Eating Disorders in Primary Care

UW FAMILY MEDICINE RESIDENCY R2 SEMINAR

LISA ERLANGER, MD

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Lisa Erlanger, MD

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- Weight inclusive primary care, mental health, eating disorder and larger bodied care at Hall Health Primary Care Center on UW campus
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All Bodies Healthcare

https://fb.me/AllBodiesHealthcare

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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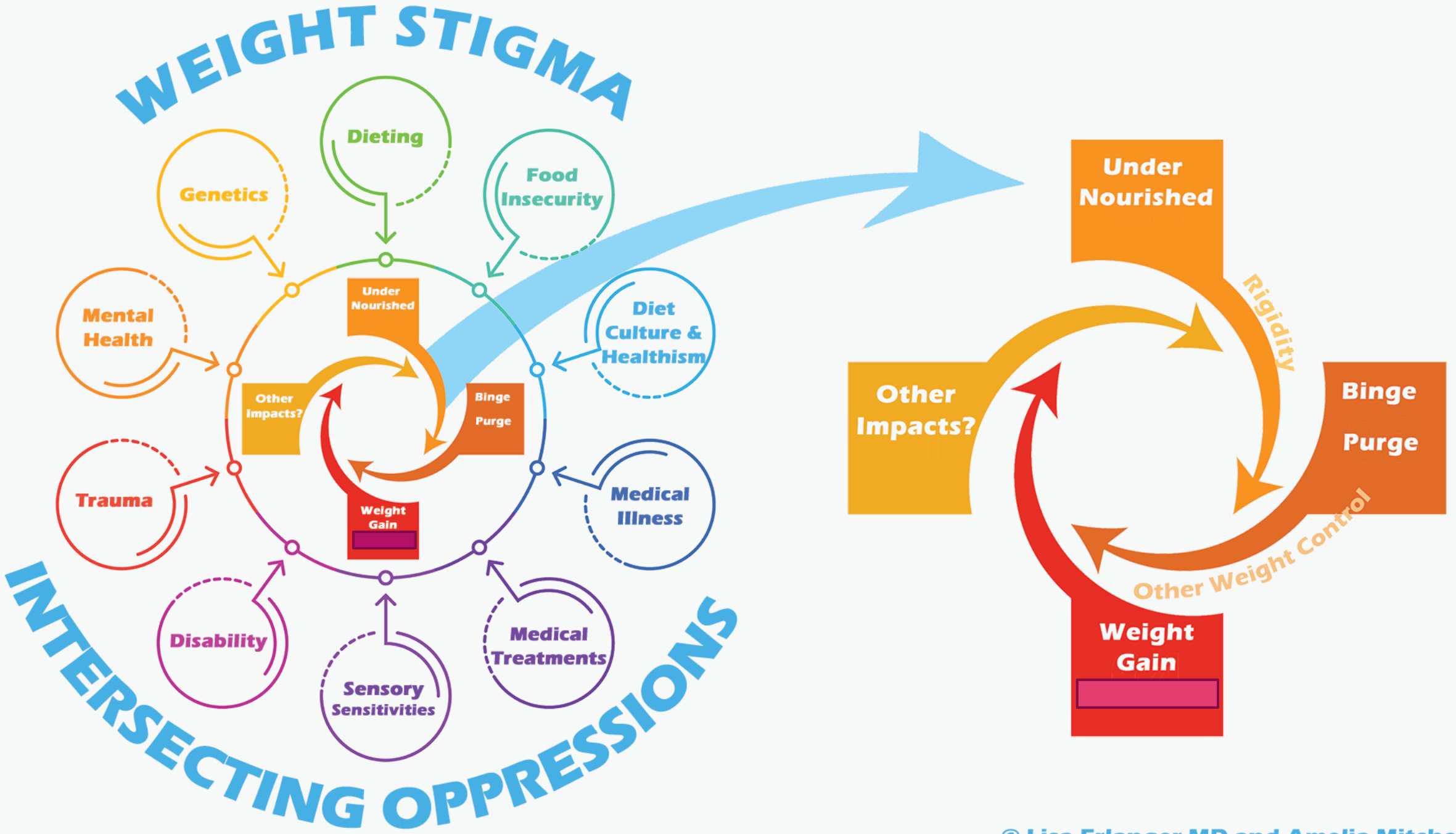
Significance

- Common
- Underdiagnosed in all marginalized populations
- High morbidity and mortality
- 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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WEIGHT STIGMA
Dieting
Genetics
Food Insecurity
Mental Health
Under Nourished
Diet Culture & Healthism
Other Impacts?
Binge
Purge
Trauma
Weight Gain
Medical Illness
Disability
Sensory Sensitivities
Medical Treatments
INTERSECTING OPPRESSIONS
Under Nourished
Rigidity
Other Impacts?
Binge
Purge
Other Weight Control
Weight Gain
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Risk factors

- Gender
- Sexuality
- Trauma
- Dieting
- Race and ethnicity
- Weight bullying
- Poverty and food insecurity
- Substance use
- Type 1 diabetes
- Athletics
- Disability
- Medical illness/unintentional weight loss
- Autism
- Media exposure

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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Athletes	Outdated menstrual criteria/inability to assess	Weight bias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

Rigid or progressively **restrictive diet**, multiple food sensitivities

Rigid or compensatory exercise, stress fractures, 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?

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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Em

18 yr old college freshman, referred to you by their soccer coach due to concerns of declining performance and persistent shin splints. Em is bothered by fatigue and poor sleep. They wonder if they might be anemic or hypothyroid because they're always cold, often constipated, and it's been harder to maintain their preferred weight. They use oral contraceptive pills continuously to suppress menses.

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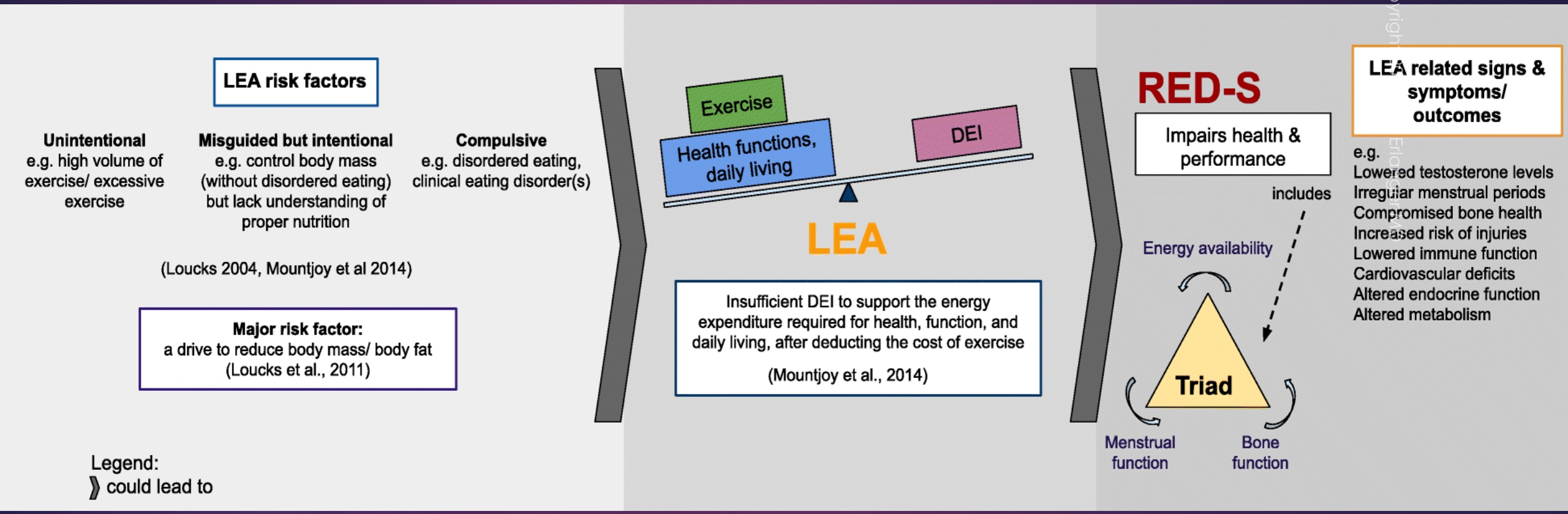
DSM V Anorexia Nervosa

A. Restriction of energy intake relative to requirements leading to a significantly low body weight.
B. Intense fear of gaining weight or becoming fat, or persistent behavior that interferes with weight gain
C. Distorted self-perception, or over-valuation of weight/shape, or lack of recognition of the seriousness of the current low body weight.

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Relative Energy Deficiency in Sport

RED-S



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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

Jamie

Jamie comes to your office wanting to address his emotional eating. He is visibly distressed when disclosing the details of his emotional eating. He reports feeling out of control when eating and eating past the point of discomfort. This happens every evening after work as well as on Sundays. This has been going on for months and he feels great disgust and shame with his behavior. “Do you have something that can help me stop bingeing?”

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Binge Eating Disorder DSM V

- Recurrent and Persistent episodes of Bingeing
- Binges associated with eating: more rapidly, until uncomfortably full, large amounts when not hungry, eating in secret, feeling shame; Causing marked distress.
- Absence of compensatory behaviors (purging, exercise or restriction)

- *Not better explained by anorexia-binge type or by bulimia*

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Binge Eating Disorder

- Strong association with intentional and unintentional food insecurity
- Strong association with trauma
- Often treated as an addiction (contrave, Vyvanse, exposure response prevention) in combination with "sensible weight loss strategies"
- First step must always be regular, adequate, satisfying nourishment at a level to MAINTAIN or restore body weight
- Trauma treatment, CBT, "stocking" foods
- Weight loss contraindicated
- Beyond the Shadow of a Diet, Judith Matz
- Binge Eating, Amy Pershing and Chevese Turner

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Harold

Harold, a 40-year-old with type 2 diabetes and a history of Roux-en-Y bariatric surgery, comes to your clinic to seek help for acute knee pain after tripping at home. He has gradually regained most of the weight he lost in the year following bariatric surgery. His last clinic visit was two years ago, at which time his A1C had risen from 7.5 to 8.5. He hasn't been back due to shame about weight gain, which he attributes to bingeing.

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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

Physical and Psychological Morbidity in Adolescents With Atypical Anorexia Nervosa.

Sawyer SM1, Whitelaw M2, Le Grange D3, Yeo M4, Hughes EK5.

PEDIATRICS. 2016 APR;137(4).

""Compared with AN, more adolescents with atypical AN were premorbidly overweight or obese (71% vs 12%). They had lost more weight (17.6 kg vs 11.0 kg) over a longer period (13.3 vs 10.2 months). ***There was no significant difference in the frequency of bradycardia (24% vs 33%;) or orthostatic instability (43% vs 38%). We found no evidence of a difference in frequency of psychiatric comorbidities (38% vs 45%) or suicidal ideation (43% vs 39%). Distress related to eating and body image was more severe in atypical AN.***

Do we praise in the overweight the same behaviors we pathologize in the underweight?

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Maude

At Maude's second trimester prenatal visit, she has already gained substantially more weight than recommended for the pregnancy. Nonetheless, her fundal height is less than expected. She lost significant weight prior to pregnancy on a low-carb diet recommended for her PCOS, ultimately requiring fertility treatment when she met a qualifying BMI. She knows the weight gain puts the pregnancy at risk and is very stressed about this. Severe GERD is making it hard to eat at all, and she describes involuntary vomiting which occurs if she "eats too much."

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Bulimia

- Recurrent episodes of binge eating (feeling out of control while eating an objectively large amount of food in a discrete period of time)
- Inappropriate compensatory behavior to prevent weight gain (includes exercise, fasting, medications, vomiting)
- Self-evaluation unduly influenced by body shape and weight
- On average once a week for three months
- Not in context of anorexia

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Jose

65-year-old you've followed for GI symptoms, anxiety and fatigue which initially got substantially better on a popular elimination diet. Despite an ever-increasing focus on "clean eating" the symptoms have returned. He'd like to be tested for food sensitivities.

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Orthorexia (not in current DSM)

- Fixation on “healthy,” “clean” or “pure” eating.
- Progressively more narrow range of foods and quantities and contexts.
- Interferes with health or quality of life

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Roan

A transgender, neurodivergent young man. After an episode of syncope and some tachycardia in the clinic, he's been diagnosed with POTS by the consulting neurologist. He tells you he doesn't have much of an appetite, and dislikes salty food. He's had trouble following the dietary recommendations of frequent snacks and a high salt diet.

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ARFID

- An eating or feeding disturbance resulting in persistent failure to meet nutritional and/or energy needs.
  - Apparent lack of interest in eating or food
  - Avoidance based on the sensory characteristics of food
  - Concern about aversive consequences of eating such as emetophobia
- Not based on body image or due to medical condition.
- Nearly half of children with ARFID report fear of vomiting or choking, and one-fifth report sensory issues.
- Nearly 20 percent have an autism spectrum condition

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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*
- Amenorrhea, signs of low estrogen/testosterone stress fracture, POTS, syncope, unexplained illness
- Trauma, substance, psychiatric history including self-harm, SI and current safety
- Complete ROS and PE including *orthostatic vitals- standing for 2-5 min*
- Labs: CMP, CBD, Mg, Phos, ECG. Consider Estrogen, LH, FSH, ESR, lipase, thyroid, vitamin D, ferritin, zinc,DEXA
- 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 amylase
- Low to normal estrogen with low LH and FSH, low testosterone
- Anemia, low vitamin D, low zinc,

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Initial treatment

- Attend to SAFETY: suicidality, harm from others, electrolytes/cardiac
- Assess appropriateness for outpatient - APA levels of care
- Address concurrent psychiatric/substance use needs
- Normalize binges
- Address exercise
- Address purging
- Move towards full nourishment (MI to identify)
- Identify supports: resources and Dr. Erlanger's HAES providers
- 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*

Significant electrolyte abnormalities

High risk of refeeding syndrome

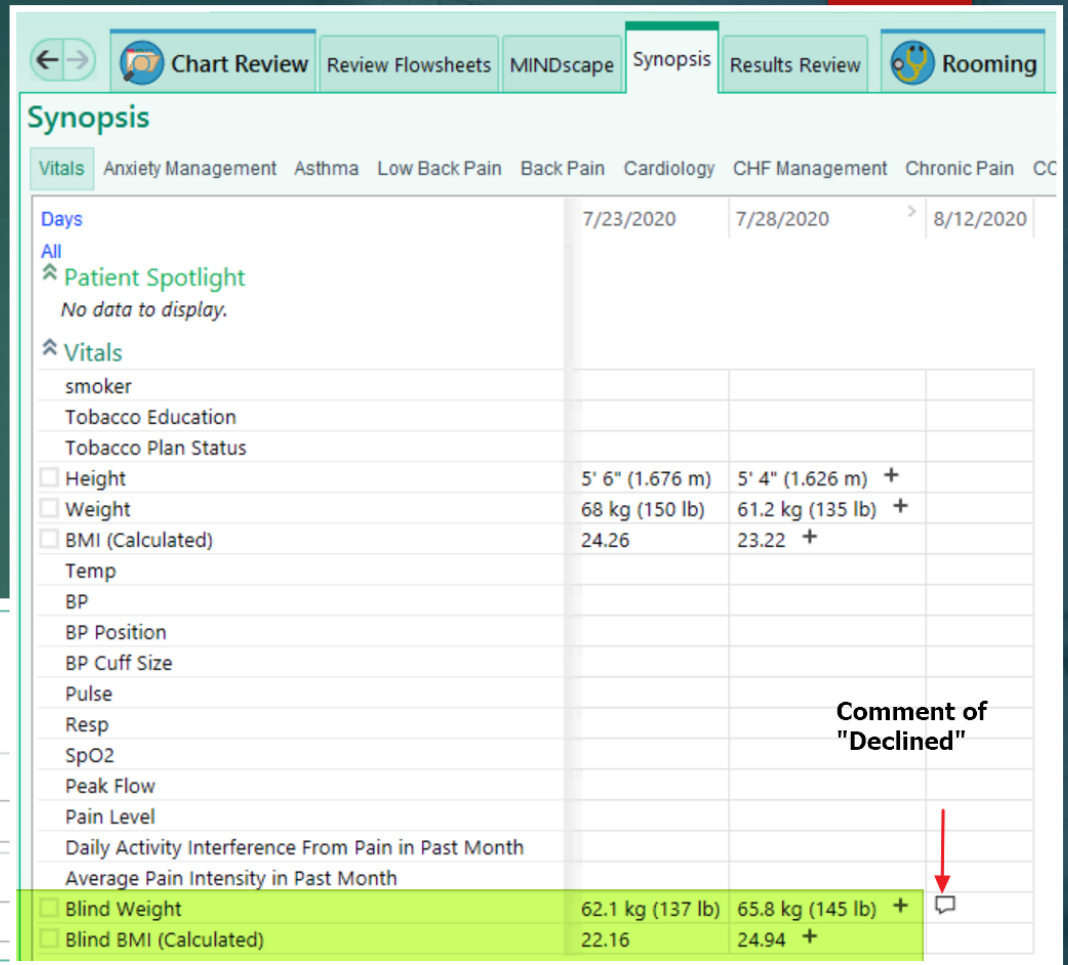
Up to date has good summary of guidelines

Special considerations

- Bone loss/amenorrhea/hypoandrogenism
- Gastroparesis: Metaclopramide 2.5-5mg qac/qhs
- Ginger, EC peppermint, miralax, lower fiber, lower glycemic, gasX, lactase/Beano
- K-Phos Neutral 400mg BID (hard to get, Walgreens), Mg 250-500 BID-TID, KCl
- Long Qt
- Kids/teens family based treatment

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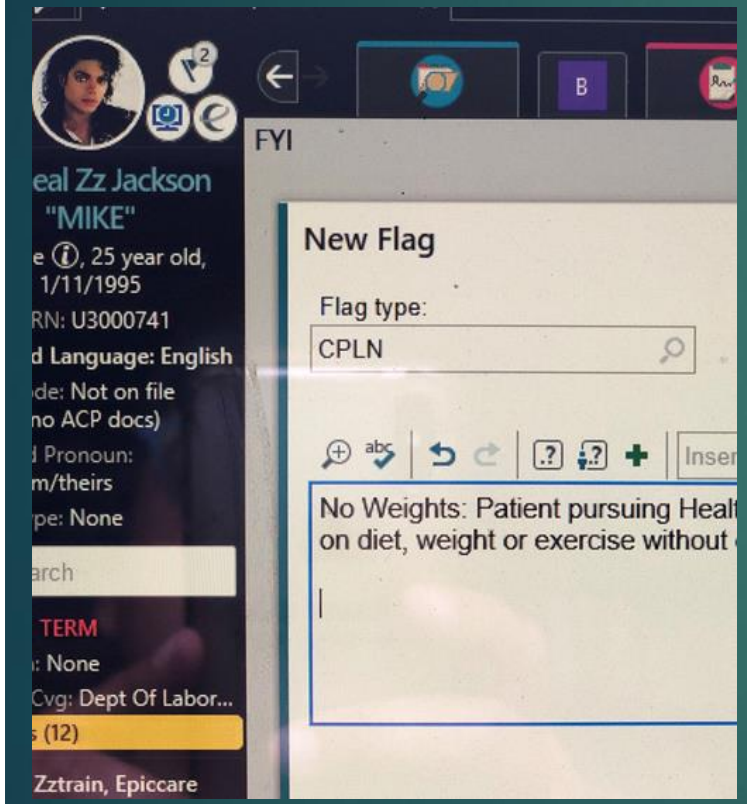
Using EMR for Weight Inclusive are

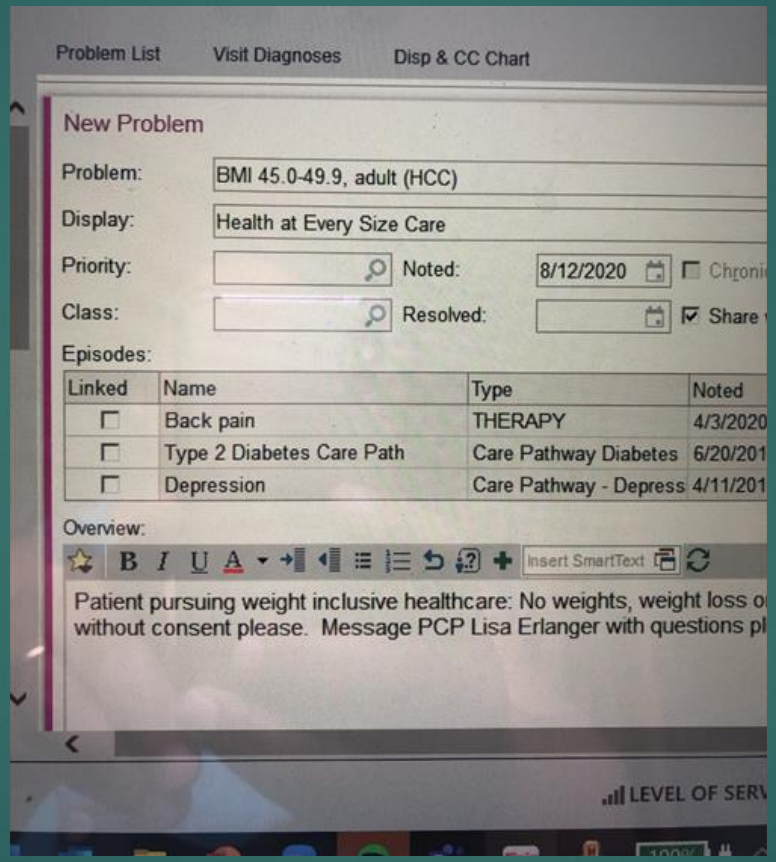


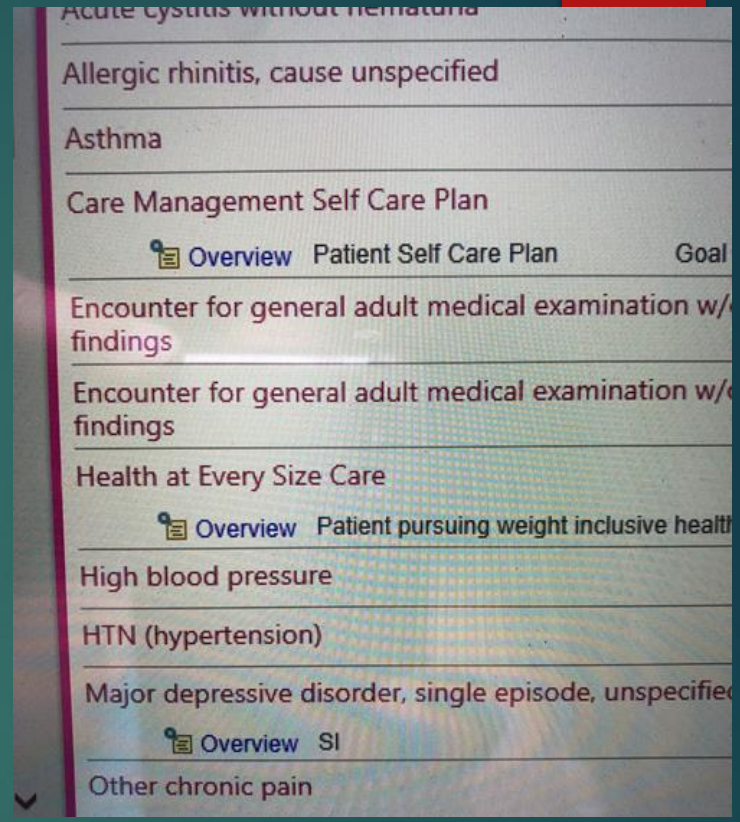


Blind weight field added by request at UW

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

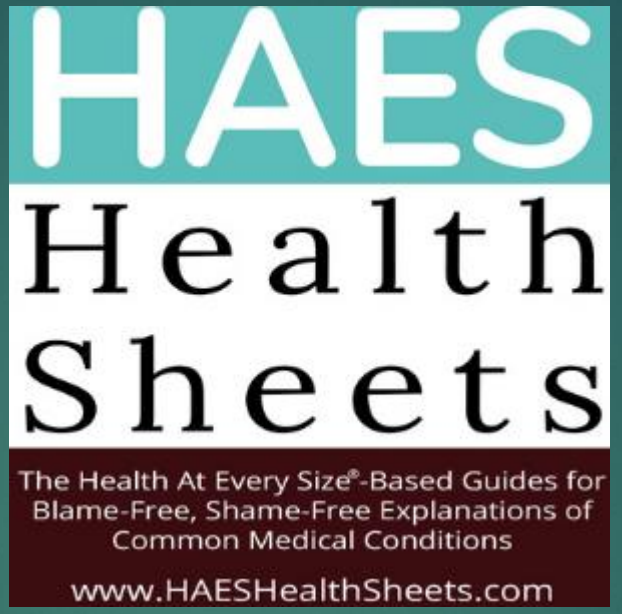
There are at present no interventions that sustainably produce weight loss in more than a small percent

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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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

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, 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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Hierarchy of Food



Biohack

Adding in fruits, veggies, whole grains, polyunsaturated fats, less red meat

If metabolic disease:

Pairing carbs with fiber, fat, protein

Regular, nourishing, satisfying meals

Adequate fuel

Ethical and Environmental

Culturally responsive

Allergy

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Christy Harrison: "Food, Psych" podcast
www.christyharrison.com

More Learning, Weight Inclusive Care



Training:
Be Nourished www.benourished.org/offerings

Books:
What We Don't Talk About When We Talk About Fat Aubrey Gordon
Anti-Diet Christy Harrison
The Body is Not an Apology Sonya Renee Taylor

Podcasts:
"Maintenance Phase" Podcast maintenancephase.com
The Fat Doctor Podcast Dr Asher Larmie www.fatdoctor.co.uk
"Unpacking Weight Science"- Fiona Willer Unpackingweightscience.Com
Christy Harrison: "Food, Psych" podcast www.christyharrison.com

Other:
Weight and Healthcare Newsletter by Regan Chastain
Non-Diet and Health at Every Size ® Research Library

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, Queer 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/

WA state ED treatment facilities (higher level of care only)

- 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. IOP and PHP are coming 2021.
- 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)

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