Families as Allies:

Rapid, Aggressive Intervention for Anorexia, Bulimia and OSFED

Expanding Access for Early and Aggressive Intervention at UWHealth

Bio

- *Lance Nelson is an Assistant Professor of Pediatrics at the Feinberg School of Medicine at Northwestern. He completed his Pediatric residency at The University of Iowa and Adolescent Medicine fellowship at Stanford University. He currently serves as the Medical Director for the Eating Disorder Program at Lurie Children's Hospital of Chicago. Lance's clinical and research interests are health equity and access as well as the medical management of males with restrictive eating*

Disclosures

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- *I do not intend to discuss an unapproved/investigative use of a commercial product/device in my presentation.*

OBJECTIVES

Following participation, attendees will be able to…

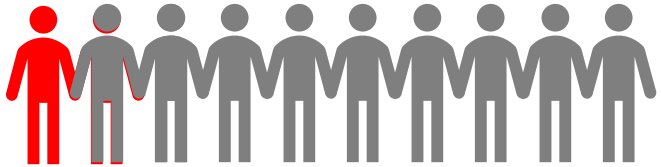
… justify the importance of getting patients with restrictive eating disorders into early, aggressive treatment

… identify pediatric patients with / at risk for restrictive eating disorders regardless of presenting concern

… compare and contrast different treatment modalities for restrictive eating disorders, focusing on FBT as the “gold standard”

… communicate an initial plan to patients and families when a new eating disorder diagnosis is suspected

Why is it important to aggressively treat adolescent eating disorders?



1/10 impacted

20% mortality

>1 death / hr

Knowledge check:

… risk of death in someone diagnosed with anorexia nervosa is…

A. Higher than from any other mental health dx aside from opioid use disorder
B. Higher than from some forms of childhood leukemia
C. Higher that that of a 6-month-old Dx'd with intermediate-risk neuroblastoma
D. Higher than the risk of death from a myocardial infarction (within 1 year of the MI)
E. All of the above

Who is at risk For an ED?

- Female sex (although males on rise)
- Athletes: Gymnastics, Running, Wrestling, Dance
- Family or Twin History of Eating Disorder
- Rigid behavior, Perfectionistic (Straight A students)
- History of Dieting in Patient or **parent (esp. if currently)**
- Autism spectrum for ARFID
- Anxiety, OCD, Depression hx
- Social media exposure????

Anorexia Nervosa-Restricting Type

- Restriction of energy intake relative to requirements leading to a significantly low body weight
- Intense fear of gaining weight or persistent behavior that interferes with weight gain
- Disturbance in the way in which one's body weight or shape is experienced, lack of recognition of the seriousness
- **Taken Out**
  - Amenorrhea for 3 months
  - BMI <15 or <85% Ideal

Bulimia Nervosa

- A. Eating **a large amount of food** (usually 1-2kcal) in 1-2 hour period of time
- B. **lack of control**.
- C. Recurrent inappropriate **compensatory behavior in order to prevent weight gain**
- D. occur, on average, **at least once a week for three months.** (used to be 2x/week)

AN-Binge Purge Type

- Combination of Anorexia and Bulimia Nervosa
- Most of the day is in restriction (aka more AN like)
- “subjective binges”
- Compensation may be purging, but more likely restriction or exercise
- Goal is continued weight loss

ARFID

- Different subtypes
  - **Lack of interest** in eating or food
  - **avoidance based on the sensory** of food
  - concern about **aversive consequences** of eating (**choking**, abdominal pain, nausea)
- Does not occur exclusively during the course of anorexia nervosa or bulimia nervosa
- **no evidence of a disturbance in the way in which one's body weight or shape is experienced (They want to gain weight).**

Knowledge check:

- A 14 year old patient presents with weight loss. Patient states that they eat 1 meal per day and then “eat way too much” late at night 2-3 times per week. This causes them to feel gross and cut back on calories by 500 the next day. The patient’s history is most consistent with the following diagnosis?

- Anorexia Nervosa Restricting Type
- Anorexia Nervosa Binge Purge Type
- Bulimia Nervosa
- Aversion subtype of ARFID

Outpatient Management

Weight

After providing a urine sample,
we get a blind gown weight

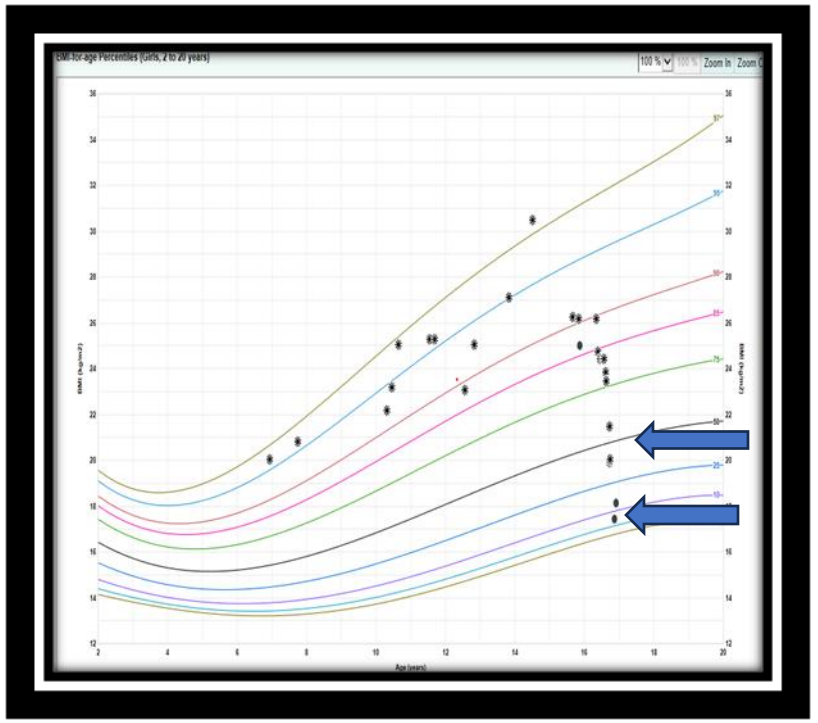
Goals:

-Goal is 1-2lb/week weight gain as outpatient for Anorexia/Bulimia

ARFID weight gain closer to 0.5-1lb/week

Hospitalization For Low Weight:

-We hospitalize patients if BMI is <75%mBMI



This patient has a BMI of 18.1
BMI at 50th percentile is 22
Take 18.1/21.9 = 82%mBMI

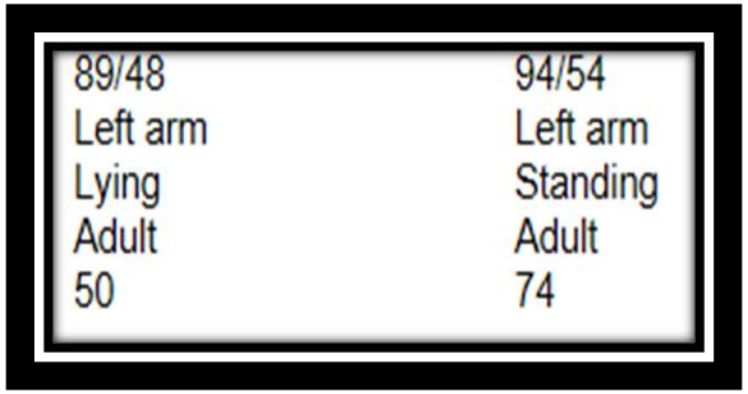
Peditools.org (CDC 2-20 yr calculator)

Vitals

After getting a weight, we will obtain vitals:

We have patient lay flat for 5 minutes and then obtain a HR and BP

Then have patient stand up for 2 minutes and repeat HR and BP



Weight Goal

We look at the following factors when determining target:

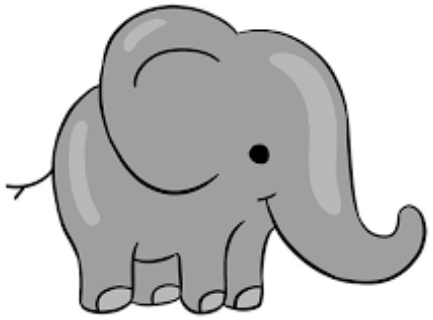
-Always a range for current age and height

-Try to get closer to original growth curve

-Want females to be having monthly periods

-Want patient in goal activity level

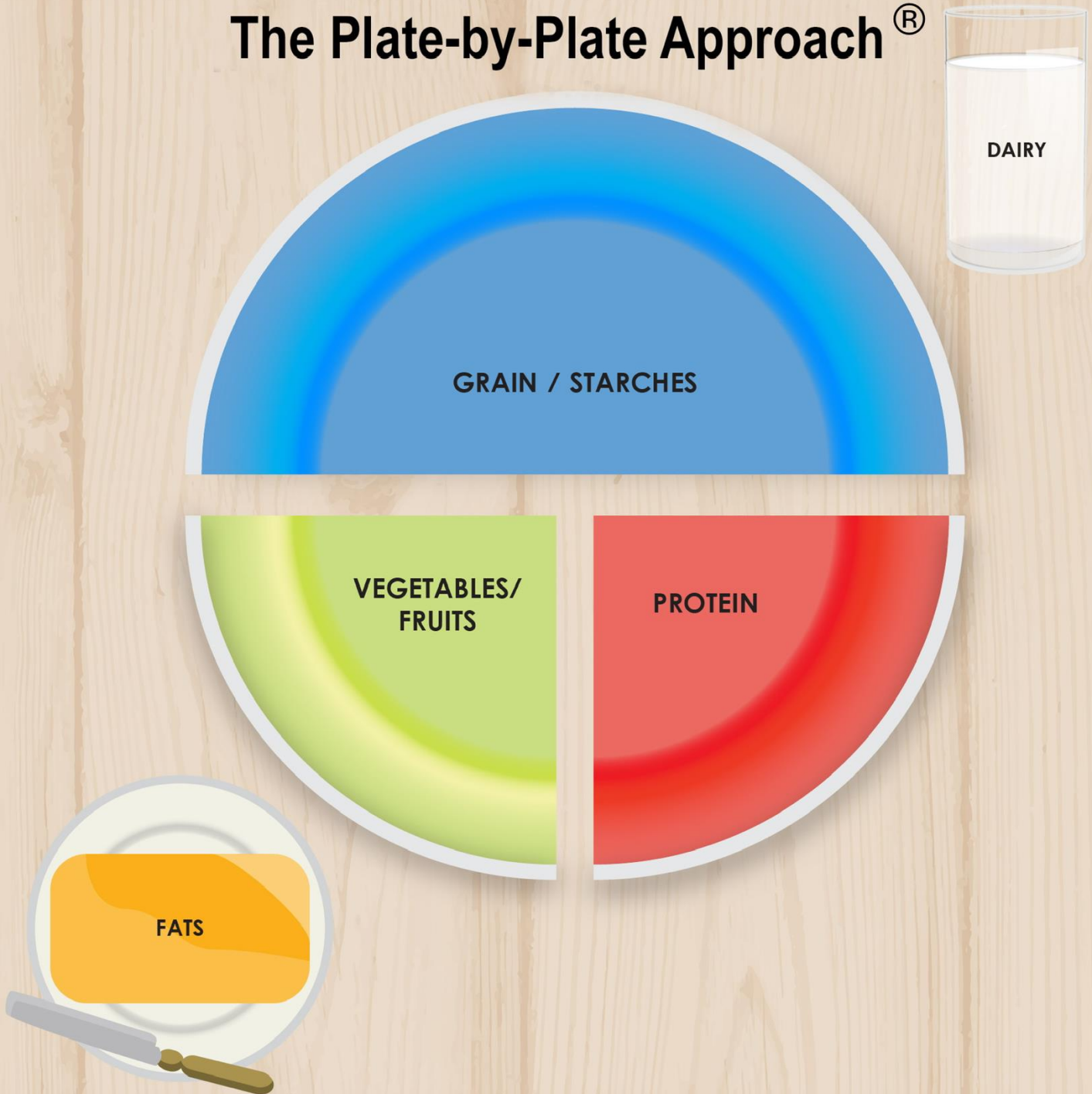
-Want patient to be therapeutically improved (like their body)

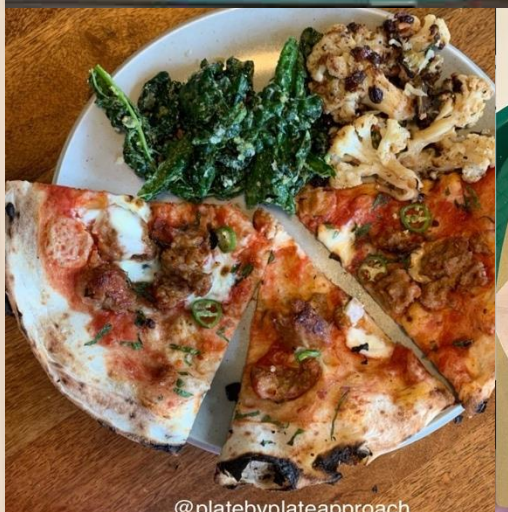


How to get to goal weight:

-3 meal and 2 snacks per day
-If an athlete, should have 3 snacks
-Snacks should have 2-3 items
-Parents plate and portion food initially
-Adolescent gains autonomy over time

The Plate-by-Plate Approach ®





Activity Clearance

Things we consider before clearing for exercise:

-Is the patient really low weight and close to being admitted?

-Have they been gaining weight or actively losing?

-Are vitals stable or is HR really low?

If the answer is **NO** to questions then we advance as follows:

-PE class is first given credits involved

-Likely few days per week of PE, then full clearance at following visit

-Then likely add walking or light weight lifting 2-3x per week

-Then increase those activities to 4-5x if desire that much

-Then introduce cardio

-If in a sport, likely clear for drills or light activity 2-3x/week

-Then advance toward goal of full participation

That’s great…

but what if they are medically unstable or not doing well?

Medically Unstable

- Either very weight (<75%mBMI)
- HR <50
- BP<90/45
- HR increase from lying to standing >40 points
- K<3.5, Phos<3.0, Mag<1.8
- QTc >460
- Syncope
- Acute food refusal >72 hours
- Failure of outpatient management

Goal of INPATIENT: STABILIZATION

- Goal of inpatient is to correct any of those on previous slide
- Set up outpatient medical and therapy plan

Knowledge check:

Which of the following is a criteria would require someone to be admitted for medical stabilization?

A BMI of 17.5
A HR of 52
A Potassium of 3.5
A QTc of 485
Amenorrhea

Medically stable… now what?

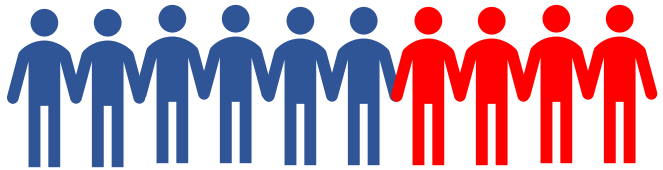
Medical Follow Up

- Initial stages: Every 1-2 weeks for weight and vitals
  - Definitely every 1-2 weeks after a hospitalization
- Then Monthly
- Eventually every 2-3 months
- When recovered, every 6 months-Annually

- *Of note, follow up may be more frequent while in sport season even though medically stable (able to advance activity sooner)*

Therapy Options

- **Residential**
  - Highest Level of care (live for 1-3 months (Or longer if severe AN)
  - ERC (Adol/Adult), CFD, Monte Nido, **Rogers (WI)**
- **PHP**
  - Usually 5-6 days per week, 8 hours per day
  - ERC, CFD, Monte nido, skyway (adult), alexian bros, sun cloud, Simply Bee
- **IOP**
  - Usually 3-5 days per week, in person or virtual
  - **ERC (Virtual in WI), Rogers (Virtual),** CFD, Monte Nido, skyway, sun cloud, simply bee, **Emily Program (MN)**
- **FBT**
  - 3 phases (typically lasts 12-18 months)
  - Weekly to start, then every 2-3 weeks, then every 1-2 months
  - Most studied



60-85% recovery FBT

Keys to FBT

- Initial stage is taking control away (hardest part)
- Meet resistance with resistance
- No negotiations or accommodations
- Parents need to be on the same page
- Plate model is key
- Focus on what they ate before the ED
- If parents are dieting, focus on what the child needs at this stage of development vs an adult
- The ED didn’t occur overnight, so it will take time

Expanding Access to FBT

Come to us?

UWHealthKids
Adolescent Medicine
(Middleton WI)
(608) 263-6421

Bring to your region?

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Questions?