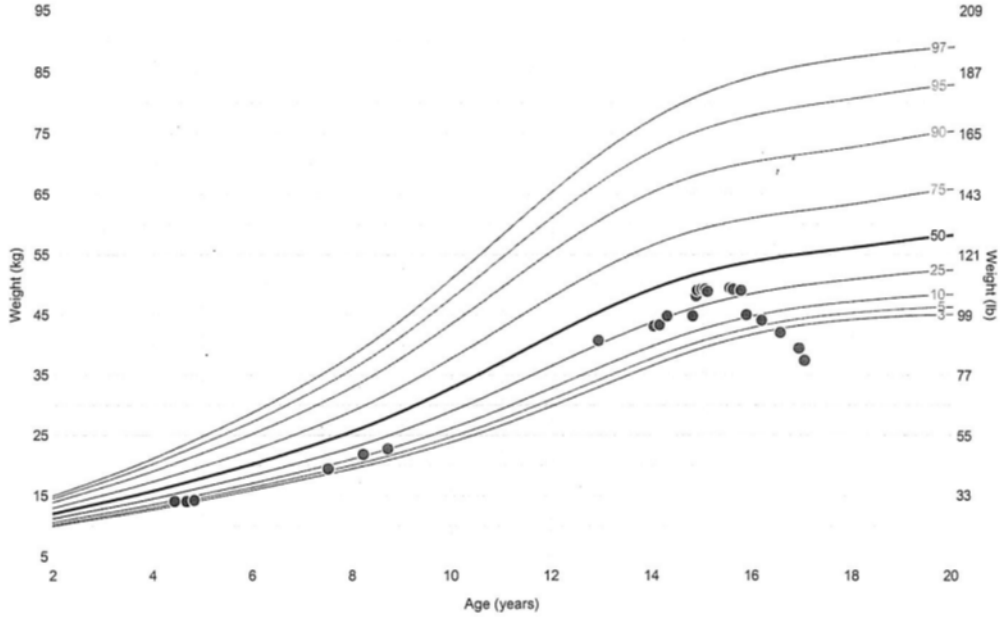
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What's the story?

- Of course, a big part is the struggle with the disease (don't worry, we will get there)

- The often unheard/underestimated story:
  - "We had to wait 3 months to get in to see you"
  - "My doctors told me they were happy I was losing weight finally"
  - "I was told that 'we don't take care of eating disorders'"
  - "I'm scared."

How is this affecting South Carolina

- SC DMH website has not updated their ED stats since 2006[1]
  - Stats are also not specific to SC residents
- Only 2 offices/centers provide specialty medical care for those struggling with an eating disorder
  - Prisma Health Adolescent Medicine
  - Friedman Center for Eating Disorders (MUSC)
- On average, Prisma Health Adolescent Medicine recommends/sends 5-10 patients to out-of-state treatment every month
  - Complete similar number of new evaluations/week
- Highest level of care in SC is Outpatient (IOP at MUSC not accepting new patients at present)

So to Summarize….

Our patients deserve better…

We need to do better…

We need help to do better!

Let's Talk the New Obesity Guidelines[2]

The "Not so Bad"

- Pediatrics 151 (2), Feb 2023
- Significant polarizing debate since publication
- Focus on integration of intensive lifestyle changes through a multidisciplinary program
- Stronger statements related to medical interventions for obesity
- **"Pediatricians should evaluate for disordered eating concerns"**
- **Reminder:**
  - **we have evidence that medical and surgical intervention for morbid oebesity + medical complications is safe and beneficial for kids[19]**

The " Could be Better"

- "Structured and professionally run pediatric obesity treatment is associated with reduced eating disorder prevalence, risk, and symptoms."
- "…multiple studies have demonstrated that, although obesity and self guided dieting consistently place children at high risk for weight fluctuation and disordered eating patterns, participation in structured, supervised weight management programs decreases current/future eating disorder symptoms…"
- Conversation around recommendations around weight loss interventions (medications and surgery) for children <13yo

What's the Rub?

- **Most of the conversation comes down to stigma**
  - By age 6, girls especially start to express concerns about their own weight or shape. 40-60% of elementary school girls (ages 6-12) are concerned about their weight or about becoming too fat. This concern endures through life.[3]

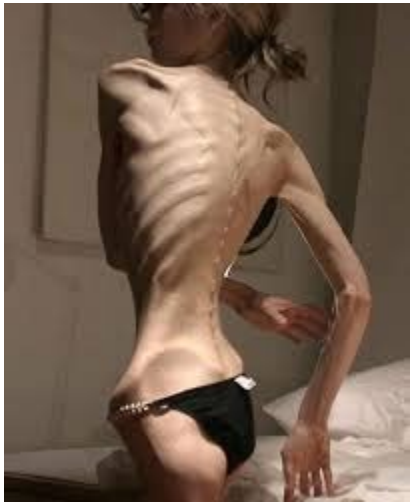
- **Prevalence of eating disorder occurrence far outweighs prevalence of structured obesity programs**
  - 1:7 men and 1:5 women experience an eating disorder by age 40, with 95% of those cases starting by age 25[4]

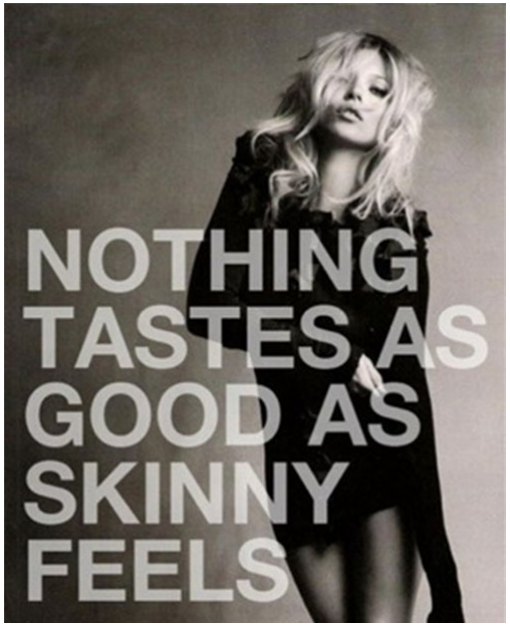
- **Statements made strongly promote referral for weight loss/surgical consultation for those who solely meet the marker of severe obesity**
  - BMI>/= 120% of the 95th percentile for age and sex

Can’t Forget About Other Populations

- **LGB Youth[5]**
  - 9% of those 13-24 have been diagnosed with an eating disorder
  - 4X greater odds of attempting suicide in the past year
- **Transgender Individuals[6]**
  - Lifetime ED diagnosis ranges from 8-14%
  - ~75% of Trans individuals with ED report suicide attempts in the past year
- **Athletes[7]**
  - Up to 45% female and 19% male athletes struggle with an eating disorder

Let’s talk ED





Quick Review of Eating Disorders[8]

Anorexia Nervosa	Bulimia Nervosa	Avoidant/Restrictive Food Intake Disorder	Binge Eating Disorder
PICA	Rumination Disorder	Other Specified Feeding/Eating Disorder (OSFED)	Unspecified Feeding/Eating Disorder (UFED)

Quick Review of Eating Disorders[8]

Active behaviors to lose weight due to distorted body image and fear of gaining weight	Bulimia Nervosa	Avoidant/Restrictive Food Intake Disorder	Binge Eating Disorder
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Significant impact on function from eating non-nutritional items/foods	Rumination Disorder	Other Specified Feeding/Eating Disorder (OSFED)	Unspecified Feeding/Eating Disorder (UFED)

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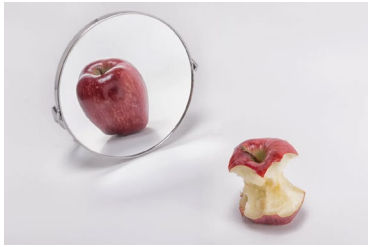
Significant impact on function from eating non-nutritional items/foods	Recurrent episodes of (often) ambivalent regurgitation outside of other eating disorder behaviors	Disordered eating behaviors belonging to a specific collection of disorders (Atypical Anorexia)	Disordered eating behaviors causing functional impact but not consistent with known criteria

General Principles of Care



- **Assess Medical Stability**
  - Vital Sign Assessment
  - Physical Exam Findings
- **Assess Nutritional Stability**
  - 24-72 hour diet recall
- **Assess Severity and Stability of Behaviors**
  - Escalation in behaviors due to a trigger? Sudden changes in otherwise stable behaviors?
- **Assess Risk Factors of Decompensation**
  - Home environment
  - Upcoming Challenges
  - Parental Involvement
- **Assess the level of care needed**[9]
  - Outpatient
  - Intensive Outpatient
  - Partial Hospitalization
  - Residential/Inpatient

Caloric Needs of AYA[10]

Estimated Calorie Needs per Day by Age, Gender, and Activity Level						
	Male			Female		
Age	Sedentary	Moderately Active	Active	Sedentary	Moderately Active	Active
12	1,800	2,200	2,400	1,600	2,000	2,200
13	2,000	2,200	2,600	1,600	2,000	2,200
14	2,000	2,400	2,800	1,800	2,000	2,400
15	2,200	2,600	3,000	1,800	2,000	2,400
16	2,400	2,800	3,200	1,800	2,000	2,400
17	2,400	2,800	3,200	1,800	2,000	2,400
18	2,400	2,800	3,200	1,800	2,000	2,400
19 - 20	2,600	2,800	3,000	2,000	2,200	2,400
21 - 25	2,400	2,800	3,000	2,000	2,200	2,400

General Outpatient management

- **Priority**
  - Assemble the Care Team
    - Medical, Therapeutic, Nutritional, +/- psychiatric
  - Get permission for communication with team
  - Assess parental involvement

- **Consistent visits for metric monitoring +/- nutritional monitoring**
  - Can be a combo of medical and nursing visits
  - 24-hour diet recall every visit unless established with nutrition
  - Anywhere from weekly – every 4 weeks based on level of concern
  - Use IBW to guide progress/concern[18]:
    - *>60 inches:*
      - F: 45.5Kg + (2.3 x every inch >60)
      - M: 50Kg + (2.3 x every inch >60)
    - *<60 inches:*
      - Estimate based on 50th percentile of BMI (or weight alone)

Initial/Baseline Labs[11]

- CBC with differential
- CMP
- Mg
- Phos
- Lipid Profile
- TSH, free T4, T3
- UA
- Prealbumin/Leptin*
- UDS*
- EKG*
- DEXA Scan*
- Pregnancy test*
- Tissue Transglutaminase*
- Serum IgA*
- Vitamin D*
- Hgb A1c*

Discussion with Patient

Discussion with Patient

- Identify and explain diagnosis
- Discuss motivations, desires, and emotions
  - Leads to engagement and rapport
- Give a clear recommendation and discuss
- Encourage negotiation with clear boundary setting
- Finish encounter with a plan and at least 2-3 specific goals

Partnership with Support Group

- Maudsley Method
  - Intensive Outpatient Approach where parents play a constructive, active, and positive role in the adolescent's treatment
- Difficult to encourage with older patients
- Engagement with parents, overall, leads to better prognosis
- If >16yo, legally have to respect patient's desire for confidentiality

Helpful Medications[11]

- **Anorexia, ARFID**
  - SSRI/SNRI
    - Manage Co-morbidities
  - Atarax/Buspar
    - Given at mealtime for associated anxiety
      - Atarax: 10-50mg 3-4 x a day
      - Buspar: 5-15mg TID
  - Reglan
    - Functional (Starvation) Gastroparesis
      - 5-10mg TID with meals
  - Remeron
    - Boost SSRI, sleep/appetite benefit
      - 7.5-15 mg 1 hour before bedtime
  - Zyprexa
    - Disordered thoughts, sleep/appetite benefit
      - 2.5-10 mg 1 hour before bedtime
- **Bulimia**
  - SSRI/SNRI
    - Classically Prozac
  - Atarax/Buspar
    - Give more regularly
- **Binge Eating**
  - Vyvanse
    - 18yo +
    - 50mg – 70mg target

Criteria for Hospitalization[12]

- Unstable/Orthostatic VS
  - HR increase >50bpm
  - BP decrease >30-40mmHg
- Hypotension
  - Any SBP <90 mmHg in the setting of restriction
- Pr0found Bradycardia
  - HR <45 bpm
  - Caution 45-50 bpm
- Hypothermia
  - Temp <97° F

- Refeeding syndrome
- Abnormal EKG
- Acute medical complication of malnutrition (syncope, seizure, cardiac or liver failure, electrolyte disturbance)
- Weight <70% IBW*
- Dehydration*
- Poor response to outpatient treatment/Escalation of behaviors*
- Partial/Total Food Refusal*

Inpatient Management tips

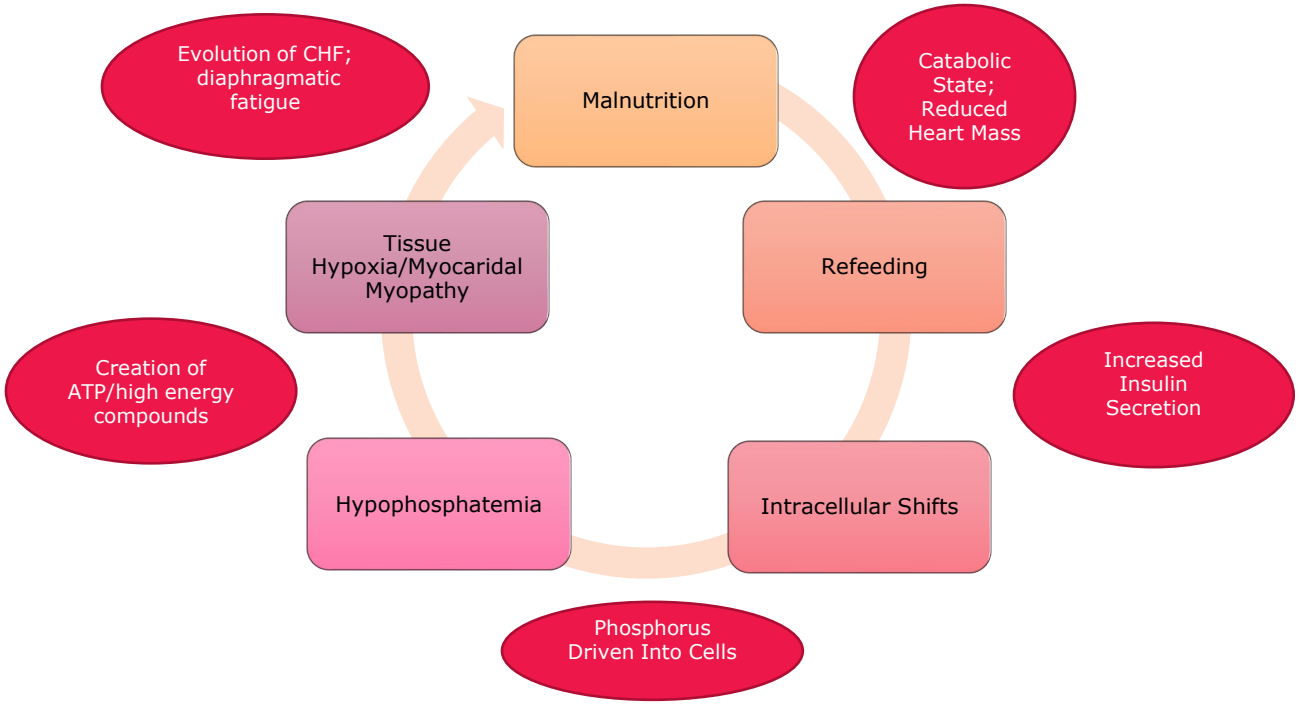
- **Develop systems of support**
  - **Order sets and Protocols**
- Prepare the family prior to admission as much as possible
- Give a general estimate of admission timeframe with the caveats
- Consider NG tube placement early based on progression/motivation
- Consistent and regulated management takes the control away from the disorder
  - Allows it to declare itself
- Document reason for continued hospitalization CLEARLY
  - Medical Instability
  - Nutritional Instability
  - Behavior Instability

What is Refeeding Syndrome?[11]

- Potentially Catastrophic
  - Microscopic alterations leading to macroscopic complications
- Seen in severely malnourished patients during early stages of refeeding
  - Key Player in the Game:

Serum Phosphorus

The Refeeding Syndrome Spiral[11, 13-16]



Complications of Refeeding Syndrome[11, 13-16]

- **Cardiac**
  - Blood Volume increases → increased demand on a weakened heart muscle
  - Cardiac Irritability
  - Arrhythmogenic Potential
  - Edema
- **Further Electrolyte Disturbances**
  - Hypokalemia
  - Hypomagnesemia
- **Neurological**
  - Seizures
- **Hematologic**
  - RBC Hemolysis
- **Musculoskeletal**
  - Skeletal muscle injury/Rhabdomyolysis

Identification of Those At Risk[16]

- **Refeeding Syndrome is 100% PREVENTABLE**
  - Main goal is early identification
  - Incidence of refeeding hypophosphatemia is ~30-40% in those most medically compromised
- **Previous Thinking:**
  - Worry about those who are at significantly low weight at admission
- **Updated Thinking:**
  - Worry about those who have recently lost a significant amount of weight
  - Worry about those who have had a significant total amount of weight loss

Management[17]

- **Measure serum electrolytes (+ Ph and Mg) and correct before refeeding**
  - Caution with Glucose in IVF, but clinical need overrides concern
- **Monitor serum electrolytes (+ Ph and Mg) regularly**
  - At least daily for at 3-5 days then as needed based on symptoms after that
  - Most restrictive patients clear Refeeding Risk in 1-2 weeks.
- **Individualize nutritional rehabilitation**
  - Start refeeding at 30-45 kcal/kg/day
  - Limit protein intake to <2.0 g/kg/day
  - Weight Restoration Goals: 3-4 lbs/week for inpatient, 1-2 lbs/week for outpatient
  - Common to see no/minimal weight gain in the first few weeks

“Sprinkles”

- **Open and Direct Approach**
  - Be clear on when hospitalization will occur
- **Helpful phrases that help with engagement and rapport**
  - 3 C’s: Cause, Cure, and Control (alleviate pressure from patient)
  - The only thing to blame is the eating disorder
  - The ED survives by killing you, and I am not ok with that (pull in parent engagement here)
- **Separate patient from their disorder**
  - Give your ED a name
    - try to avoid family member names ☺
- **Assign “baby steps” to accomplish between visits and allow patient decision making in what these will be**
  - Get rid of the scale
  - Don’t have any days where you go without any nutrition
  - Reduce purging/binging by “X” between now and next visits
- **Validate every feeling patient has**

Let’s Talk Areas to Target

Access to Care	Appropriate Levels of Care	Cohesive Outpatient Support
• Patients with public insurance 1/3 as likely to receive recommended treatment compared to those with private insurance	• Highest level of care in SC is Outpatient	• Many ED treatment providers don’t know each other exist • Specialty level care is often fragmented

What is my vision for Eating Disorder Care in South Carolina

- At least 1 facility with all levels of care
- More comprehensive and more consistent insurance coverage for eating disorder care
  - Specifically, around nutritional services
- More eating disorder research!!!
- Enhanced cross-institutional collaboration
- Streamlined and consistent medical stabilization protocols

Questions?

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