Eating Disorders in Primary Care

FMIG WORKSHOP

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TESS MOORE, MD

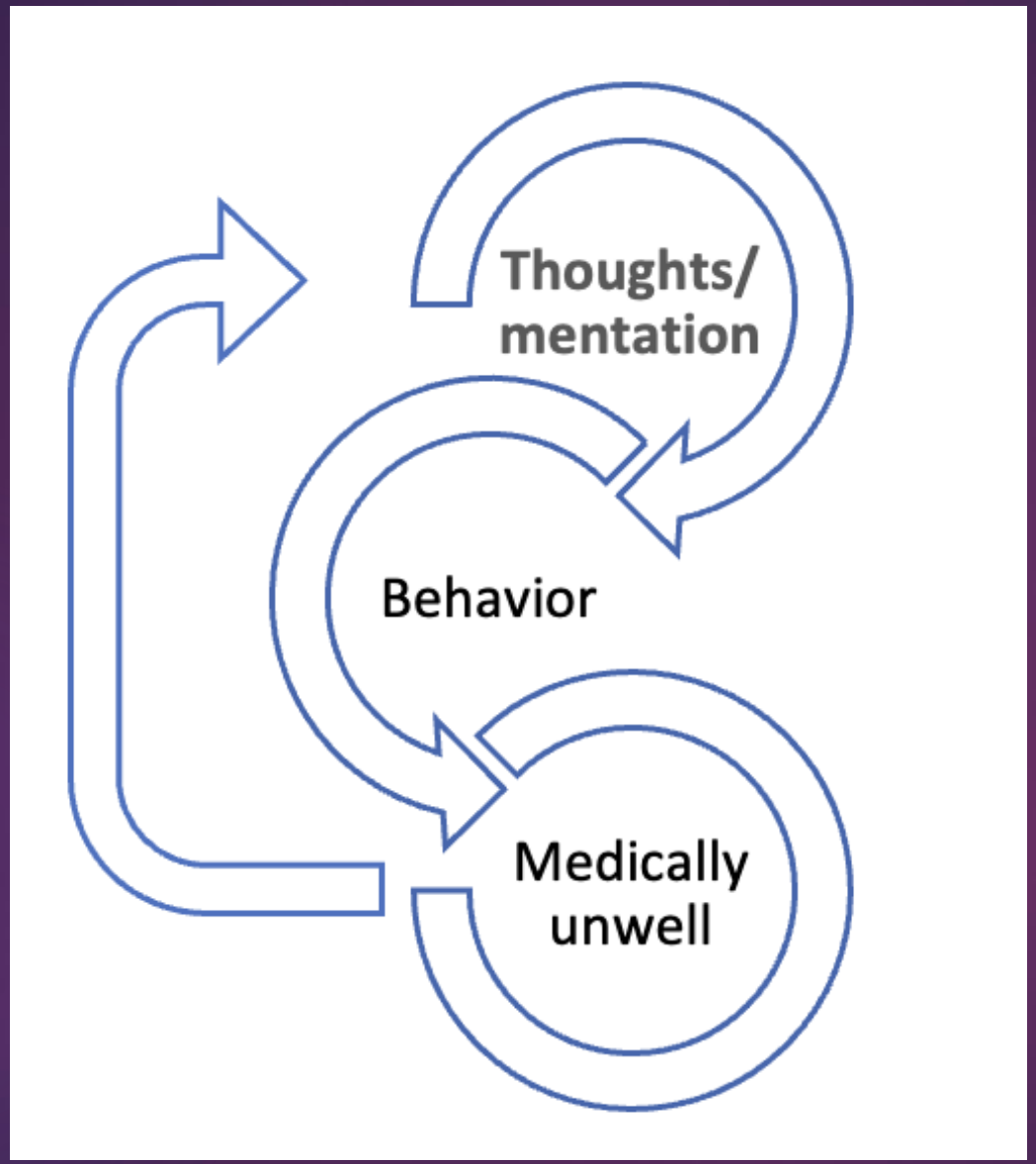
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Objectives:

- Recognize symptoms and signs of common eating disorders in diverse populations
- Understand the role of undernourishment in eating disorder physiology
- Discuss the impact of weight-centric practice on the development, recognition and treatment of eating disorders

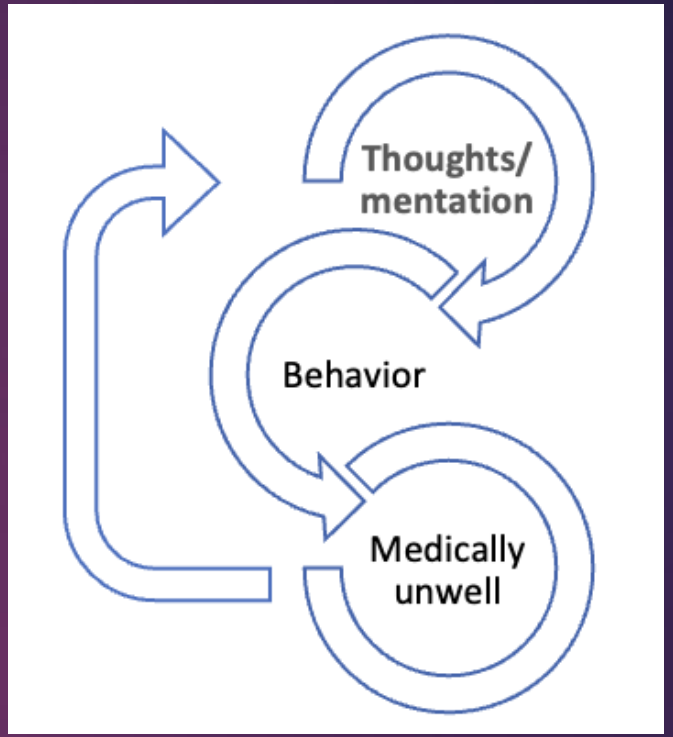
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Clinical Pearls for Eating Disorders

- Eating disorders are mental illnesses.
  - Behaviors are along for the ride.
  - Bodies can be unwell as a consequence of behaviors.
- People in any size body, of any ethnicity, socioeconomic status, or gender can have behavior that is medically and psychologically harmful.
- Learn behaviors before you learn diagnosis.
- Eating disorders are not caused by need for control.
  - That implies choice in having them and people with eating disorders will tell you there is not a choice when the eating disorder speaks loudly.



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Clinical Pearls for Eating Disorders, cont

- Malnourished brains are rigid and cannot get unstuck or repair until they are fed.
- Malnourished bodies have multisystem symptoms that are treated with gross refeeding first.
- Treatment needs to be multidisciplinary and compassionate, focusing on distress awareness and skills, and psychosocial restoration of relationship with food and body.
- Many (most?) eating disorder patients have not experienced care or neutrality about their bodies with their doctors. This is the single most important gift you can give them.

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Jesse

18 yr old presents to primary care with dizziness and fatigue.

- Notes fogginess in school
- Hair loss and cold a lot
- Feet turn purple in the shower
- Drinking plenty of water, but not really hungry
- Bloating when eating
- Sometimes morning nausea and has not had a bowel movement in a couple of days

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Jesse cont

You learn that Jesse started doing some “healthy” changes with a friend group and has been cutting out some foods and counting steps for the last year or so.

They had been going to the gym daily.

Symptoms noted above started 3 months ago.

They have lost weight.

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Jesse, cont

On Exam:

- Alert and no distress but with poor eye contact
- Heart rate 56, BP 94/54
- Skin is dry and hair is thin at hairline
- Gingiva swollen but moist
- Chest clear and breathing unlabored, heart regular but slow
- Abdomen is soft, but you notice patient flinching and slight guarding with hands but denies tenderness
- Extremities are cool, no edema or cyanosis but feet are mottled when dependent

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IT'S TIME TO TALK ABOUT IT

When presented with **identical case studies demonstrating disordered eating symptoms in white, Hispanic and Black women**, clinicians were asked to identify if the woman's eating behavior was problematic:[15]



44%

IDENTIFIED THE WHITE WOMAN'S EATING BEHAVIOR AS PROBLEMATIC



41%

IDENTIFIED THE HISPANIC WOMAN'S EATING BEHAVIOR AS PROBLEMATIC



17%

IDENTIFIED THE BLACK WOMAN'S EATING BEHAVIOR AS PROBLEMATIC

LEARN MORE: WWW.MYNEDA.ORG

CITATIONS: WWW.MYNEDA.ORG/INFOGRAPHICS

NEDA
Feeding hope.
National Eating Disorders Association

Significance

- Common
- Underdiagnosed in all marginalized populations
- Highest mortality of any other psychiatric illness than opioid dependence
- Highly treatable
- Early diagnosis and *full weight restoration* are correlated with better outcomes, including lower risk of relapse

Medical providers are one of the largest sources of weight stigma and diet culture, two strong factors in the development of eating disorders

https://www.nationaleatingdisorders.org/statistics-research-eating-disorders

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Risk factors

- Gender/ Sexuality
- Trauma
- Dieting and prescribed weight loss
- Weight stigma and bullying
- Poverty and food insecurity
- Substance use
- Type 1 diabetes
- Athletics
- Disability
- Medical illness/unintentional weight loss
- Autism
- Media and social media exposure
- Pathologizing body size in medicine

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Pitfalls in Diagnosis

Culturally congruent behaviors	Ego syntonic	Gender bias
Cultural bias/racism	Bingeing and/or purging (missing restriction)	ARFID/Orthorexia (not weight focused)
Athletes	Outdated menstrual criteria/inability to assess	Weight bias

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Red flags for eating disorders

Hypokalemia, hypoglycemia, ketonuria

Bradycardia, tachycardia, syncope, post prandial symptoms, POTS diagnosis

Amenorrhea, irregular periods, infertility, PCOS dx, delayed menarche

Low testosterone symptoms

Frequent or large **weight fluctuations**

Chronic GI symptoms, GERD, fear of choking/emesis

Ongoing dieting, rigid or progressively **restrictive diet**, multiple food sensitivities

Rigid or compensatory exercise, stress fractures, non healing injuries

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Eating Disorder Screen for Primary Care (ESP)

- **Are you satisfied with your eating patterns?** (A "no" to this question is classified as an abnormal response).
- Do you ever eat in secret? (A "yes" to this and all other questions is classified as an abnormal response).
- **Does your weight affect the way you feel about yourself?**
- Have any members of your family suffered with an eating disorder?
- Do you currently suffer with or have you ever suffered in the past with an eating disorder?

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Screening for disordered eating

How are you feeling about food and body?

Are you trying to gain or lose weight?

Any bingeing, purging, restricting of calories, times or food groups?

How are you fueling your exercise? How do you feel if you miss planned exercise?

What percent of your thoughts are about food and/or body?

National Eating Disorders Association online screening tool

How would it feel for you to receive diet or exercise suggestions from me today?

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Disordered Behaviors

- Restrict food intake (skip meals, limit portions, not eat when hungry)
- Binge eat
- Overeat
- Self-induced vomiting
- Chew food and spit it out
- Dieting
- Food rituals or rules (special utensils, only eat alone, eat small bites or certain order)
- Eat in middle of night
- Drink water or other fluids excessively
- Restricting water intake
- Eliminate certain foods
- Eat non-food items
- Check body/appearance
- Feel preoccupied with food or weight
- Abuse laxatives
- Take diet pills
- Exercise compulsion
- Control appetite with smoking/drugs/alcohol
- Use caffeine or nicotine to not be hungry

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Diagnoses

	Criteria	Notes
Anorexia Nervosa - Restrictive - Binge Purge - Atypical	• Persistently restricted intake below energy needs • Intense fear of gaining weight • Disturbance in how one experiences one's body	Atypical has all features of other types but despite significant weight loss they are not underweight – technically OSFED
Binge Eating Disorder	• Recurrent binging (discrete time, loss of control, more than another would eat, guilt afterwards) • No compensatory behaviors	Over diagnosed – atypical anorexia with weight cycling Is not compensatory feeding
Bulimia Nervosa	• Recurrent binging • Recurrent compensatory behaviors • Disturbance in how one experiences one's body	Severity based on frequency of behaviors Later onset, can go undiagnosed for years
OSFED	• Behaviors not meeting major criteria • Medical or psychosocial impact • Includes night eating, PICA, rumination and atypical anorexia	

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Diagnoses, cont

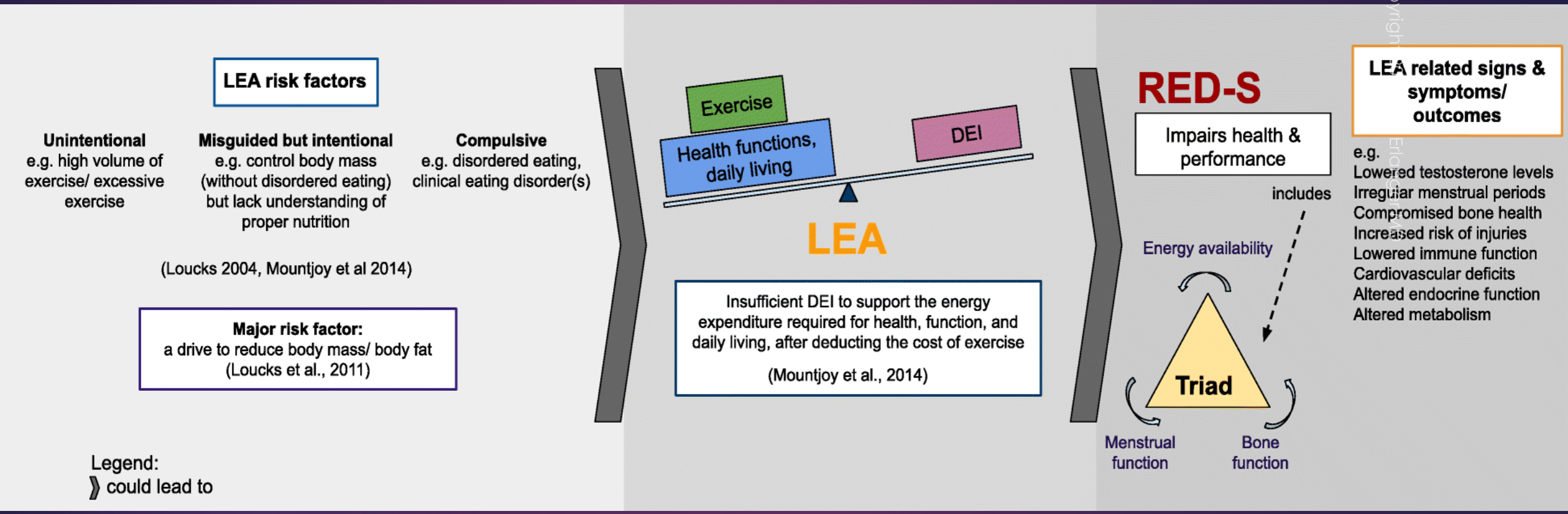
	Criteria	Notes
Disordered eating	Not meeting major criteria but interfering with life, health, relationships	
RED-s	Relative energy deficiency of an athlete causing multisystem disease – not fueling for movement Amenorrhea, low testosterone and other endocrine dysfunction Osteopenia and pathologic injury Bradycardia or other cardiac changes	Often presents as injuries or loss of endurance. Treating amenorrhea with OCP will mask rather than treat bone density loss

ARFID Avoidant/ restrictive food intake disorder	• Disturbance resulting in failure to meet nutritional needs and one of these:
	  • Weight loss or faltering growth
	  • Nutritional deficiency
	  • Dependence on supplementation
	  • Marked interference with psychosocial functioning
	• Not due to a medical condition but can co-occur
	• Not exclusively during another eating disorder
	• No disturbance experience of body shape or weight
		• Can refer to ARFID + or add "with ARFID features" to other diagnosis
		• Tightly associated with autism, food trauma and severe allergies
		• Half of children with ARFID have fear of vomiting or choking
		• Treated differently with more gentle exposure to fear foods

Orthorexia	• Fixation on "healthy," "clean" or "pure" eating. • Progressively more narrow range of foods and quantities and contexts. • Interferes with health or quality of life	
Body dysmorphic disorder	• Preoccupation with perceived flaws • At some point person has done repetitive or compulsive behaviors such as body checking or skin picking • Interferes with health or quality of life • Not better explained by ED	Often describe "I don't know what I will see when I look in the mirror" Cognitive dissonance similar to ED

Relative Energy Deficiency in Sport

RED-S



Copyright © Elaine Sim

Sim, A., Burns, S.F. Review: questionnaires as measures for low energy availability (LEA) and relative energy deficiency in sport (RED-S) in athletes. *J Eat Disord* **9,** 41 (2021). https://doi.org/10.1186/s40337-021-00396-7

Initial assessment

- "Food and Body" history
- Past diagnoses/treatment
- Current Patterns:
  - 1-2 day recall
  - Skipping meals, fasting, limiting food types or quantity, counting calories
  - Binges, night eating
  - Compensatory behaviors- restricting, vomiting, exercise, laxatives, diuretics
  - Other behaviors- water loading, chew/spit, compulsive exercise
- Weight history *growth charts if available, Use z scores when possible*
- Amenorrhea, signs of low estrogen/testosterone stress fracture, POTS, syncope, unexplained illness or injuries that do not heal
- Trauma, substances, psychiatric history including self-harm, SI and current safety
- Complete ROS and PE including *orthostatic vitals- laying 10 min then to standing for 2-5 min. Ask for symptoms with standing.*
- Labs: CMP, CBD, Mg, Phos, ECG. Consider Estrogen, LH, FSH, ESR, lipase, thyroid, vitamin D, ferritin/iron studies, zinc, DEXA, lipids, pregnancy test
- Eating disorder smart set in EPIC. BLIND WEIGHT.

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Physical exam findings

- Orthostatic HR abnormalities
- Cuts and callouses on back of hands
- Dry brittle nails and hair, lanugo
- Dental problems
- Swelling of salivary glands
- Fine hair on the body
- Carotenemia
- Cold, mottled hands and feet, bruising, poor wound healing
- Dressed in layers or cold

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Other lab abnormalities

- Low K, Mg, Phos
- Low free T4 with low-normal TSH "sick euthyroid"
- Low urine spec gravity
- Low glucose
- Low WBC
- High bicarb, low Cl, high or low Na
- High amylase
- Low to normal estrogen with low LH and FSH, low testosterone
- Anemia, low vitamin D, low zinc,

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Jesse recap

18 yr old presents to primary care with dizziness and fatigue.

- Hair loss, cold frequently
- Mental fogginess
- Vague GI symptoms
- Has been making what they think are healthy changes
- Bradycardia
- Abdominal exam avoidance
- Cool and mottled extremities

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Small Groups

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Initial treatment

- Attend to SAFETY: suicidality, harm from others, electrolytes/cardiac, glucose level
- Assess appropriateness for outpatient - APA levels of care
- Address concurrent psychiatric/substance use needs
- Normalize binges
- Address exercise
- Address purging
- Move towards full nourishment
- Refer to a HAES dietitian or ED treatment center
- Flag chart- "Eating disorder" or "HAES" "No weights or diet or exercise counseling without patient consent"

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Refeeding syndrome, pseudo-Barrter

National Institute for Clinical Excellence (NICE) Guidelines for Management of Refeeding Syndrome	
Patients at risk for refeeding syndrome	
ONE or more of the following: -OR-	TWO or more of the following:
BMI < 16 kg/m^2	BMI <18.5 kg/m^2
Unintentional weight loss of >15% in the previous 3-6 months	Unintentional weight loss of >10% in the previous 3-6 months
Little or no nutritional intake for >10 days	Little or no nutritional intake for >5 days
Low levels of potassium, phosphorus, or magnesium before refeeding	History of alcohol abuse or drugs including insulin, chemotherapy, antacids, or diuretics

Consider inpatient care if:

HR <40 in adult, <45 in a child *regardless of Qt*

Symptomatic hypotension

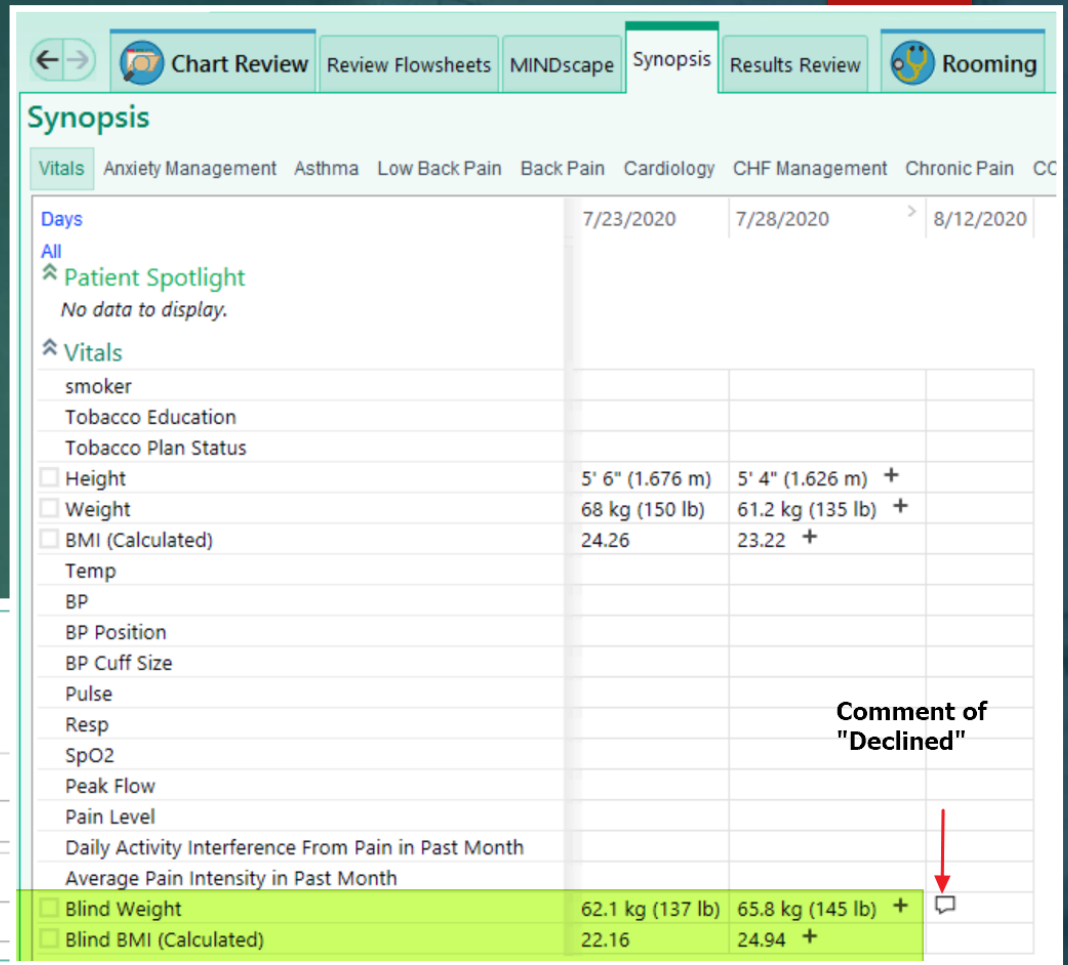
<18yo and food refusal

Significant electrolyte abnormalities

High risk of refeeding syndrome

Up to date has good summary of guidelines

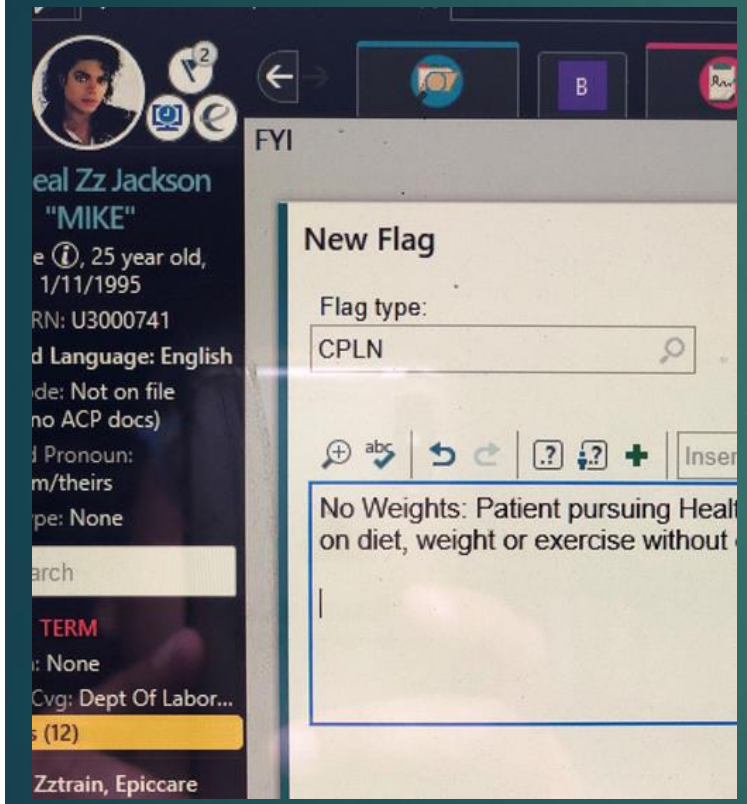
Using EMR for Weight Inclusive are

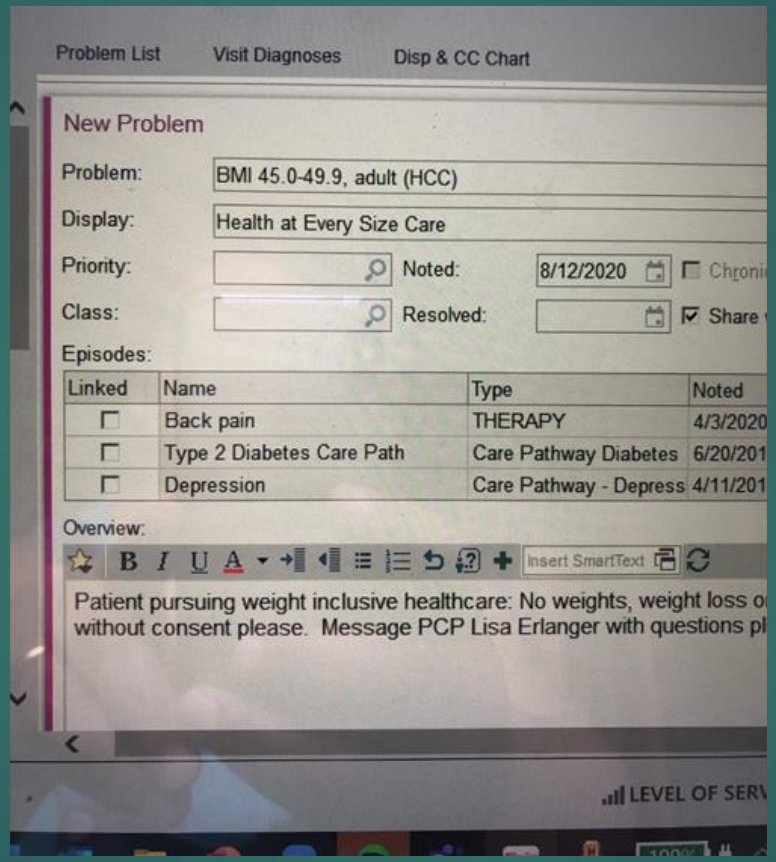


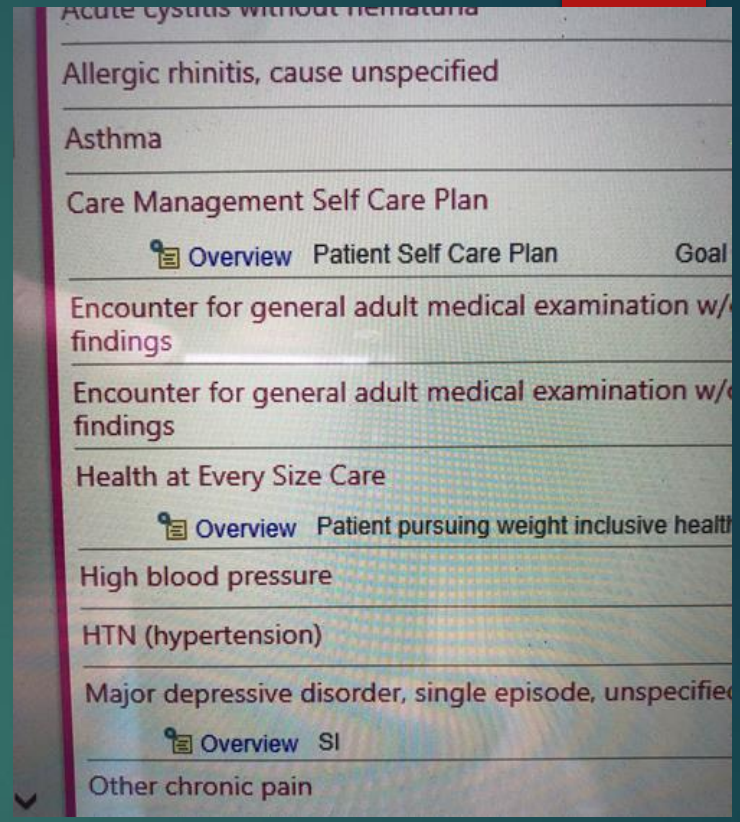


Blind weight field added by request at UW

Using EMR for Weight Inclusive Care







FYI CPLN ALERTS: "No weights" or "Health at Every Size"
Change BMI HCC dx to "HAES" or "Weight Inclusive"

Preventing Eating Disorders

The connections between weight and health are controversial at best

There are at present no interventions that sustainably produce weight loss in more than a small percent

There are many serious side effects of weight centric practice including weight stigma

There are many ways individuals can improve health without reducing weight

Providers have significant power to improve health by promoting weight neutral, non diet healthcare and recognizing disordered eating

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Before prescribing specific diet or exercise

Would I be prescribing this for a person in a smaller body?

Is my –or the patient's- expectation or hope that this will lead to weight loss?

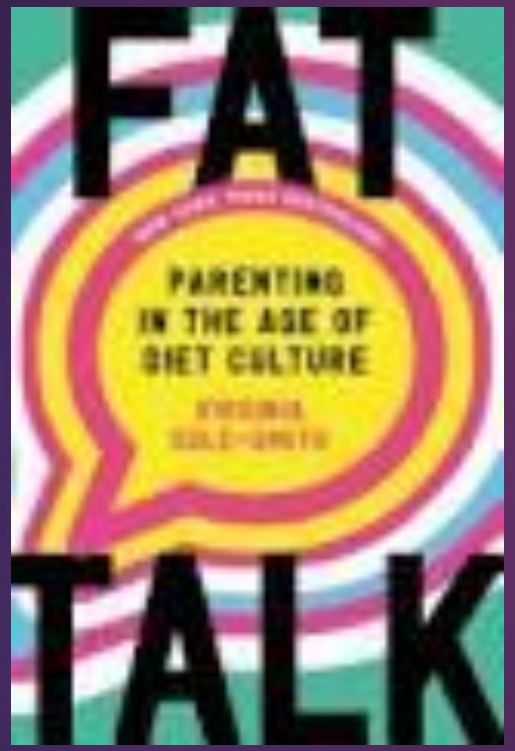
Have I screened for a history of dieting, disordered eating, food insecurity, eating disorders or perceived overweight and taken the risk of triggering "dieting" or weight stigma into consideration?

Have I set clear goals and endpoints for the intervention?

Have I supported patient choice, values and self-efficacy?

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Child Feeding



Division of Responsibility



Parent is responsible for:

- what to feed
- when to feed
- where to feed

Child is responsible for:

- how much they eat
- whether they eat from what is offered

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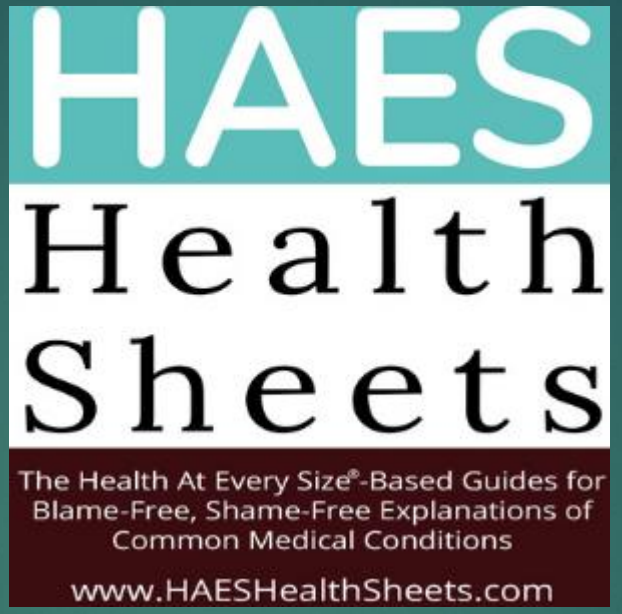
https://www.amaon.com/Fat-Talk-Parenting-Diet-Culture-ebook/dp/B0B1Y5TKLP

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Diet culture waters are treacherous



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Health At Every Size®-Based Guides for Blame-Free, Shame-Free Explanations of Common Medical Conditions (ASDAH- Association for Size Diversity and Health)

https://haeshealthsheets.com/

Meghan Cichy RD Gentle Nutrition Handouts

The Fat Doctor #NoWeigh and Webinars

Resources- Weight Inclusive Care

- Training: Center for Body Trust

  Webinars, handouts: NoWeigh.org

  Blog: Weight and Healthcare Newsletter by Regan Chastain

  Books:
  Fat Talk: Parenting in the Age of Diet Culture Virginia Sole-Smith
  Reclaiming Body Trust, A Path to Healing and Liberation by Dana Sturtevant and Hilary Kinavey
  Anti-Diet Christy Harrison
  You Just Need to Lose Weight and 19 Other Myths about Fat People, Aubrey Gordon
  also What We Don't Talk About When we Talk About Fat

  Podcasts:
  “Maintenance Phase” Podcast maintenancephase.com

Thank you!

QUESTIONS?

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Resources

EATING DISORDER AND WEIGHT INCLUSIVE CARE

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Provider resources, ED care:

Sick Enough A guide to the Medical Complications of Eating Disorders, Dr. Jennifer Gaudani

Eating Disorders, A Guide to Medical Care and Complications, Third Edition, Drs. Philip Mehler and Arnold Anderson

Beyond the Shadow of a Diet, Second Edition, Judith Matz and Ellen Frankel

National Eating Disorders Association (NEDA)- helpline, resources www.Nationaleatingdisorders.org

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Patient Resources:

Binge Eating Disorder: The Journey to Recovery and Beyond, Amy Pershing and Chevese Taylor

The Intuitive Eating Workbook, 2017 edition, Evelyn Tribole, Elyse Resch, Tracy Tylka

https://christyharrison.com/book-anti-diet-intuitive-eating-christy-harrison

Decolonizing Wellness: a QTBIPOC-Centered Guide

The Body is Not an Apology: Sonya Renee Taylor

Not All Black Girls Know How to Eat Stephanie Covington Armstrong

The Care and Feeding of Ravenously Hungry Girls Anissa Gray

When Black Girls Hear that 'Our Bodies are All Wrong" NYT Mikki Kendall

Hunger, Roxanne Gay

Nalgona Positivity Pride website, groups, scholarships www.nalgonapositivitypride.com

Feeding Children:

How to Raise an Intuitive Eater, Sumner Brooks and Amee Severson

Dr. Katja Rowell, The Feeding Doctor (blog, resources, books and consultations)

Burnt Toast Blog Virginia Sole Smith

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Promoting Body Trust in Clinical Practice. An E-Course for Helping Professionals, and No More Weighting. The Body Trust E-Course by Be Nourished

Resources: weight inclusive healthcare

Huffington Post Everything You Know About Obesity Is Wrong, Michael Hobbes Sept 19, 2018

Food Psych Podcast, and Anti-Diet, Christy Harrison RD

Promoting Body Trust in Clinical Practice E-Course, Be Nourished

Guidelines for Healthcare Providers with Fat Clients National Association to Advance Fat Acceptance (NAAFA)

Association For Size Diversity and Health (ASDAH) Provider search and resources

Fearing the Black Body, Sabrina Strings

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Eating disorder support groups

www.nalgonapositivitypride.com BIPOC and Black only groups, also has scholarships for treatment

www.centerfordiscovery.com/groups

https://www.eatingrecoverycenter.com/families/events

https://www.liberatingjasper.com/offerings (BIPOC, Quee, Neurodiverse and larger bodied specific groups)

National Eating Disorders Association (NEDA)- helpline, resources www.Nationaleatingdisorders.org

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Resources- Eating Disorder Care

Find a Weight Inclusive Provider - outpatient care https://asdah.org/haes-professional/

Online ED treatment: Equip and Within Health

WA state ED treatment facilities

- https://centerfordiscovery.com/ BED program is weight inclusive. Residential, PHP, IOP
- https://emilyprogram.com/locations/washington/seattle/ Residential, PHP, IOP. Contracts with medicaid.
- https://www.eatingrecoverycenter.com/recovery-centers/bellevue highest level of medical care and has an inpatient facility available out of state. Case exceptions for Medicaid.
- https://www.opalfoodandbody.com/ (adults only, no residential) weight inclusive, equity access for BIPOC. PHP and IOP. Has an apartment for clients.
- https://www.liberatingjasper.com/ Weight-inclusive, gender affirming, trauma informed. Groups, outpatient care, BIPOC specific care.
- https://thirahealth.com/ Residential, PHP, IOP for mood disorders with co-occurring food/body concerns.
- Seattle Children's adolescent clinic and limited inpatient care, typically up to age 18.

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Eating disorder prevention

Body Trust (patient and provider online and retreat groups and trainings)

The Body Project (facilitator training available, programs for students through college)

Be Body Positive (facilitator training available, programs for kids and adults)

Fat Talk: Parenting in the Age of Diet Culture

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