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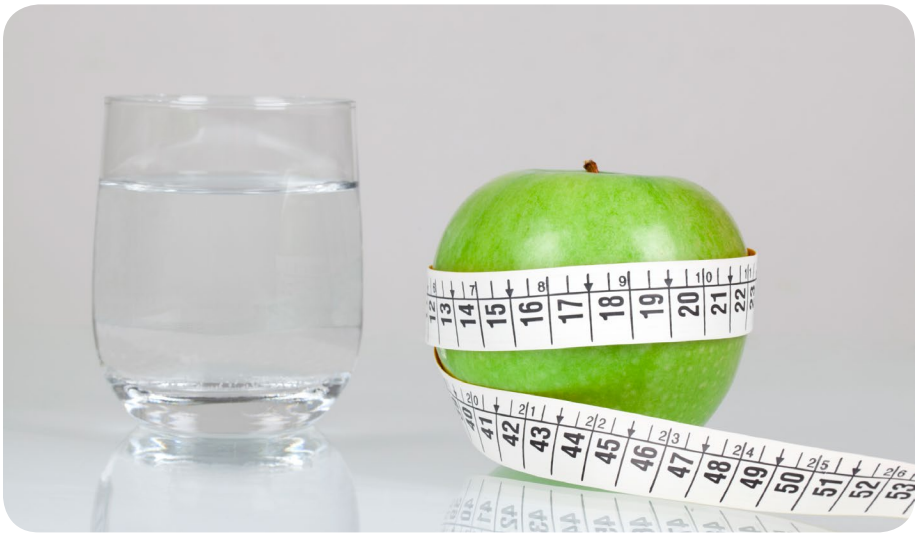

Eating Disorders Toolkit

for Primary Care Practitioners

Interior Health

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the northern way of caring

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Purpose of this Document

The aim of this document is to provide a quick reference to primary care practitioners (PCPs) that promotes recognition and prevention of medical morbidity and mortality associated with eating disorders.

This document also aims to clarify the role of the PCP, what to expect with individuals with eating disorders, and how to engage them in necessary treatments.

Many individuals with eating disorders will do well with outpatient support while others may require hospitalization or intensive specialized treatment services.

We believe patients deserve to receive the right treatment, in the right place, at the right time.

Important Things To Know About Eating Disorders

Your Role As A Primary Care Practitioner [3]

Expertise in eating disorders is not a prerequisite to effective screening and early prevention.

Despite frequent contact, more than half of eating disorders cases go undetected in primary care settings.

By understanding the presentation of these patients, you will be better equipped to screen patients who are at risk or showing common signs or symptoms.

Patients With Eating Disorders In Primary Care [1,3]

Acute malnutrition is a medical emergency. Malnutrition can occur at any body weight, not just at low weight.

Patients with eating disorders are often in denial of the seriousness of their illness or they may not be prepared to begin treatment. Minimizing, rationalizing, or hiding symptoms and behaviours are common and can disguise the severity of the illness.

Males can have eating disorders too.

Statistics [1,3,7]

Anorexia Nervosa has the highest mortality rate of any other psychiatric illness, up to 20% will die.

Almost ½ of deaths in patients with Anorexia Nervosa are related to cardiac failure and medical complications.

Up to 1/3 of deaths related to eating disorders are due to suicide. ALWAYS assess for psychiatric risk, including self-harm or suicidal ideation, thoughts, plans, intent, lethality and accessibility of plan.

The Patient's Experience [3, 5]

Patients with eating disorders experience their behaviours as fulfilling a valued need (e.g. avoid difficult emotions or painful experiences, feel better about oneself, sense of control, feeling special or different).

Ambivalence or lack of interest in change is an expected part of the illness.

Patients may be reluctant to describe their symptoms or readiness if they fear honest responses will result in judgment, blame or unwanted treatment.

Building Therapeutic Alliance

Motivational Interviewing [2,3]

Website: https://motivationalinterviewing.org/

Motivational Interviewing is an effective means to building therapeutic alliance and engaging patients who are ambivalent about change. This involves mindful observing, listening and eliciting the patient's own motivation to change. Therapeutic alliance is foundational to treatment effectiveness.

- Approach with a spirit of acceptance, compassion, and collaboration.
- Express empathy.
- Engage patients with open questions, show interest, make efforts to see the world through their eyes, affirm their strengths and efforts and acknowledge the inherent worth of the patient as an individual.
- Minimize patient-clinician discord: Use reflective listening to disarm resistance and differences; avoid arguing, refuting, or contradicting the patient's point of view; respond non-defensively and non-judgmentally.
- Listen for underlying emotions, make guesses at what the patient means, validate the emotion so that the patient knows you "get it":
  - Patient: "I'm not going to the hospital…it was horrible last time!"
  - PCP: "You're afraid it won't go well. It makes sense you don't want to go again. That was horrible for you. And you need help"
- Reflect back discrepancies: Verbalize the discrepancy between the patient's current state and what they are actually hoping for.
  - Patient: "I'm not going to eat and you can't make me!"
  - PCP: "You're so scared to eat and you have no energy. Neither is what you really want. It's hard to do this on your own…and there is help."
- Support change:
  - "How would you like things to change?"
  - "How might you go about making this change?"
  - "What have you done before to make things better?"

Therapeutic Boundaries & Non-Negotiables [3,4]

- Balance therapeutic alliance with therapeutic boundaries.
- Non-negotiables are mandatory treatment components to ensure safety and manage risk. See page 8 for indications for hospitalization.
- Effective non-negotiables require a sound rationale and need to be consistently implemented. Aim to maximize autonomy and collaborate on decisions without surprise.
- For children and youth in outpatient settings, parents are in the best position to set and support treatment non-negotiables with you. Involve school where applicable and with patient consent.
- **Criteria for Involuntary Admission** (BC Practice Guidelines, pp. 127-129):

  Website: https://cfe.keltyeatingdisorders.ca/res/clinical-practice-guidelines-bc-eating-disorders-continuum-services-1

- Eating disorders are mental disorders. There is medical consensus that psychiatric treatment under the Mental Health Act includes any and all treatment, including nasogastric tube feeding and medical stabilization. The Mental Health Act authorizes involuntary psychiatric treatment for people with eating disorders who meet the following criteria:

- Person is suffering from a mental disorder (eating disorder) that seriously impairs ability to react appropriately to circumstance;
- Person requires care, supervision & control in or through a designated facility to prevent the person's substantial mental or physical deterioration or for the person's own protection of others;
- Person is not suitable as a voluntary patient; and
- Person requires psychiatric treatment in or through a designated facility.

Risk Factors & At-Risk Populations [3]

- Early puberty
- Poor or abnormal growth curves in children and adolescents
- Activities and occupations that emphasize body, shape, and weight (e.g., ballet, gymnastics, modeling)
- Low or high BMI, or weight fluctuations
- Type 1 diabetes
- Amenorrhea (primary or secondary)
  WARNING: BCPs/HRTs DO NOT PREVENT BONE LOSS.
- Family history of eating disorders
- Weight concerns among normal weight individuals

Early Recognition – Common Signs & Symptoms [1,3,7]

General

- Marked weight loss, gain, or fluctuations
- Failure to gain expected weight in a child or adolescent
- Cold intolerance
- Weakness, fatigue, lethargy
- Dizziness, syncope
- Hypoglycemia

Dermatologic

- Lanugo
- Hair loss
- Carotenemia
- Russell's sign
- Poor healing

Cardiorespiratory

- Chest pain
- Bradycardia
- Hypotension
- Heart palpitations
- Arrhythmias
- Shortness of breath
- Edema

Endocrine

- Amenorrhea, irregular menses or unexplained infertility
- Loss of libido
- Low bone mineral density

Oral & Dental

- Oral trauma/lacerations
- Dental erosion
- Perimolysis
- Parotid enlargement

Gastrointestinal

- Epigastric discomfort
- Early satiety, delayed gastric emptying
- Gastroesophageal reflux
- Constipation

Neuropsychiatric

- Seizures
- Memory loss/poor concentration
- Insomnia
- Depression/anxiety/ obsessive behaviours

Initial Assessment: History [3]

"S.C.O.F.F." Screening Tool for Eating Disorders (AGE 14 AND UP)

Website: http://www.ceed.org.au/sites/default/files/resources/documents/SCOFF%20Questionnaire%20August%202016.pdf

Over the past three months:

- Do you make yourself **SICK** because you feel uncomfortably full?
- Do you worry that you have lost **CONTROL** over how much you eat?
- Have you recently lost more than **ONE** stone (14 lbs or 6.4 kgs) in a three-month period?
- Do you believe yourself to be **FAT** when others say you are too thin?
- Would you say that **FOOD** dominates your life?

Two or more answers of "yes" provides 100% sensitivity for anorexia and bulimia.

Areas of Inquiry to Gain a Thorough Clinical Picture:

- **Eating behaviours:**
  - Dietary rules or rituals
  - Food avoidance
  - Contents of meals and snacks (food record)
- **Compensatory behaviours:**
  - Purging
  - Binge/purge cycles
  - Excessive exercise
  - Laxative use
  - Medication use
- **Weight history:**
  - Lowest and highest weights (at current height)
  - Ideal weight
- **Menstrual history (Prolonged amenorrhea, consider bone loss)**
- **Screen for co-occurring psychiatric conditions:**
  - Depression
  - Anxiety
  - Personality disorders
  - Self-harm
  - Substance use
  - Suicidal thoughts or ideation
- **Family and social history:**
  - Family medical and mental health history
  - Status of current relationships

Initial Assessment: Physical Exam [3,6]

- Vital signs:
  - Supine and standing heart rate and blood pressure
  - Oral temperature
- Measurement of height, weight and BMI (kg / m2)
- For children & adolescents, plot a growth chart
- Sit up-Squat-Stand Test to assess muscle weakness

Ongoing Medical Monitoring is Necessary

- As long as eating disorder symptoms are active
- Frequency will depend on severity and potential risk for decline

DSM5 Severity Specifiers:

- AN: Mild: BMI > 17, Moderate: 16-16.99, Severe: 15-15.99 and Extreme: < 15.
- BN: Mild: Average 1-3 episodes / week, Moderate: 4-7 / week, Severe: 8-13 / week, Extreme: 14 or more / week

Initial Assessment: Labs And Interpretation Of Results [1,3]

Investigation:	If HIGH, may indicate:	If LOW, may indicate:
CBC	Neutrophils may be high with excessive exercise	Leukopenia, anemia (check ferritin and B12), or thrombocytopenia
Glucose	Insulin omission (with Type 1 Diabetes)	Poor nutrition
Sodium	Dehydration	Water loading or laxative use
Potassium	Dehydration	Vomiting, laxative or diuretic use, refeeding
Chloride	Laxative use	Vomiting
Bicarbonate	Vomiting	Laxative use
Blood Urea Nitrogen	Dehydration *(High urea and creatinine may indicate excessive use of protein powder with body building)*	
Creatinine	Dehydration, renal dysfunction *(Normal results may be considered "relatively elevated" given low muscle mass)*	Low protein intake or muscle mass
Calcium		Poor nutrition
Phosphate		Poor nutrition or refeeding syndrome
Magnesium		Poor nutrition, laxative use, or refeeding syndrome
Total Protein / Albumin	Seen in early malnutrition, at expense of muscle mass	Seen in later malnutrition
Liver Function Test	Liver dysfunction	Poor RBC mass
Ferritin	Inflammatory marker	Poor iron intake & anemia
Vitamin B12		Vegan diet
25OH Vitamin D		At risk of poor bone health
Zinc		Poor nutrition
Amylase	Vomiting, pancreatitis	
TSH and T4		Sick euthyroid syndrome (may be low to normal)

ECG

Abnormal Findings:

- Bradycardia and / or arrhythmias
- Prolonged QTc interval (> 450 msec.)
- T wave inversion
- Non-specific ST-T wave changes including ST segment depression
- U waves with hypokalemia or hypomagnesemia

DEXA Scan

NB: Indicate Hypothalamic Pituitary Suppression on Requisition

Indications For Hospitalization: [3,7] Consider Consultation To Local Or Provincial EDP

Note: These include indications for involuntary admission under the BC Mental Health Act

Indicator	Child / Adolescent	Adult
Temperature	< 35.6°C or 96.0°F	< 35.5°C or 96.0°F
Heart Rate	< 45 bpm or symptomatic postural tachycardia	< 40 bpm or symptomatic postural tachycardia
Blood Pressure	Systolic < 90 mmHg, or orthostatic change of >20 mmHg coupled with signs of hypovolemia.	< 90 / 60 mmHg, or orthostatic change of >20 mmHg coupled with signs of hypovolemia.
Sodium	<130 mmol / L	< 127 mmol / L
Potassium	< 3.2 mmol / L	< 2.3 mmol / L
Magnesium	<0.7 mmol / L	< 0.6 mmol / L
Phosphate	<0.8 mmol / L	Below normal on fasting
Serum Chloride	< 88 mmol / L	
Blood Glucose	<3.0 mmol / L	< 2.5 mmol / L
Weight	< 75% of ideal body weight, < 10% body fat, or ongoing weight loss	Rapid and progressive weight loss
General Signs And Symptoms:	• Suicide Risk • Dehydration that does not reverse within 48 hours • Cardiac arrhythmias, including prolonged QTc interval (> 450 msec.) • Intractable vomiting • Esophageal tears • Hematemesis • Syncope • Severe acrocyanosis • Muscular weakness or diaphragmatic wasting not accounted for by a correctable deficiency • Signs of inadequate cerebral perfusion (confusion, syncope, loss or altered level of consciousness, ophthalmoplegia, seizure, tetany, ataxia) • Poorly controlled diabetes • Pregnancy with an at-risk fetus • Failure to respond to outpatient treatment	

Goals of Treatment [1]

- Restoration of nutritional status
- Restoration of weight (where applicable)
- Medical stabilization, prevention of serious medical complications
- Resumption of menses (where applicable)
- Cessation of binging, purging & eating disordered ideations
- Restoration of meal patterns that promote health and social connections
- Re-establishment of social engagement
- **For children and youth**: Review pre-pubertal growth & development, prevent stunting, as well as bone loss
- Recovery

Gastrointestinal Discomfort with Refeeding [1]

- Semi-starvation leads to reduced GI motility.
- Expect bloating, stomach pain and constipation during refeeding.
- Reassure the patient that the gut will start working and symptoms will improve over time.
- Medications are usually not necessary. However, treatment of constipation may improve and aid the refeeding process but must be watched carefully to avoid laxative abuse.

Re-feeding Syndrome [1]

- Refeeding syndrome describes a potentially fatal shift of fluid and electrolytes that can occur when refeeding a malnourished patient. If concerned, consult local EDP, SPH or BCCH.
- The following individuals are more at risk:
  - Young age
  - Chronic undernourishment
  - Those who have had little or no energy intake for more than 10 days e.g. prolonged fasting or low energy diet
  - Rapid or profound weight loss, including individuals who present at a normal weight after weight loss
  - Obesity and significant weight loss, including after bariatric surgery
  - Malnourishment, especially if in combination with significant alcohol intake
  - A history of misuse of medications to purge or lose weight
  - Abnormal electrolytes, especially hypophosphatemia

NB: Phosphate supplementation (e.g. 500 mg phosphate bid) and regular monitoring of electrolytes are recommended. Consult your local pediatrician/internist for further details.

Provincial Consultation For Eating Disorders

Provincial Adult Tertiary Services for Eating Disorders Program (PATSEDP) St. Paul's Hospital

- **Business Hours (M-F, 9-5), Phone: 604-806-8654** Intake Coordinator, will triage consult requests.
- **After hours, phone EDP 4NW Inpatient at 604-682-2344, ext. 62971** contact info for the internist on-call will be provided.

Rapid Access to Consultative Expertise (RACE)

- **Business Hours (M-F, 8-5), Phone: 1-877-696-2131 (Toll-free) or 604-696-2131 (Lower Mainland)** Eating Disorder Psychiatry: Option 3, Menu 6

Website: http://www.raceconnect.ca/

BC's Children's Hospital Eating Disorders Program

- **Phone: 1-604-875-2161 during business hours for the Intake Coordinator or 1-604-875-2345 after hours** ask for Adolescent Medicine on-call.

Specialized Intensive Treatment Centres, BC

Provincial Specialized Eating Disorder Program BC's Children's Hospital, Vancouver, BC

Outpatient, day treatment, and inpatient services for children and adolescents up to age 17.

Phone: **1-604-875-2106 (Intake Coordinator)**
Website: http://www.bcchildrens.ca/our-services/mental-health-services/eating-disorders#Treatment

Provincial Adult Tertiary Specialized Eating Disorder Program St. Paul's Hospital, Vancouver, BC

Specialized, tertiary care for adults 17 years of age and older:

- 4NW – Specialized inpatient acute care for eating disorders
- Discovery Vista – Residential treatment for eating disorders

Phone: **1-604-806-8347 (Ask for Intake Coordinator)**

Website: http://mh.providencehealthcare.org/programs/provincial-adult-tertiary-eating-disorders-program

Looking Glass Residence, Vancouver, BC

A 14-bed youth residential treatment facility for ages 16-24.

Phone: **1-604-829-2585**
Website: http://www.lookingglassbc.com/residential-care

Local Referrals

See website for details of services in your locale:
Website: https://keltyeatingdisorders.ca/finding-help/locate-programs-treatment-centres/

Resources and Useful Websites

Kelty Mental Health Resource Center at BC's Children's Hospital (Vancouver, BC)

Free information, referrals, online resources and drop-in access for individuals and their families with eating disorders (**all ages**). Peer support is also available for individuals of any age struggling with an eating disorder or disordered eating.

Phone: **1-800-665-1822**
Website: http://www.keltyeatingdisorders.ca

Looking Glass Foundation for Eating Disorders (Vancouver, BC)

Provincial online support groups for parents / caregivers, adults, and adolescents. Community initiatives including research, annual scholarships, speakers and annual fundraiser.

Phone: **1-604-314-0548**
Website: http://www.lookingglassbc.com

Jessie's Legacy (North Vancouver, BC)

Offers education, resources & inspiration in the prevention of eating disorders and addresses disordered eating.

Website: http://jessieslegacy.com/

National Eating Disorders Information Centre (Toronto, Ontario)

Website: http://nedic.ca/

Clinical Practice Guidelines for the BC Eating Disorders Continuum of Services

Website: https://cfe.keltyeatingdisorders.ca/res/clinical-practice-guidelines-bc-eating-disorders-continuum-services-1

Excellence in Motivational Interviewing

Website: https://motivationalinterviewing.org/

SCOFF

Website: http://www.ceed.org.au/sites/default/files/resources/documents/SCOFF%20Questionnaire%20August%202016.pdf

Rapid Access to Consultative Expertise (RACE):

Hours: Monday-Friday 0800 - 1700

Phone: **1-877-696-2131 (toll free) or 604-696-2131 (Lower Mainland)**

Website: http://www.raceconnect.ca/

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