EATING DISORDER QUICK REFERENCE MEDICAL GUIDE

Eating disorders and related concerns are a complex medical issue. Please refer to the following guide to better understand signs to look for, labs to run and when to refer to a higher level of care.

Diagnosing Eating Disorders

Please review the DSM-5 for full diagnostic criteria. Please note, many patients will not meet criteria for Anorexia or Bulimia; however, medical concerns **can be as severe** for someone with Other Specified Feeding or Eating Disorder.

Disorders Include:

- **Anorexia Nervosa** - Restricting behaviors resulting in **low body weight**. Fear of gaining weight. Disturbance in body image.) Specify: Restricting Subtype or Binge/Purge subtype.
- **Bulimia Nervosa** - Recurrent episodes of binge eating. Recurrent episodes of compensatory behaviors (purging, exercise, laxatives, etc). Frequency of at least 1x week/3 months.
- Binge Eating Disorder - Recurrent episodes of binge eating without compensatory behavior. Frequency of at least 1x week/3 months
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- **Avoidant Restrictive Feeding and Eating Disorder** - Avoidance of eating due to sensory aversion to food or fear of consequences of eating resulting in nutritional deficiencies. Desire to lose weight/body images concerns are not present.
- **Pica** - Persistent eating of nonnutritive, nonfood substances over the period of at least 1 month.
- **Rumination Disorder** - Repeated regurgitation of food over the period of at least one month. Regurgitated food may be re-chewed, re-swallowed, or spit out.
- **Other Specified Feeding and Eating Disorder** - Appropriate diagnosis for when symptoms do not meet other criteria but food concerns are noted. Examples: atypical anorexia (not meeting weight requirement) , purging disorder or night eating syndrome.
- **Unspecified Feeding and Eating Disorder** - Appropriate diagnosis for when symptoms do not meet criteria for a feeding and eating disorder and there is not sufficient information to make a specific diagnosis.

Signs to identify

General

- Weight gain or loss
- Fatigue
- Weakness
- Presyncope
- Syncope

Endocrine

- Amenorrhea or oligomenorrhea (absent or irregular menses)
- Loss of libido
- Stress fractures due to low bone mineral density/osteoporosis
- Infertility

Gastrointestinal

- Bloating
- Early fullness
- GI Distress
- Gastroesophageal reflux (heartburn)
- Hematemesis (blood in vomit)
- Hemorrhoids and rectal prolapse
- Constipation

Neuropsychiatric

- Increased depression/anxiety
- OCD or obsessive thinking
- Poor concentration
- Memory loss
- Increased stress
- Difficulties with sleep

Cardio/Respiratory

- Chest pain
- Heart palpitations
- Orthostatic tachycardia/hypotension (low blood pressure)
- Dyspnea (shortness of breath)
- Edema (swelling)

Dermatologic

- Lanugo hair
- Hair loss
- Carotenoderma (yellowish discoloration of skin)
- Russell's sign (Calluses or scars on the back of the hand)
- Poor wound healing
- Dry brittle hair and nails

Labs to run

For all patients:

- Complete blood count (CBC)
- Comprehensive metabolic panel (CMP)
- Urinalysis
- Thyroid function tests
- Testosterone

For additional concerns:

- For Emesis: Amylase and Lipase
- For Amenorrhea: Pregnancy Test, Hormone levels
- For IBS: erythrocyte sedimentation rate (ESR), immune globulin A

Common medical concerns in severe or chronic restriction

Lab findings:

- Leukopenia
- Anemia
- Thrombocytopenia
- Hypophosphatemia
- Hypocalcemia
- Hypercarotenemia - yellowing of the skin
- Mildly elevated AST, ALT
- Bicarbonate - can be low, normal or elevated
- Thyroid changes - low or normal T4, low T3, increase reversed T3
- Decreased ESR (sedimentation rate)
- Elevated Cholesterol - good cholesterol
- Decreased FSH (reproductive hormone), LH, Estradiol
- Decreased testosterone

Medical complications:

- Osteoporosis - onset of bone loss can be rapid
- Metabolic Concerns
- Constipation, Diarrhea
- Gastroparesis
- Superior Mesenteric Artery Syndrome
- Dysphagia - trouble swallowing
- Low blood pressure
- Bradycardia
- Tachycardia with minimal exertion
- Mitral valve prolapse
- Pericardial effusion
- Increased risk of sudden death
- Heart muscular atrophy
- Sarcopenia
- Lowered hormone production
- Amenorrhea
- Euthryoid Sick Syndrome
- Increased cortisol
- Hypoglycemia
- Tri-linear hypoplasia
- Gelatinious bone marrow
- Hypothermia

Common medical concerns in binge/purging behaviors

Lab findings:

- Hypokalemia - low potassium
- Hypomagnesemia - low magnesium
- Decreased sodium, chloride
- Increased blood bicarbonate

Complications from laxative abuse:

- GI distress, diarrhea, passing blood
- Dehydration
- Dizziness
- Dependent bowels
- Hypomagnesemia

Medical complications:

- Pseudo-Barrter's Syndrome
- Edema (common during refeeding)
- Acute Sialadenosis
- Enamel erosion
- Risk of cardiac hypertrophy (with use of Ipecac)

Refeeding Syndome

What it is:

Refeeding syndrome is a dangerous and potentially life threatening condition that can occur when a patient is severely malnourished and refed inappropriately. Often this occurs when refed too much, too fast.

Symptoms can include edema, hemolysis, seizures, hypophosphatemia, heart failure and death.

If a patient is at risk of refeeding syndrome, **refeeding will likely need to occur in a controlled, hospital environment**.

Treatment recommendations:

- Monitor electrolytes closely
- Start refeeding at 1400-1800 cals/day and increase 300-400 every 3-4 days with a goal of 3-4lb gain weekly
- Keep carbs at 50-60% total calories to minimize hypophosphatemia
- Monitor fluid replacement closely. Replace losses slowly with a continuous IVF at low rates.
- Following refeeding, patients may need a high caloric intake (3500-4000/day) to gain necessary weight

Treatment Goals and levels of care

Goals (Sequential Order):

- Medical stabilization
- Nutritional stabilization
- Psychological stabilization

Inpatient/Hospitalization

- Complete food refusal
- Suicidality
- Complex medical concerns
- Need supervised refeeding

Partial Hospitalization

- Lower levels of care have been insufficient
- Complex ongoing medical concerns
- Complex mental health presentation
- Need for **most** meals to be supervised

Outpatient Treatment

- Generally able to function on own
- Is able to work toward treatment goals
- Can maintain nutritional intake with assistance
- Medically stable or exhibiting few medical concerns

Residential Treatment

- Lower levels of care have been insufficient
- Complex ongoing medical concerns
- Complex mental health presentation
- Need for **all** meals to be supervised
- Need for supervision during off-treatment hours

Intensive Outpatient Programming

- Lower level of care has been insufficient
- Would benefit from group and individual therapy
- Need for additional accountability with nutritional and therapeutic goals

References

American Psychiatric Association. (2006). Practice guideline for the treatment of patients with eating disorders (3rd Edition). Washington, DC: American Psychiatric Association.

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Notes