MEDICAL STABILIZATION FOR ANOREXIA NERVOSA: PUTTING ORDER TO THIS DISORDER

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August, 2019

Objectives

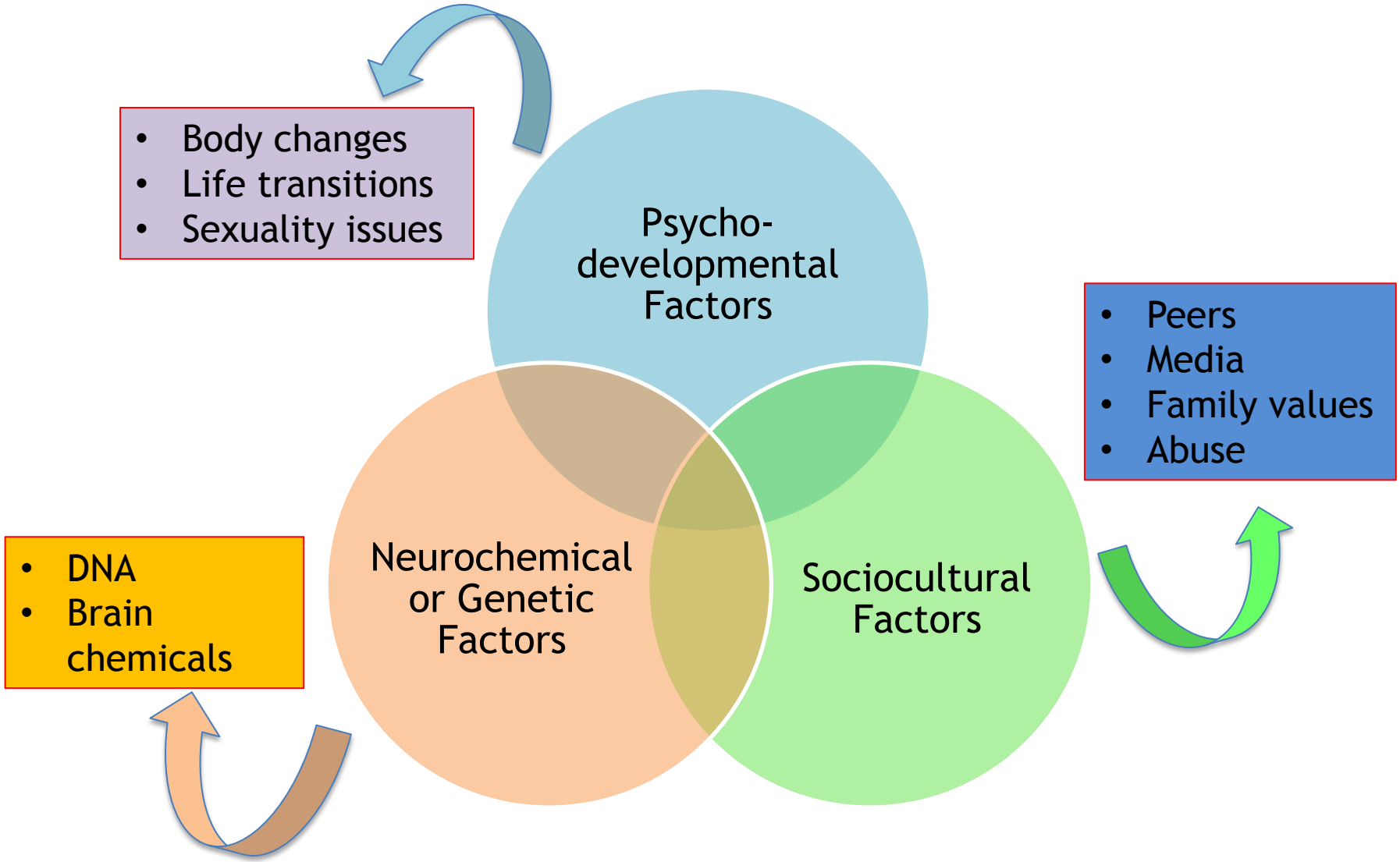
- Understand the different types of Eating disorders.
- Identify patient populations at risk for Anorexia Nervosa.
- Understand hospital based medical stabilization for anorexia nervosa performed by Multidisciplinary team.
- Identify common complications of Malnutrition due to anorexia nervosa and the intervention of Registered Dietitian.
- Identify 2 of the responsibilities of the psychiatric social worker in disposition planning.
- Identify 2 barriers to access eating disorder treatment for CHLA population.

Eating Disorders

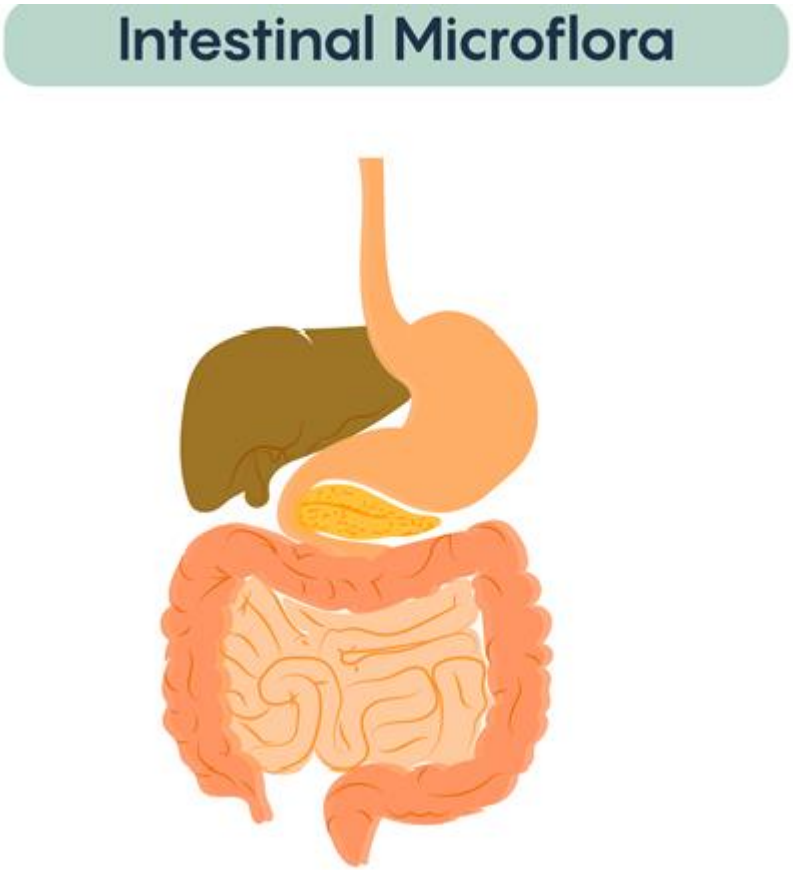
Picture: www.brainscape.com

- Anorexia Nervosa
- Bulimia Nervosa
- Binge eating disorder
- Avoidant/restrictive food intake disorder (ARFID)

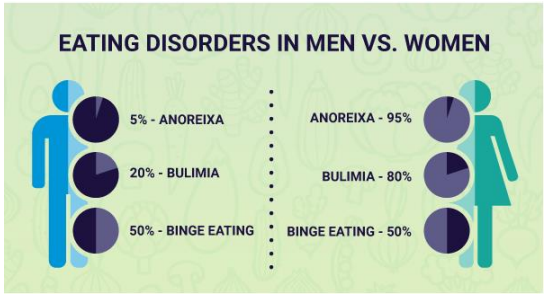
Etiology


• Body changes
• Life transitions
• Sexuality issues
Psycho-developmental Factors
• Peers
• Media
• Family values
• Abuse
• DNA
• Brain chemicals
Neurochemical or Genetic Factors
Sociocultural Factors

Imbalance of gut flora?

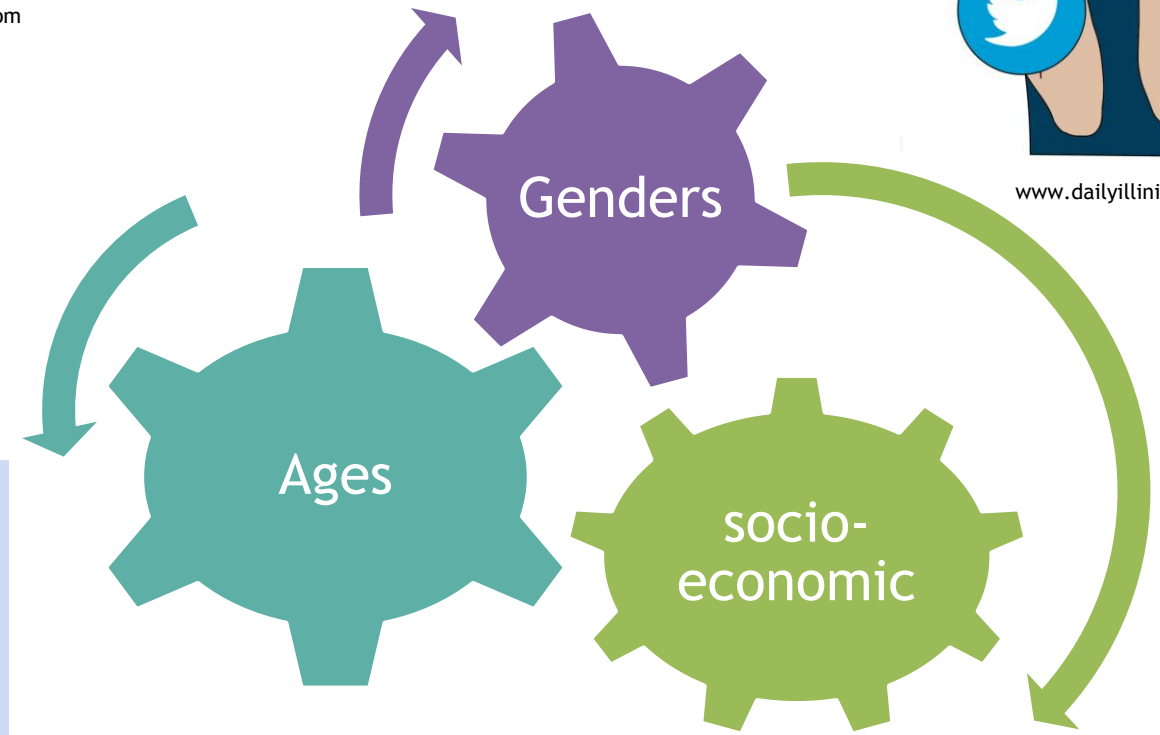


At Risk



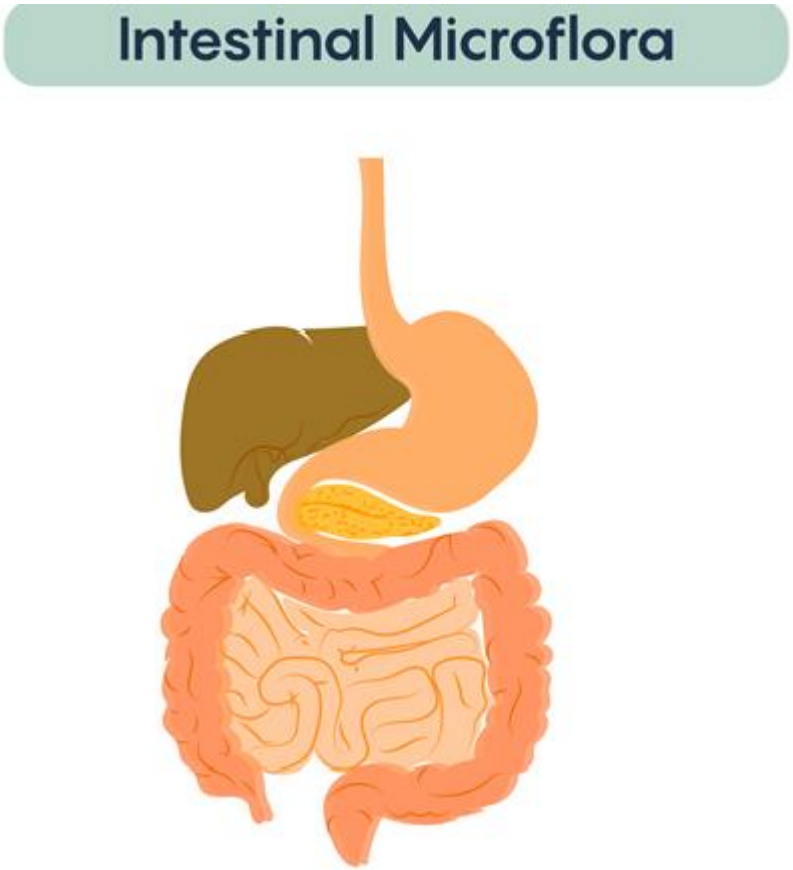
www.therecoveryvillage.com

www.dailyillini.com

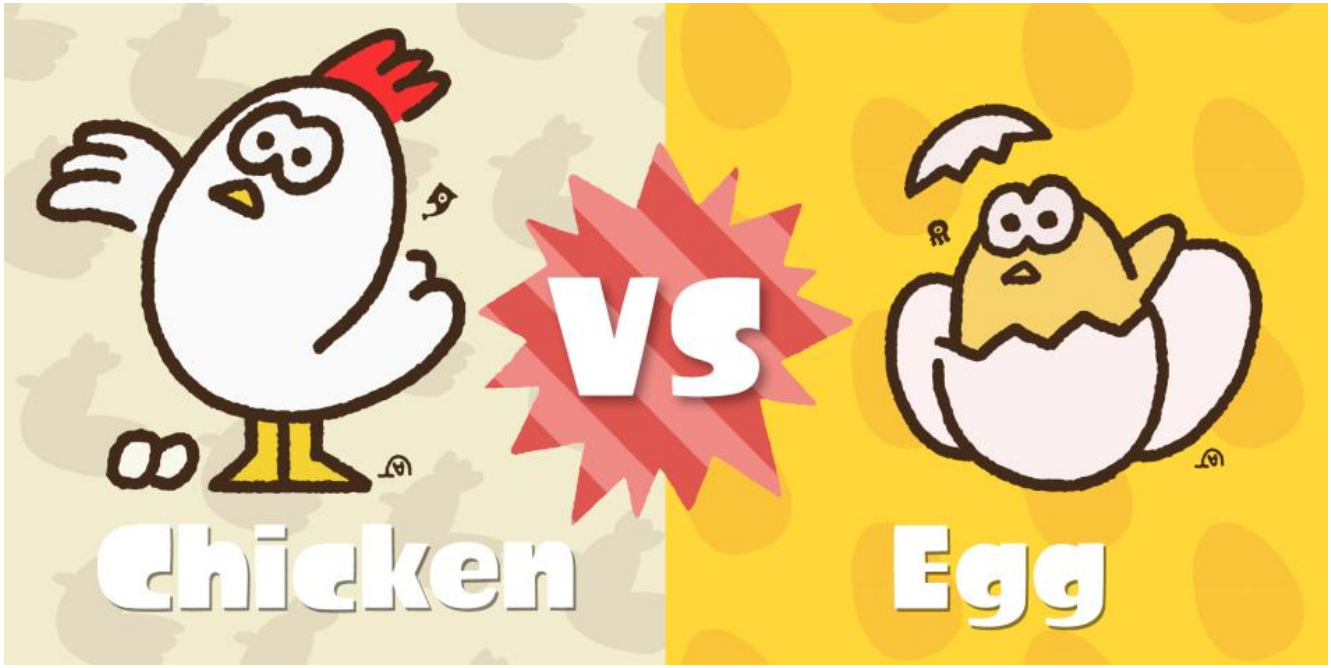


www.freepik.com

Imbalance of gut flora?



Causal or Causative → to be determine



https://topclues.in/question/which-came-first-the-chicken-or-the-egg/

Anorexia Nervosa Statistics

- **1.0% to 4.2% of women** have suffered from anorexia in their lifetime.
- Anorexia has the **highest fatality** rate of any **mental illness**.
- Only **one third** of individuals struggling with anorexia nervosa in the United States **obtain treatment**.

Key points

- Malnutrition resulting from chronic starvation → erratic and irregular eating behaviors.
- Complications → Cardiovascular, gastrointestinal, neurological, endocrine, pulmonary, hematologic.
- The primary risk factors for developing medical complications in anorexia nervosa are the degree of weight loss and the chronicity of the illness.

PUTTING ORDER TO THIS DISORDER

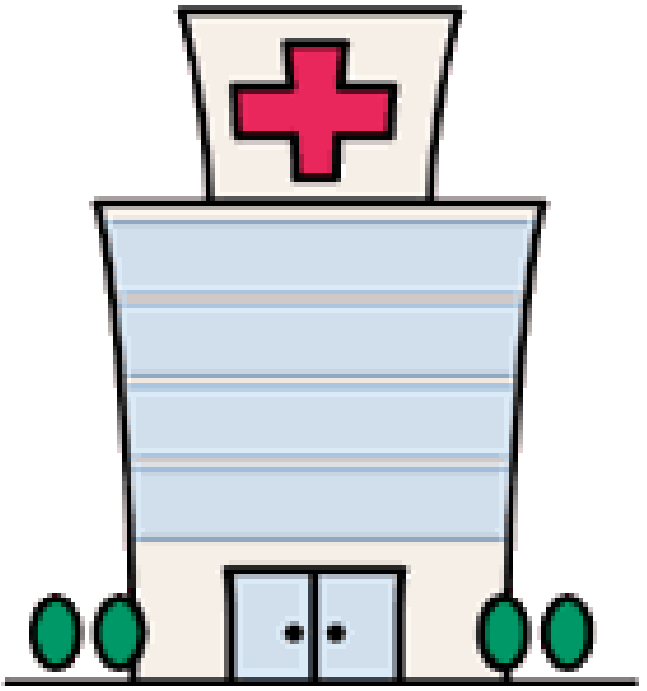
CHLA entry points

Inpatient Setting

Outpatient Setting

Acute Transfers

Emergency Room



What do we do at CHLA?

4 STEPS

1. Rule out → PMD, Outpatient therapists
2. Acuity → Based on Criteria for admission
3. Evaluation → Multidisciplinary
4. Plan of care

What do we do at CHLA?

STEP 2. Criteria for admission: 2 or more

- <75% IBW
- Food refusal
- HR < 50 bpm during the day and <45 bpm at night
- Systolic pressure <90 mmHg
- Orthostatic changes
- Hyponatremia (<96 degrees F)
- Arrhythmia

What do we do at CHLA?

Medical stabilization is the **Goal**

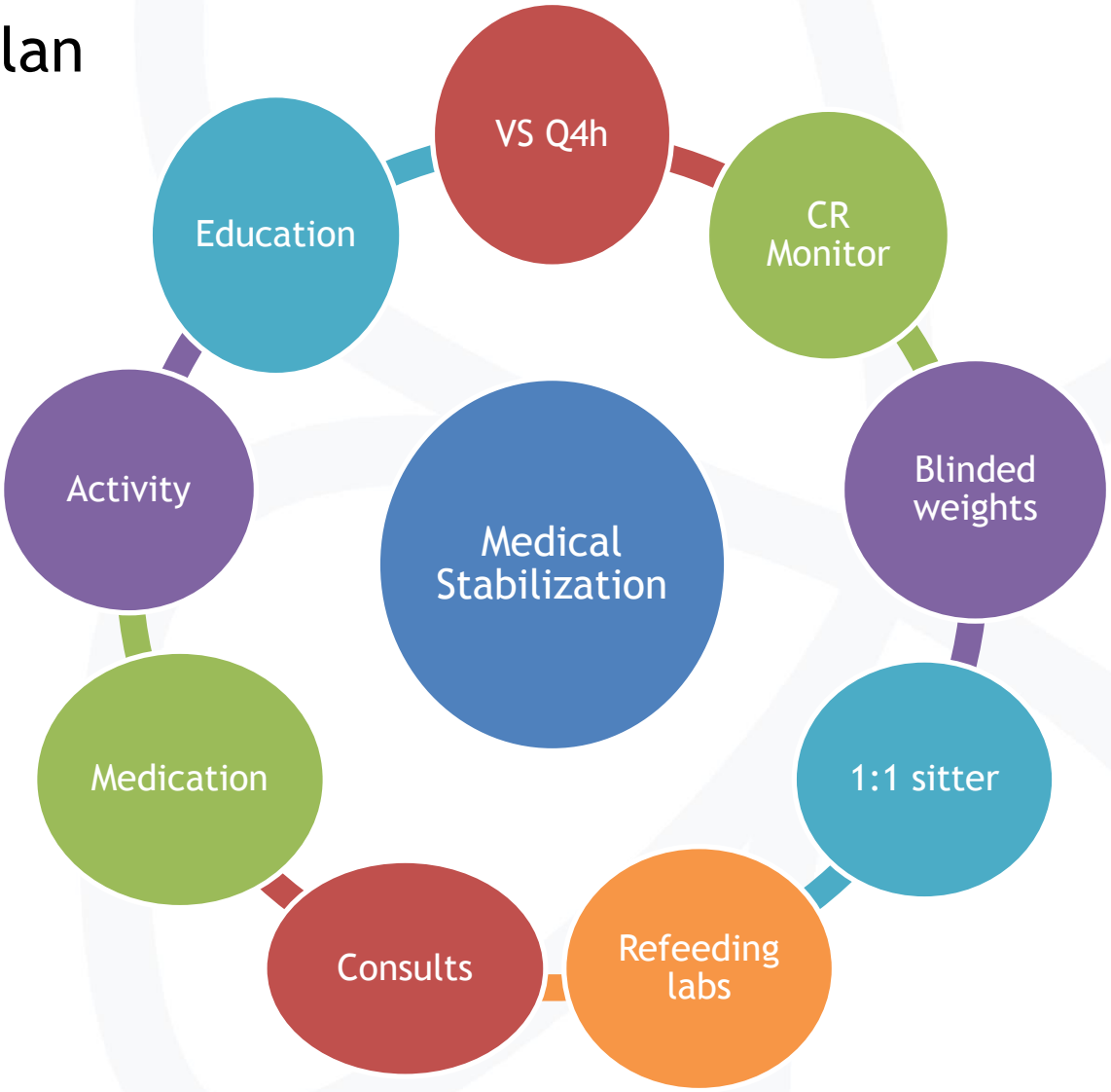
STEP 3. Multidisciplinary team evaluates patient →

Medical team, Adolescent Medicine, Psychology and Clinical Nutrition Services

https://www.bing.com/images

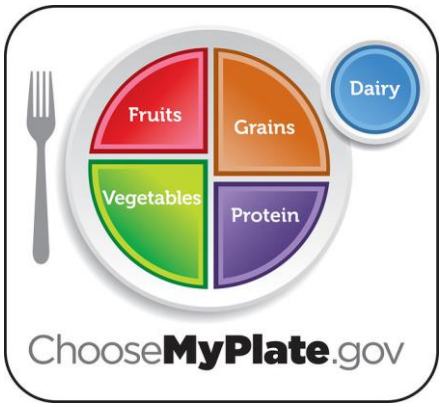
What do we do at CHLA?

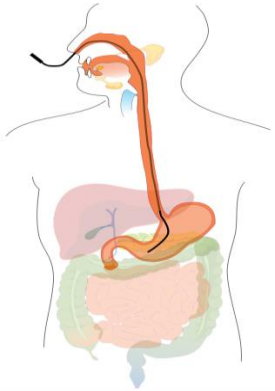
STEP 3.
Medical Plan



What do we do at CHLA?

- Food is now referred to as the Medicine
- All nutritional discussions should only be conducted with clinical team
- 3 choices: Eat, boost plus PO or NGT

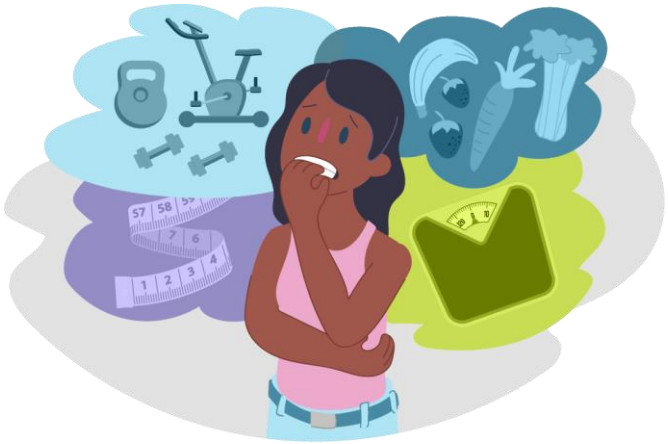




What do we do at CHLA?

Case Study

Rule out | Criteria | Evaluation | Complication | Discharge planning



CG -> 13 yo female. No prior medical history. PMD referred her 2/2 concern of continued wt loss in 3 months.

1 week prior admission→ seen by a psychologist → no Dx was given.

Case Study

Rule out | Criteria | Evaluation | Complication | Discharge planning

-<75% IBW

-Food refusal

-HR < 50 bpm during the day and <45 bpm at night

-Systolic pressure <90 mmHg

-Orthostatic changes

-Hyponatremia (<96 degrees Fahrenheit or 35.5 Celsius)

-Arrhythmia

UBW 150lbs (68.18 Kg) → 55Lbs (25 Kg) in 3 months→ %IBW 69.7

8 months before admission (restrictive eating (PMD visit, religion) as well as increased physical activity).

Temp 36.9 C

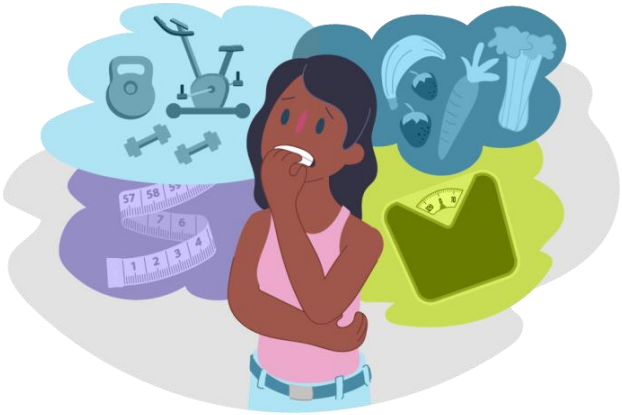
BP: 105/65

HR 68 bpm

Respiratory rate 12 breaths/ min

Case Study

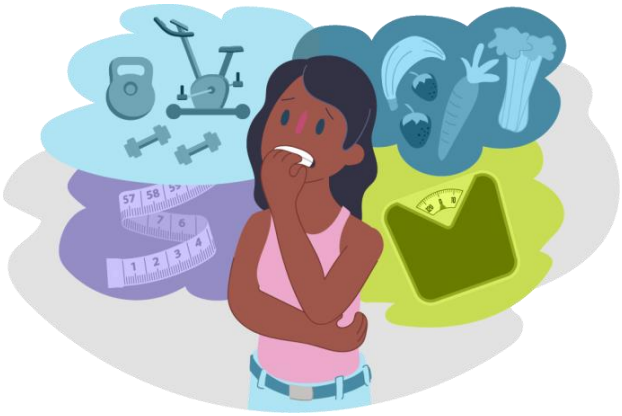
Rule out | Criteria | **Evaluation** | Complication | Discharge planning



- Decreased PO and intentional weight loss.
- 8 months before admission (PMD visit, religion) as well as increased physical activity).
- Counting calories.
- CG began to focus just on losing weight.
- Exercises 4-5 times per week (1 hour).
- Denied vomiting, binge eating.

Case Study

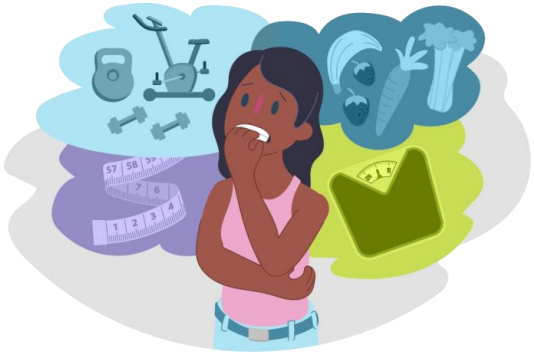
Rule out | Criteria | **Evaluation** | Complication | Discharge planning



- Anthropometrics
  - BMI: 14.97 Kg/m2 (<3 %ile Z score: -2.2)
  - Arm circumference: 19 cm (<5% Ile)
- Clinical:
  - Lytes: K 3.2, Mg 2.2, phos: 3.8, Urine Ketones 15, glucose 60
  - Dizziness, feeling cold
  - LMP ~3 months ago

Case Study

Rule out | Criteria | **Evaluation** | Complication | Discharge planning



P: Moderate Malnutrition

E: related to disordered eating and excessive exercise

S: as evidence by drop in wt 40% in 8 months, BMI 14.97 Kg/m2 Z-score -2.2, muscle wasting, inadequate intake of food compared to estimated needs.

Case Study

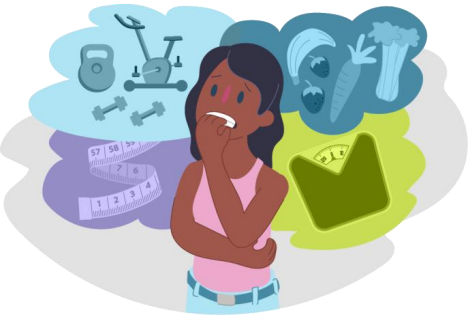
Rule out | Criteria | **Evaluation** | Complication | Discharge planning

- Goals:
  - Prevent weight loss, then 0.14-0.2 Kg/d of weight gain
  - Optimize Nutrient intake
  - Prevent refeeding syndrome
  - Inter-professional collaboration

- Intervention:
  - Monitor weight
  - Initiate 1600 Kcal (advance 200Kcal each day) -> Goal 2400 Kcal
  - Monitor meals (time)
  - Oral supplement for every Kcal no consumed
  - No media
  - Supplementation: Thiamine, MVI, Lytes as needed
  - Therapies (pet, art, music, sunshine)

Case Study
What happened to CG?

Rule out | Criteria | Evaluation | **Complication** | Discharge planning



Superior mesenteric artery syndrome (SMAS)

WHAT? duodenum is compressed between the aorta and the superior mesenteric artery CAUSING partial or complete blockage of the duodenum.

WHY? loss of the mesenteric fat pad → weight loss

SYMPTOMS: abdominal pain, fullness, nausea, vomiting, and/or weight loss.

What do we do at CHLA?

STEP 4.
Plan of care/Discharge Planning

Who is involve? → CCC with adolescent team, Psych, SW to determine best placement

Limitations → Insurance inquiry for inpatient eating disorders programs, behavioral health programs and dietary resources

Criteria →

- BMI & Medical Stablization: Provider United
- Direct Transfer ?
- Available resources
- Solidified acess to outpatient plan
- Buy-in

Case Study
What happened to CG?

Rule out | Criteria | Evaluation | Complication | **Discharge planning**

- Medical clearance to continue attending school.
- Directly admitted for medical stabilization.
- Her family had a challenging time
- The cause and drive of her eating dx was largely influenced by religious practices.
- Required a significant amount of psychoeducation
- CG was accepted to UCLA Inpatient Eating Disorder Program, the length of time was determined by their clinical team.

Barriers to treatment

- Medical stabilization
- BMI
- Insurance access: Center for Discovery, Monte Nido, Eating Disorder Los Angeles, Bhc Reason's
- DMH recognition of eating disorder treatment
- Gap times in access to untrained clinicians
- Timeline alignments with outside facilities
- Family contribution
- Family competency
- Cultural Awareness
- Psychosocial stressors
- Child Protective Services

Take Home Messages

- Safety first
- Safety net
- CHLA -> is not a full comprehensive behavioral eating disorder program
- CHLA -> we do our absoulute best to provide our families with preperation for what their up against.

We must first re-nourish the body before we can re-train the brain

RD

Eating Disorder thoughts are not true, though they seem so

RD

Not getting your nutrition is not an option

RD

We wouldn't let someone with Diabetes not take their insulin. Similarly, we won't let you not take your food medicine

RD

Nothing the parents did or didn't do could have prevented the Eating Disorder. The stars just aligned

RD

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Thank you!

QUESTIONS?