

AED REPORT 2016 | 3RD EDITION



EATING DISORDERS

A GUIDE TO MEDICAL CARE

Critical Points for Early Recognition & Medical Risk
Management in the Care of Individuals with Eating Disorders

DISCLAIMER: This document, created by the Academy for Eating Disorders' Medical Care Standards Committee, is intended as a resource to promote recognition and prevention of medical morbidity and mortality associated with eating disorders. It is not a comprehensive clinical guide. Every attempt was made to provide information based on the best available research and current best practices. For further resources, practice guidelines and bibliography visit: www.aedweb.org and www.aedweb.org/Medical_Care_Standards

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KEY GUIDELINES

All eating disorders (EDs) are serious mental illnesses with significant, life-threatening medical and psychiatric morbidity and mortality, regardless of an individual's weight. Patients with EDs have the highest mortality rates of any psychiatric disorder. The risk of premature death is 6-12 times higher in women with Anorexia Nervosa (AN) as compared to the general population, adjusting for age.

Early recognition and timely intervention, based on a developmentally appropriate, evidence-based, multidisciplinary team approach (medical, psychological & nutritional) is the ideal standard of care, whenever possible. Members of the multidisciplinary team may vary and will depend upon the needs of the patient and the availability of these team members in the patient's community. In communities where resources are lacking, clinicians, therapists, and dietitians are encouraged to consult with the Academy for Eating Disorders (AED) and/or ED experts in their respective fields of practice.

EATING DISORDERS

For the purpose of this document, we will focus on the most common EDs including:

- 1. Anorexia Nervosa (AN):** Restriction of energy intake relative to an individual's requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory and health status. Disturbance of body image, an intense fear of gaining weight, lack of recognition of the seriousness of the illness and/or behaviors that interfere with weight gain are also present.
- 2. Bulimia Nervosa (BN):** Binge eating (eating a large amount of food in a relatively short period of time with a concomitant sense of loss of control) with purging/compensatory behavior (e.g. self-induced vomiting, laxative or diuretic abuse, insulin misuse, excessive exercise, diet pills) once a week or more for at least 3 months. Disturbance of body image, an intense fear of gaining weight and lack of recognition of the seriousness of the illness may also be present.

3. **Binge Eating Disorder (BED):** Binge eating, in the absence of compensatory behavior, once a week for at least 3 months. Binge eating episodes are associated with eating rapidly, when not hungry, until extreme fullness, and/or associated with depression, shame or guilt.
4. **Other Specified Feeding and Eating Disorder (OSFED):** An ED that does not meet full criteria for one of the above categories, but has specific disordered eating behaviors such as restricting intake, purging and/or binge eating as key features.
5. **Unspecified Feeding or Eating Disorder (UFED):** ED behaviors are present, but they are not specified by the care provider.
6. **Avoidant/Restrictive Food Intake Disorder (ARFID):** Significant weight loss, nutritional deficiency, dependence on nutritional supplement or marked interference with psychosocial functioning due to caloric and/or nutrient restriction, but without weight or shape concerns.

Consult www.aedweb.org, DSM-5 or ICD-10 for full diagnostic descriptions.

IMPORTANT FACTS ABOUT EATING DISORDERS

- **All** EDs are serious disorders with life-threatening physical and psychological complications.
- EDs do not discriminate. They can affect individuals of all ages, genders, ethnicities, socioeconomic backgrounds, and with a variety of body shapes, weights and sizes.
- Weight is not the only clinical marker of an ED. People who are at low, normal or high weights can have an ED and individuals at any weight may be malnourished and/or engaging in unhealthy weight control practices.
- Individuals with an ED may not recognize the seriousness of their illness and/or may be ambivalent about changing their eating or other behaviors.
- All instances of precipitous weight loss or gain in otherwise healthy individuals should be investigated for the possibility of an ED as rapid weight fluctuations can be a potential marker of an ED.
- In children and adolescents, failure to gain expected weight or height, and/or delayed or interrupted pubertal development, should be investigated for the possibility of an ED.

- All EDs can be associated with serious medical complications affecting every organ system of the body.
- The medical consequences of EDs can go unrecognized, even by an experienced clinician.

PRESENTING SIGNS AND SYMPTOMS

Individuals with EDs may present in a variety of ways. In addition to the cognitive and behavioral signs that characterize EDs, the following physical signs and symptoms can occur in patients with an ED as a consequence of restricting food or fluid intake, nutritional deficiencies, binge-eating, and inappropriate compensatory behaviors, such as purging. However, it is important to remember that a life-threatening ED may occur without obvious physical signs or symptoms.

GENERAL:

- Marked weight loss, gain, fluctuations or unexplained change in growth curve or body mass index (BMI) percentiles in a child or adolescent who is still growing and developing
- Cold intolerance
- Weakness
- Fatigue or lethargy
- Presyncope (dizziness)
- Syncope (fainting)
- Hot flashes, sweating episodes

ORAL AND DENTAL:

- Oral trauma/lacerations
- Perimyolysis (dental erosion on posterior tooth surfaces) and dental caries (cavities)
- Parotid (salivary) gland enlargement

CARDIORESPIRATORY:

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

GASTROINTESTINAL:

- Epigastric discomfort
- Abdominal bloating
- Early satiety (fullness)
- Gastroesophageal reflux (heartburn)
- Hematemesis (blood in vomit)
- Hemorrhoids and rectal prolapse
- Constipation

ENDOCRINE

- Amenorrhea or oligomenorrhea (absent or irregular menses)
- Low sex drive
- Stress fractures
- Low bone mineral density
- Infertility

NEUROPSYCHIATRIC

- Depressive/Anxious/
Obsessive/Compulsive
symptoms and behaviors
- Memory loss
- Poor concentration
- Insomnia
- Self-harm

- Suicidal thoughts, plans
or attempts
- Seizures

DERMATOLOGIC

- Lanugo hair (fine hair growth on
the body and face)
- Hair loss
- Carotenoderma (yellowish
discoloration of skin)
- Russell’s sign (calluses or scars
on the back of the hand from
self-induced vomiting)
- Poor wound healing
- Dry brittle hair and nails

EARLY RECOGNITION

Consider evaluating an individual for an ED who presents with any of the following:

- Precipitous weight changes (significant weight lost or gained)
or fluctuations
- Sudden changes in eating behaviors (new vegetarianism/veganism,
gluten-free, lactose-free, elimination of certain foods or food groups,
eating only “healthy” foods, uncontrolled binge eating)
- Sudden changes in exercise patterns, excessive or compulsive exercise
or involvement in extreme physical training
- Body image disturbance, the desire to lose weight despite low or
normative weight, or extreme dieting behavior regardless of weight
- Abdominal complaints in the context of weight loss behaviors
- Electrolyte abnormalities without an identified medical cause
(especially hypokalemia, hypochloremia, or elevated bicarbonate)
- Hypoglycemia

- Bradycardia
- Amenorrhea or menstrual irregularities
- Unexplained infertility
- Type 1 diabetes mellitus with poor glucose control or recurrent diabetic ketoacidosis (DKA) with or without weight loss
- Use of compensatory behaviors (i.e., self-induced vomiting, laxative abuse, dieting, fasting or excessive exercise) to influence weight after eating or binge eating
- Inappropriate use of appetite suppressants, caffeine, diuretics, laxatives, enemas, ipecac, artificial sweeteners, sugar-free gum, prescription medications that affect weight (insulin, thyroid medications, psychostimulants, or street drugs) or nutritional supplements marketed for weight loss

Malnutrition is a serious medical condition that requires urgent attention. It can occur in patients engaging in disordered eating behaviors, regardless of weight status. Individuals with continued restrictive eating behaviors, binge eating or purging, despite efforts to redirect their behavior, require immediate intervention.



COMPREHENSIVE ASSESSMENT

COMPLETE HISTORY TO INCLUDE:

- Rate and amount of weight loss/change in past six months
- Nutritional history to include dietary intake (quantity and variety of foods consumed), restriction of specific foods or food groups (such as fats or carbohydrates)
- Compensatory behaviors and their frequency (fasting or dieting, self-induced vomiting, exercise, laxative, diuretic or ipecac abuse, insulin misuse, use of diet pills and/or other over-the-counter supplements)
- Exercise (frequency, duration and intensity). Is the exercise excessive, compulsive or rigid or is it used to manage weight?
- Menstrual history (menarche, last menstrual period, regularity, oral contraceptive use)
- Current medications including any supplements & alternative medications
- Family history including symptoms or diagnosis of EDs, obesity, mood & anxiety disorders, substance use disorders
- Psychiatric history including symptoms of mood, anxiety and substance use disorders
- History of trauma (physical, sexual or emotional)
- Growth history (obtain past growth charts whenever possible)

PHYSICAL EXAMINATION TO INCLUDE:

- Measurement of height, weight, and determination of body mass index ($BMI = \text{weight (kg)}/\text{height (m}^2\text{)}$); record weight, height and BMI on growth charts for children and adolescents
- Lying and standing heart rate and blood pressure
- Oral temperature

INITIAL DIAGNOSTIC EVALUATION:

- Laboratory and other diagnostic studies recommended for consideration in evaluating a patient with an ED, along with potential corresponding abnormalities seen in patients with EDs, are outlined in the following chart.
- It is important to note that laboratory studies may be normal even with significant malnutrition.

DIAGNOSTIC TESTS INDICATED FOR ALL PATIENTS WITH A SUSPECTED ED

BASIC TESTS	POTENTIAL ABNORMAL FINDINGS AND CAUSES
Complete blood count	Leukopenia, anemia, or thrombocytopenia
Comprehensive panel to include electrolytes, renal function tests and liver enzymes	Glucose: ↓ <i>poor nutrition</i> Sodium: ↓ <i>water loading or laxatives</i> Potassium: ↓ <i>vomiting, laxatives, diuretics</i> Chloride: ↓ <i>vomiting, laxatives</i> Blood bicarbonate: ↑ <i>vomiting</i> ↓ <i>laxatives</i> Blood urea nitrogen: ↑ <i>dehydration</i> Creatinine: ↑ <i>dehydration, renal dysfunction, muscle wasting</i> Calcium: <i>slightly</i> ↓ <i>poor nutrition at the expense of bone</i> Phosphate: ↓ <i>poor nutrition</i> Magnesium: ↓ <i>poor nutrition, laxative use</i> Total protein/albumin: ↑ <i>in early malnutrition at the expense of muscle mass,</i> ↓ <i>in later malnutrition</i> Prealbumin: ↓ <i>in protein-calorie malnutrition</i> Aspartate aminotransaminase (AST), Alanine aminotransaminase (ALT): ↑ <i>starvation</i>
Electrocardiogram (ECG)	Bradycardia (low heart rate), prolonged QTc (>450msec), other arrhythmias

ADDITIONAL DIAGNOSTIC TESTS TO CONSIDER

ADDITIONAL TESTS	POTENTIAL ABNORMAL FINDINGS
Leptin level	Leptin: ↓ <i>in malnutrition</i>
Thyroid stimulating hormone (TSH), thyroxine (T4)	TSH: ↓ <i>or normal</i> T4: ↓ <i>or normal euthyroid sick syndrome</i>
Pancreatic enzymes (amylase and lipase)	Amylase: ↑ <i>vomiting, pancreatitis</i> Lipase: ↑ <i>pancreatitis</i>
Gonadotropins (LH and FSH) and sex steroids (estradiol and testosterone)	LH, FSH, estradiol (women) and testosterone (men) levels: ↓ <i>or normal</i>

Erythrocyte sedimentation rate (ESR)	ESR: ↓ <i>starvation</i> or ↑ <i>inflammation</i>
Dual Energy X-ray Absorptiometry (DEXA)	Patients with EDs are at risk of low <i>bone mineral density (BMD)</i> . There is no evidence that hormone replacement therapy (estrogen/progesterone in females or testosterone in males) improves BMD. Nutritional rehabilitation, weight recovery, and normalization of endogenous sex steroid production are the treatments of choice.

CRITERIA FOR HOSPITALIZATION FOR ACUTE MEDICAL STABILIZATION

PRESENCE OF ONE OR MORE OF THE FOLLOWING:

1. $\leq 75\%$ median BMI for age, sex, and height
2. Hypoglycemia
3. Electrolyte disturbance (hypokalemia, hyponatremia, hypophosphatemia and/or metabolic acidosis or alkalosis)
4. ECG abnormalities (e.g., prolonged QTc > 450 , bradycardia, other arrhythmias)
5. Hemodynamic instability
 - Bradycardia
 - Hypotension
 - Hypothermia
6. Orthostasis
7. Acute medical complications of malnutrition (e.g., syncope, seizures, cardiac failure, pancreatitis, etc.)
8. Comorbid psychiatric or medical condition that prohibits or limits appropriate outpatient treatment (e.g., severe depression, suicidal ideation, obsessive compulsive disorder, type 1 diabetes mellitus)
9. Uncertainty of the diagnosis of an ED

CRITERIA FOR HOSPITALIZATION FOR ACUTE PSYCHIATRIC STABILIZATION

PRESENCE OF ONE OR MORE OF THE FOLLOWING:

1. Acute food refusal
2. Suicidal thoughts or behaviors
3. Other significant psychiatric comorbidity that interferes with ED treatment (anxiety, depression, obsessive compulsive disorder)

OTHER CONSIDERATIONS REGARDING HOSPITALIZATION:

1. Failure of outpatient treatment
2. Uncontrollable binge eating and/or purging by any means
3. Inadequate social support and/or follow up medical or psychiatric care

REFEEDING SYNDROME

Refeeding syndrome describes the clinical and metabolic derangements that can occur during refeeding (orally, enterally, or parenterally) of a malnourished patient. The clinical features of refeeding syndrome include edema, cardiac and/or respiratory failure, gastrointestinal problems, profound muscle weakness, delirium and, in extreme cases, death. Laboratory abnormalities may include hypophosphatemia (most significant), hypoglycemia, hypokalemia, hypomagnesemia and hyponatremia. Refeeding syndrome can occur in patients of any age and weight, and is a potentially fatal condition requiring specialized care on an inpatient unit.

RISK FACTORS FOR REFEEDING SYNDROME INCLUDE:

- The degree of malnutrition at presentation (< 70% median BMI in adolescents, BMI <15 most at risk in adults)
- Patients who are chronically undernourished and those who have had little or no energy intake for more than 10 days
- History of refeeding syndrome
- Patients with rapid or profound weight loss, including those who present at any weight after rapid weight loss (> 10-15% of total body mass in 3-6 months)

IMPORTANT – Consider initiating refeeding in an inpatient setting if one or more risk factors for refeeding are present. Ideally patients should be admitted to a hospital that has access to, or onsite ED specialist support.

- Patients with significant alcohol intake (these patients are also at risk for the development of Wernicke’s encephalopathy with refeeding. Prior to refeeding they should receive thiamine and folate supplementation)
- Post-bariatric surgery patients with significant weight loss (increased risk with electrolyte losses from malabsorption)
- Patients with a history of diuretic, laxative or insulin misuse
- Patients with abnormal electrolytes prior to refeeding

HOW TO PREVENT AND MANAGE REFEEDING SYNDROME:

- Know the signs, symptoms and risk factors for refeeding syndrome.
- Whenever possible, refer patients at risk for refeeding syndrome to physicians with expertise in medical and behavioral management of EDs and/or admit to an inpatient medical or med-psych unit with this expertise.
- Serum electrolytes (sodium, potassium, phosphorous and magnesium) and glucose should be checked prior to initiating refeeding. Be aware that these may be normal prior to refeeding. Phosphorus will reach its lowest point 3-7 days after initiation of nutritional rehabilitation.
- While treating a patient on an inpatient unit, monitor serum electrolytes and glucose frequently (at least daily if significantly abnormal) during early refeeding until stabilized (at least 72 hours).
- Aggressively replete all electrolyte deficiencies. Oral repletion is preferable but IV supplementation may be necessary. It is not necessary to correct fluid and electrolyte imbalance before initiating feeding. With careful monitoring, this can be safely achieved simultaneously.
- Start a multivitamin daily prior to initiating and throughout refeeding. Add thiamine supplementation in severely malnourished patients due to the risk of Wernicke’s encephalopathy.
- In consultation with a nutrition specialist with expertise in refeeding patients with ED, adjust rate of refeeding according to the age, developmental stage, and degree of malnourishment.

- Monitor fluid replacement to avoid overload. The preferred rehydration route is oral. In cases where IV fluid is deemed necessary, it is best to avoid large fluid boluses. Replace losses slowly instead with continuous IVF at low rates (e.g., 50–75 cc/hour for adult patients or ½ normal maintenance in children).
- Closely monitor vital signs and cardiac and mental status of all patients during refeeding.
- Monitor blood glucose frequently. Postprandial glucose is often low in severely starved patients with AN.

UNDERFEEDING

Underfeeding due to overly cautious rates of refeeding can lead to further weight loss, and may be associated with a worse prognosis, slower response to treatment, and even death in seriously malnourished patients.

METHODS OF REFEEDING:

- “Start low and go slow” methods of refeeding have recently been challenged and more rapid refeeding with close medical monitoring is now preferred during **inpatient** treatment. For instance, an adult with an ED who is significantly malnourished, and has had very low intake prior to hospitalization, might be safely started at approximately 1600 kcal/day and increased by 300 kcal/day every 2–3 days until consistent weight gain of at least 2–4 lb (1–2 kg)/week is achieved.
- Most patients will require high calorie intake (3500–4000 kcal/day) to achieve consistent weight gain once medically stabilized beyond the initial stages of refeeding. This may be initiated as an inpatient and continued as an outpatient (once the patient is medically stabilized) until complete weight restoration is achieved. At this time, a reassessment of nutritional needs should be performed for weight maintenance and/or growth.
- Children/adolescents and their families may need to be reminded that they are in a state of growth and development. Treatment goal weights and nutritional needs will change with time as children and adolescents continue to grow and develop.
- Oral refeeding is always preferred. Supplemental enteral feeds may be indicated when rates of weight gain are low (<2 lb/week) or access to an expert behavioral refeeding program is limited. Parenteral feeding is not recommended and should only be used in patients without a functional gut.

INFORMATION FOR MEDICAL SPECIALTY PROVIDERS

Individuals with EDs are frequently referred to specialty providers for evaluation of medical complaints. It is important that every provider, regardless of specialty, recognize the signs and symptoms consistent with an ED, manage complications appropriately, and know when to refer a patient for specialized ED evaluation and treatment and/or when to refer for hospital admission due to significant medical compromise. Collaborative care with an ED specialist is in the best interest of all patients.

FOR ALL PROVIDERS: Please maintain a high index of suspicion for EDs, especially in high-risk patients. Keep in mind that EDs may be present in patients of any age, race, gender or size. Screen and refer to specialty care as indicated. A validated screening tool such as the SCOFF (see Appendix 1) may be used in identifying adult patients who would benefit from further evaluation for an ED.

CARDIOLOGY

- Bradycardia is a physiologic, adaptive response to starvation and is the most common arrhythmia in patients with EDs. Bradycardia should not be automatically attributed to athleticism or training in patients who are underweight, who have experienced rapid weight loss, or who have inadequate nutritional intake for their level of activity.
- Cardiologists should consult with ED specialists if they are considering an ED, or evaluating a known patient with an ED. Collaborative care helps put the patient's diagnosis and clinical presentation into an appropriate context.
- Arrhythmias due to electrolyte abnormalities are a common cause of death in patients with EDs.

EMERGENCY MEDICINE

- Patients with EDs present to emergency departments at rates higher than individuals without EDs for a variety of complaints.
- An emergency department visit may be the first interaction with health-care providers for a patient with an ED. The severity and treatment resistance of EDs increase with length of illness. The sooner a patient receives appropriate treatment, the more likely they are to fully recover from their illness. A positive clinician-patient interaction in the emergency department, and referral to appropriate ED specialty care may help to significantly reduce the length and severity of illness.

- Consult with ED specialists if unclear about the appropriate disposition and follow-up.
- Avoid overly aggressive fluid resuscitation in patients with EDs as this may precipitate volume overload and heart failure. Use low volume continuous IV fluid rather than large boluses to rehydrate.
- Avoid **excess** glucose administration in the emergency department as this may precipitate refeeding syndrome. If blood glucose is low, continuous infusion of D5 is preferred to administration of boluses of D50.

ENDOCRINOLOGY

- Adolescent females with Type I diabetes are at increased risk of EDs. They may underdose insulin and may suffer increased long-term complications of diabetes, including early death. Poor glucose control and/or frequent episodes of DKA in any diabetic patient should prompt evaluation for an ED.
- Consider Euthyroid Sick Syndrome (ESS) in a low weight patient with abnormal thyroid studies. Thyroid hormone supplementation is not required for ESS and will resolve with weight restoration.

GASTROENTEROLOGY

- GI complaints such as constipation, abdominal pain, nausea, hematemesis, frequent heartburn, and early satiety are amongst the most common physical symptoms in persons with EDs.
- Slightly elevated aminotransferases are also frequently seen in patients with EDs.
- These signs and symptoms often prompt referral to a gastroenterologist. Symptomatic treatment for GI symptoms may be initiated. It is important to note that most GI symptoms improve or resolve with resolution of the ED.

OBSTETRICS AND GYNECOLOGY

- Amenorrhea or oligomenorrhea without other identified cause should prompt evaluation for an ED.
- Oral contraceptive pills (OCPs) for treatment of amenorrhea or oligomenorrhea are not indicated for most patients with ED who do not otherwise require contraception.
- There is no current evidence to support the use of OCPs for treatment of low bone mineral density in a low weight patient with amenorrhea. Weight restoration and resumption of menses is the treatment of choice.
- Although individuals with EDs may have suppressed ovarian function, pregnancy can still occur.
- Infertility may also be a presenting complaint in patients with EDs. Assisted reproductive technology (ART) is contraindicated in low weight patients with EDs. These patients are at increased risk of miscarriage, intrauterine growth retardation, low birth weight and other pregnancy and birth complications with the use of ART.

PSYCHIATRY

- Patients with EDs have high rates of comorbidity with other psychiatric disorders including depression, anxiety, obsessive compulsive disorder, post-traumatic stress disorder, self-harm behaviors and substance use, and are at high risk of suicide.
- Patients with EDs may report symptoms of depression or other mental illness without recognizing or revealing ED thoughts or behaviors.
- Patients with EDs have the highest mortality rates of any psychiatric disorder. Their identification and appropriate treatment by an ED specialist is imperative.

PEDIATRICS

- Children and adolescents presenting with failure to thrive, fussy or selective eating, gastrointestinal symptoms (e.g., nausea, loss of appetite, constipation), unexplained weight loss, lack of weight gain or delayed growth and development should be evaluated for a possible ED.
- Carefully consider a parent's concerns about any change in their child's eating behaviors, mood, weight or growth.

TIMELY INTERVENTIONS

1. Patients with EDs may not acknowledge that they are ill, and/or they may be ambivalent about accepting treatment.

This is a symptom of their illness. Patients may minimize, rationalize, or hide ED symptoms and/or behaviors. Their persuasive rationality and competence in other areas of life can disguise the severity of their illness. Outside support and assistance with decision-making will likely be necessary regardless of age.

2. Parents/guardians are the frontline help-seekers for children, adolescents, and young adults with EDs.

Trust their concerns. Even a single consultation about a child's eating behavior or weight/shape concerns is a strong predictor of the presence or potential development of an ED.

3. Diffuse blame.

Help families understand that they did not cause the illness; neither did their child/family member choose to have it. This recognition facilitates acceptance of the diagnosis, referral, treatment, and minimizes undue stigma associated with having the illness.

4. Monitor physical health including vital signs and laboratory tests.

Patients with an ED should be regularly monitored for acute and chronic medical complications. Assessments should be interpreted in the context of physiological adaptation to malnutrition and purging behavior. Clinicians need to remember that physical exam and laboratory tests may be normal even in the presence of a life-threatening ED.

5. Psychiatric risk.

Always assess for psychiatric risk, including suicidal and self-harm thoughts, plans and/or intent. Up to 1/2 of deaths related to EDs are due to suicide.

GOALS OF TREATMENT

It is important to note that full resolution of symptoms may take an extended period of treatment. Psychological symptoms may transiently increase with initial treatment and improvement in physical health. Recognize that EDs are not merely fads, phases, or lifestyle choices. They are biologically-based, heritable disorders. People do not choose to have EDs and they can recover fully from them.

Medical stabilization, nutritional rehabilitation to achieve weight restoration, management of refeeding and its potential complications, and interruption of purging/compensatory behaviors should be the immediate goals of treatment for all patients with EDs. Additional psychological and other therapeutic goals can be addressed in parallel when appropriate.

MEDICAL STABILIZATION—AS PRESENTED ABOVE

- Management of acute and chronic medical comorbidities and complications
- Includes resumption of menses (where appropriate)

NUTRITIONAL REHABILITATION

- Weight restoration
- Restore meal patterns that promote health and social connections

NORMALIZATION OF EATING BEHAVIOR

- Cessation of restrictive or binge eating and/or purging behaviors
- Elimination of disordered or ritualistic eating behaviors

PSYCHOSOCIAL STABILIZATION

- Evaluation and treatment of any comorbid psychological diagnoses
- Re-establishment of appropriate social engagement
- Improvement in psychological symptoms associated with ED
- Improved body image

ONGOING MANAGEMENT

Following initial stabilization, ongoing evidence-based treatment delivered by healthcare professionals with expertise in the care of patients with EDs is essential for full recovery. Optimal care includes a multidisciplinary team approach by ED specialists including medical, psychological, nutritional, and psychopharmacologic services. Families (i.e., parents, spouses, partners) should be included in ED treatment whenever possible.

In low weight patients with ED, restoration of an appropriate, healthy weight will significantly improve their physical, psychological, social, and emotional functioning. Failure to fully restore weight correlates with poor outcomes, and maintenance of a healthy weight strongly correlates with improved outcomes.

For full recovery from an ED, however, weight restoration alone is not sufficient for full recovery. It is equally important that distorted body image and other ED thoughts/behaviors, psychological comorbidities and any social or functional impairments be addressed by qualified professionals during the treatment of patients with EDs.

APPENDIX 1: An example of a validated screening tool for eating disorders—The SCOFF.* Other screening tools are available.

- S** Do you make yourself **S**ick because you feel uncomfortably full?
- C** Do you worry you have lost **C**ontrol over how much you eat?
- O** Have you recently lost more than **O**ne stone (6.35 kg or 14 lb) in a three-month period?
- F** Do you believe yourself to be **F**at when others say you are too thin?
- F** Would you say **F**ood dominates your life?

*Two or more positive responses on the SCOFF indicates a possible ED and should prompt referral for further evaluation.

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For further references and information about the diagnosis and treatment of EDs visit:

www.aedweb.org



ABOUT THE ACADEMY FOR EATING DISORDERS (AED):

The AED is a global multidisciplinary professional association committed to leadership in promoting EDs research, education, treatment, and prevention. The AED provides cutting-edge professional training and education, inspires new developments in the field of EDs, and is the international source for state-of-the-art information on EDs.

JOIN THE AED: Become a member of a global community dedicated to ED research, treatment, education, and prevention. Join online at: www.aedweb.org



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