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

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

Picture: www.brainscape.com
Etiology

Psycho-developmental Factors

- Body changes
- Life transitions
- Sexuality issues

Neurochemical or Genetic Factors

- DNA
- Brain chemicals

Sociocultural Factors

- Peers
- Media
- Family values
- Abuse
Etiology

Imbalance of gut flora?
At Risk

EATING DISORDERS IN MEN VS. WOMEN

- 5% - ANOREXIA
- 20% - BULIMIA
- 50% - BINGE EATING

ANOREXIA - 95%
BULIMIA - 85%
BINGE EATING - 50%

www.therecoveryvillage.com

Ages

Genders

socio-economic

www.dailyillini.com

www.freepik.com
At Risk

Imbalance of gut flora?

Intestinal Microflora
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?

STEP 3. Multidisciplinary team evaluates patient →

Medical team, Adolescent Medicine, Psychology and Clinical Nutrition Services

Medical stabilization is the Goal
What do we do at CHLA?

STEP 3.
Medical Plan

- Education
- VS Q4h
- CR Monitor
- Blinded weights
- Medication
- Activity
- Consults
- Refeeding labs
- 1:1 sitter
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?

- 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

- 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.
• **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

#### 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.
• 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)
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 involved? → 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 Stabilization: Provider United
- Direct Transfer?
- Available resources
- Solidified access to outpatient plan
- Buy-in
Case Study

What happened to CG?

• 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 absolute best to provide our families with preparation for what their up against.
We must first re-nourish the body before we can re-train the brain

Eating Disorder thoughts are not true, though they seem so

Not getting your nutrition is not an option

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

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


Thank you!

QUESTIONS?