



# MANAGEMENT OF Eating Disorders

2021 Update

This care process model (CPM) and accompanying patient education were developed by a multidisciplinary team including primary care physicians (PCPs), psychiatrists, psychotherapists, mental health specialists, registered dietitians, and eating disorder specialists, under the leadership of Intermountain Healthcare’s Behavioral Health Clinical Program. Based on national guidelines and emerging evidence and shaped by local expert opinion, this CPM provides practical strategies for early recognition, diagnosis, and effective treatment of anorexia nervosa, bulimia nervosa, binge-eating disorder, and other eating disorders.

## ► Why Focus ON EATING DISORDERS?

- **Eating disorders are very common and often underdiagnosed.** In the U.S., 20 million women and 10 million men suffer from a clinically significant eating disorder during their lives, and many cases are unlikely to be reported.<sup>NEDA</sup> Anorexia is the third most common chronic disease among young people.<sup>SMI, FIC</sup> Mean age of onset for eating disorders is 18 to 21.<sup>AFP2</sup> Diagnosis can be challenging due to the denial and secretive behaviors often associated with eating disorders.
- **Eating disorders lead to significant morbidity and mortality.** Risk of premature death is 6 to 12 times higher in women with anorexia nervosa.<sup>AED</sup> Men represent 25% of individuals with anorexia nervosa, and they are at a higher risk of dying since they are often diagnosed later since many people assume males don’t have eating disorders. Young people between the ages of 15 to 24 who suffer from eating disorders have 10 times the risk of dying compared to their peers.<sup>SMI, FIC</sup>
- **Early diagnosis and treatment can prevent hospitalizations, morbidity, and mortality.** Early diagnosis with intervention is correlated with improved outcomes.<sup>AFP1</sup>
- **Better communication and collaboration between PCPs, eating disorder specialists, dietitians, therapists, and hospitalists can improve care.** In treating patients with eating disorders, no single approach is adequate because the problem itself is multidimensional.<sup>JOY</sup>
- **There are no easy fixes — treatment takes time.** The outcomes associated with anorexia nervosa are poor — between 35% to 85% recover, and recovery takes from nearly 5 years to more than 6 years.<sup>SMI</sup> For some patients, education, support, and empowerment is enough to change behavior. For others, eating disorders can develop into chronic illnesses. Every patient is different, and individualized care is critical to improve outcomes.

### WHAT’S NEW IN THIS CPM?

- New and updated clinical algorithms for outpatient and inpatient care.
- Expanded content on the role of pediatricians, psychiatrists, and gastroenterologists in assessing and managing patients with eating disorders.
- Expanded content on psychotherapy modalities that assist in the recovery from eating disorders including cognitive behavioral therapy, eye movement desensitization and reprocessing (EMDR), and family based therapy.
- Expanded content on pharmaceutical management of eating disorders and comorbid psychiatric and medical conditions.

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## GOALS

- Provide guidelines to help clinicians identify and diagnose patients at risk or in the early stages of eating disorders so they can intervene early in the course of the disease
- Encourage use of evidence-based tools and conversation guides for screening and diagnosis
- Establish multidisciplinary teams to provide medical, nutrition, and mental health treatment
- Provide effective, patient-focused care for eating disorders in emergency departments and hospitals
- Improve communication and coordination across the continuum of care for patients with eating disorders

**TABLE 1: Comparison of anorexia and bulimia<sup>AFP1</sup>**

Anorexia nervosa	Bulimia nervosa
<b>History, common symptoms</b>	
Amenorrhea, constipation, headaches, fainting, dizziness, fatigue, cold intolerance	Bloating, fullness, lethargy, GERD, abdominal pain, alternating diarrhea and constipation, sore throat (from vomiting)
<b>Physical findings</b>	
Cachexia, acrocyanosis, dry skin, hair loss, bradycardia, orthostatic hypotension, hypothermia, loss of muscle mass and subcutaneous fat, lanugo	Knuckle calluses, dental enamel erosion, parotid and other glandular enlargement
<b>Labs</b>	
Hypoglycemia, leukopenia, elevated liver enzymes, euthyroid sick syndrome (low TSH level but normal T3, T4 levels)	Hypochloremia, hypokalemia, or metabolic alkalosis (from vomiting, laxatives, or diuretics); elevated salivary amylase
<b>ECG findings</b>	
Low voltage, prolonged QT interval, bradycardia	

## ► THINGS TO CONSIDER

Early diagnosis of eating disorders can be challenging. However, because of the risk for rapid progression, chronicity, and mortality, early identification is vital. This section provides practical tips for identifying eating disorders early. It also identifies comorbidities, treatment approaches, and diagnostic criteria.

### Early identification

**Early identification** requires watching for signs or symptoms that may not be specified, even overweight or obesity, in diagnostic criteria. Do not rely primarily on weight. People at normal weight can have eating disorders, and a variety of presenting symptoms and/or risk factors may indicate the need for screening (see [page 4](#)).

Tools for screening and diagnosis include:

- The **Eating Disorders in Primary Care (ESP) Questionnaire**, which has been proven to be reliable as an eating disorder screening tool and is brief enough to use in a standard primary care visit.<sup>ESP</sup> Ask the ESP questions when you suspect an eating disorder and during pre-adolescent and adolescent well checks (see [page 4](#)).
- **Patient conversation techniques** that support an effective discussion about eating disorders with the patient or family, especially in the early stages (see [page 7](#)).

**Mental Health Integration (MHI) team members** can also help assess eating disorders at the early stages, identify comorbidities, and suggest intervention.

### Common comorbidities and prognostic indicators

**Common comorbidities** include substance use disorders, depression, anxiety, and personality disorders.<sup>APA</sup> If a patient screens positive for an eating disorder, consider a full evaluation using the *Mental Health Integration (MHI) Child/Adolescent Baseline Packet* or *Adult Baseline Packet*.

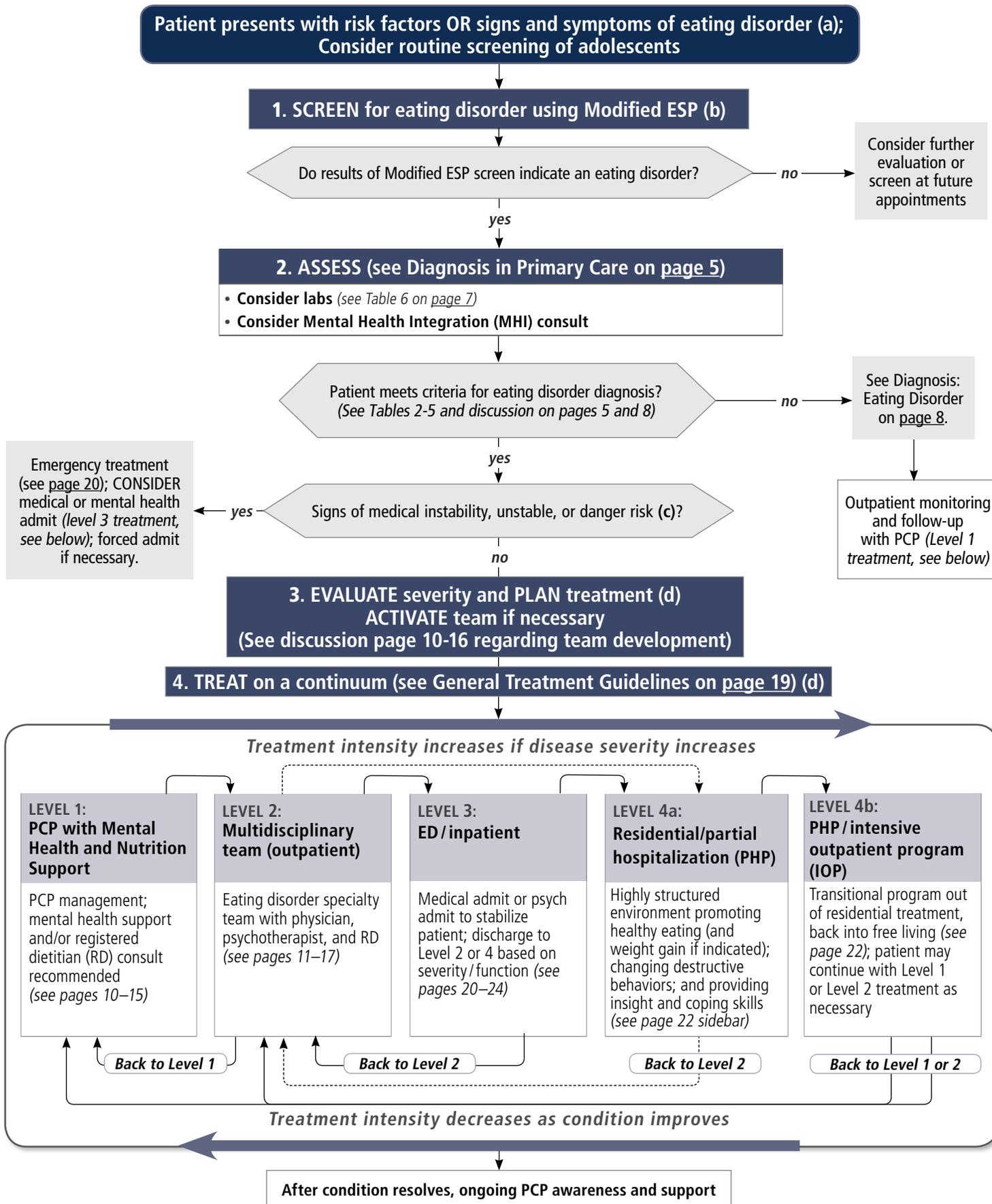
**Factors that predict poor outcomes** include psychiatric comorbidities, a chaotic family structure, inadequate family or social support, duration of illness, male gender, and a history of hospitalizations. For some patients, eating disorders become chronic; treatment then shifts from resolving the condition to building management skills and strategies to avoid serious complications.

## TREATMENT APPROACH AND GOALS

- **For children and adolescents, family involvement in treatment is vital; for adults, involving partners can be helpful.** It is important to assess family stressors without implying blame or prompting family members to blame each other.<sup>APA</sup>
- **A stepped-care approach fosters effective treatment.** This CPM defines 5 treatment levels, based on treatment stages defined in major guidelines<sup>APA</sup> but modified to conform to local resources and expertise:
  - Level 1: Primary care management with MHI support if registered (see [pages 4–8, 15, 19](#))
  - Level 2: Multidisciplinary team treatment with a physician, therapist, dietitian, and others (see [pages 4–5, 9–16, 19](#))
  - Level 3: Emergency department (ED)/inpatient treatment, with mental health or medical admit as needed (see [pages 4–5, 16–18](#))
  - Level 4a: Partial hospitalization and residential treatment, based on illness severity and ability to function
  - Level 4b: Intensive outpatient treatment, as a transition out of residential treatment
- **Treatment goals include:** Restoring patients to a healthy weight (anorexia); reducing or eliminating bingeing (binge eating disorder) and purging (bulimia); treating comorbidities and physical complications; enhancing the patient's motivation to participate in treatment; educating the patient on healthy eating patterns; helping patients change core dysfunctional thoughts, attitudes, and behaviors related to the eating disorder; enlisting family support and provide family treatment; and preventing relapse.

The algorithm and notes on [pages 4–5](#) guide the choice of treatment level.

## ▶ EATING DISORDERS: OUTPATIENT SCREENING, DIAGNOSIS, AND TREATMENT



ALGORITHM NOTES AND ASSESSMENT TOOLS

**(a) Presenting signs / symptoms or risk factors**<sup>AFP1, AAP</sup>

Signs/symptoms	Risk factors
<ul style="list-style-type: none"> <li><b>General:</b> Marked or sudden weight loss, gain, or fluctuation; failure to gain expected weight in child/adolescent who is still growing and developing; crossing 2 or more lines on weight or BMI growth curve; cold intolerance; weakness, fatigue, or lethargy; dizziness; syncope; hot flashes/sweating episodes; multiple food allergies</li> <li><b>Oral/dental and throat:</b> Oral trauma/lacerations; dental erosion or caries; perimolysis; parotid enlargement; recurrent sore throats</li> <li><b>GI:</b> Epigastric discomfort; early satiety and delayed gastric emptying; acid reflux; vomiting blood; hemorrhoids and rectal prolapse; constipation; diarrhea; abdominal pain</li> <li><b>Endocrine:</b> Irregular or missed menses; loss of libido; low bone density; stress fractures; infertility</li> <li><b>Neuropsychiatric:</b> Seizures; memory loss/poor concentration; insomnia; depression/anxiety/obsessive behavior; self-harm; suicidal ideation/attempt</li> <li><b>Cardiorespiratory:</b> Chest pain; skin palpitations; bradycardia; arrhythmias; shortness of breath; edema</li> <li><b>Dermatologic:</b> Lanugo hair; hair loss; yellowish skin discoloration; perioral acne (especially with purging behavior); calluses or scars on the dorsum of the PIP joints of the hand (Russell’s sign); poor healing</li> <li><b>Electrolytes:</b> Hypokalemia; hypochloremia; elevated CO<sub>2</sub> (High normal CO<sub>2</sub> with low normal chloride and/or urine pH 8.0 to 8.5 can indicate recurrent vomiting.)</li> </ul>	<ul style="list-style-type: none"> <li>Age: 12 to 18 years</li> <li>Family history of an eating disorder</li> <li>Excessive exercise or involvement in extreme physical training or athletics (see <a href="#">page 9</a> sidebar)</li> <li>Type 1 diabetes and unexplained weight loss and/or poor metabolic control or diabetic ketoacidosis</li> <li>Weight-related behaviors:                         <ul style="list-style-type: none"> <li>Diet and/or weight loss behaviors when weight is in normal range</li> <li>Compensatory behavior(s) after eating, perceived overeating, or binge eating (self-induced vomiting, fasting, excessive exercise)</li> <li>Use/abuse of appetite suppressants, caffeine, diuretics, enemas, laxatives, excessive hot or cold fluids, artificial sweeteners, sugar-free gum</li> </ul> </li> <li>Vegetarianism (in adolescents)</li> </ul>

**(b) Screening tool for eating disorders**

The *Modified ESP (Eating Disorders Screen in Primary Care)* is effective in identifying patients who require further evaluation for eating disorders.<sup>ESP</sup>

**Modified ESP questions:**

1. Are you concerned with your eating patterns?
2. Do you ever eat in secret?
3. Does your weight affect the way you feel about yourself?
4. Have any members of your family suffered from an eating disorder?

**Scoring:**

- 0 – 1 “Yes” responses: Eating disorder ruled out
- ≥ 2 “Yes” responses: Eating disorder suspected, evaluate further

Consider additional questions from Table 7: *Conversation guide for diagnosis of eating disorders* on [page 7](#).

**Avoid overemphasis on weight in ED diagnosis and recovery.** Weight alone is not an absolute indicator of an eating disorder; nor is change in weight an absolute indicator of progress in recovery.

**(c) Signs of medical instability or danger risk**

- **Adults:** HR <50 bpm; BP <90/50 mm Hg; glucose <60 mg/dL; electrolyte abnormalities (potassium <2.5 mEq/L; sodium <125 mEq/L); temperature <97.0° F (36.1° C); dehydration; hepatic, renal, or cardiovascular compromise; poorly controlled diabetes
- **Children and adolescents:** HR near 40 bpm; orthostatic BP changes; BP <80/50 mm Hg; hypokalemia; hypophosphatemia; hypomagnesemia
- **Suicide risk:** Specific plan with lethality or intent; depression with poor impulse control and/or social support; previous suicide attempt (see *Intermountain’s Depression CPM* for suicide risk assessment details)
- **Psychosocial stressors:** Family/relationship dysfunction, sexual trauma
- **Risk to self or others:** Self-harm behaviors toward self or others
- **Inability to function:** Significant thought disturbances with regard to food and eating; body dysmorphic disorder (see *sidebar page 12*); downward trajectory in disease course
- **Things to consider when determining medical instability:** Severe undernutrition status and history of progressive weight loss despite outpatient efforts, including at home, should be sufficient criteria for designation of “medical instability” mandating intervention and admission. This should be taken as a high risk for irreversible morbidity and mortality, independent of the intentionality in these patients with pathologically impaired cognition.

**(d) Factors that determine treatment level**<sup>AFP1, AFP2</sup>

Factor	Level 1: PCP with MHI	Level 2: Multidisciplinary team	Level 3: ED/inpatient	Level 4a: Residential	Level 4b: Partial hospitalization/ intensive outpatient
<b>Medical status</b>	Stable		Unstable; see note (c)	Stable	
<b>Psych status</b>	No psych comorbidities or suicide risk	One or more comorbid psych diagnoses	Risk of danger to self or others; see note (c)	One or more comorbid psych diagnoses	
<b>Diagnosis</b>	Screen positive, but does not meet diagnostic criteria		Patient meets diagnostic criteria for anorexia nervosa, bulimia nervosa, binge-eating disorder, or other eating disorder; see <a href="#">page 2</a>		
<b>Weight, BMI*</b>	BMI within acceptable limits for age	Persistent weight loss; Adult BMI <18; Child/adolescent BMI that has crossed 2 or more lines on growth chart;binging and/or purging behavior 2 or more times per week	Weight <75% ideal body weight (IBW); rapid weight loss over 30 days prior to admission (see <i>admission criteria page 17</i> )	75% to 80% IBW	85% to 90% IBW
<b>Function</b>	Function not impaired	Daily function somewhat impaired	N/A	Cannot function in environment	Function improved, but needs help for transition
<b>Support</b>	Good social support	Good social support	N/A	Insufficient social support	Insufficient social support

**Treatment level transitions as condition worsens or resolves**

Transition options	Level 1 if decreased BMI or function Level 3 if medical or psychiatric instability	Level 3 if medical or psychiatric instability Level 4a if cannot function in environment and lack of improvement with comprehensive multidisciplinary specialty care in outpatient setting	Level 2 or 4a, based on recommendation of Level 2 care team	Level 2 or 4b, based on recommendation of Level 2 care team	Level 1 or 2, based on recommendation of Level 2 care team

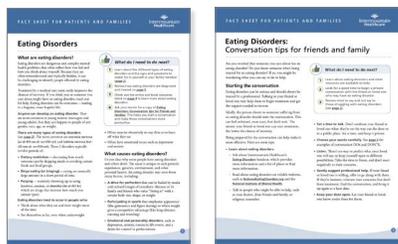
\*BMI alone is not an indication for residential or intensive outpatient care and should be evaluated in the context of other physical and psychological factors.

## ✓ KEY PRINCIPLES

- Patients with a suspected eating disorder may be more or less willing to reveal information based on your language and tone.
- Any time you feel uncomfortable working with the patient, bring in a mental health professional or another expert for support.
- After diagnosis, a multidisciplinary team provides the best outcomes.
- If you rule out an eating disorder but still suspect the patient is at risk, provide patient/family education and follow up with the patient regularly.
- Consider referral to a registered dietitian for evaluation of dietary intake and recommendations for improvement as indicated.

## PATIENT EDUCATION

Education is a critical element of the diagnosis process. Use Intermountain resources (which also provide links to other materials) to educate patients and their families:



Eating Disorders

Eating Disorders:  
Conversation Tips for  
Friends and Family

## PHYSICAL ACTIVITY VITAL SIGN (PAVS):

1. On average, how many days a week do you perform physical activity or exercise?
2. On average, how many total minutes of physical activity or exercise do you perform on those days?  
Days/week X minutes/day = min/week (PAVS)
3. How would you describe the intensity of your activity?
  - Light = casual walk
  - Moderate = brisk walk
  - Vigorous = jogging

## ► DIAGNOSIS IN PRIMARY CARE

Primary care providers serve an important role in evaluating disordered eating and diagnosing eating disorders. Of adults with eating disorders, at least half were diagnosed by PCPs.<sup>51M</sup> If at any time during the diagnosis process you feel uncomfortable or unprepared to work with the patient, rely on other experts to support you (MHI care manager, an on-site mental health provider, etc.).

## Process of diagnosing eating disorders

The process of diagnosing eating disorders is two-fold:

- **A comprehensive medical evaluation**, including a medical history, review of systems, physical examination, and laboratory and diagnostic testing.
- **A patient and family conversation** to determine whether an eating disorder is present.

These two steps can happen in any appropriate order. For example, if you notice a low heart rate and weight loss in a standard physical, you might begin a conversation about eating and dieting patterns with the patient.

## Comprehensive medical evaluation

Check the following during the physical exam (See algorithm note ‘a’ on [page 4](#) for a list of presenting signs/symptoms.):

- **Vital signs:** Supine and standing heart rate, blood pressure, Physical Activity Vital Sign (PAVS) (see sidebar), temperature, etc.
- **Medical history:** Eating behavior, weight, menstrual history, family history, psychological history, prescribed and over-the-counter medications, dietary supplements, vitamins, and minerals.
- **Review of symptoms. Restriction:** light-headedness, syncope, weakness, palpitations, overuse injuries, decreased school/work/athletic performance. **Binging-purging:** Sore throats, dental caries, gum disease, bloating, abdominal pain, diarrhea, constipation, rectal prolapse, GI bleeding, overuse injuries, decreased school/work/athletic performance.
- **Physical exam. Restriction:** hypotension, bradycardia, hypothermia, cachexia, lanugo hair, dry skin and/or mucous membranes, hair loss, lower extremity edema. **Binging-purging:** “puffy” appearance, glandular hypertrophy, dental caries, periodontal disease, characteristic odor (gastric acid), pharyngeal erythema, epigastric tenderness, Russell’s sign (callouses on dorsum of proximal interphalangeal joints).
- **Lab tests as indicated:** Use the tests in [Table 6](#) for diagnosis and follow up if initial results are abnormal (e.g., the patient has abnormal electrolytes at diagnosis).

## Patient and family conversation

The *Modified Eating Disorder Screen in Primary Care* (ESP; see [Table \(b\) page 4](#)) can help you determine whether an eating disorder is present, but it may not be enough. A conversation is helpful in determining diagnosis and/or the need for team-based treatment.

- **Situation:** When appropriate, it may be helpful to talk to patients with their family member(s) first, then talk to the patient alone (depending on the patient’s age). Ask general questions when the family is present and more sensitive questions when alone with the patient. For adolescent patients, ask questions in a developmentally appropriate, precise, non-judgmental way.<sup>AFP1</sup>
- **Support:** If you feel uncomfortable or unprepared to have this conversation, rely on other experts for support (MHI care manager, on-site therapist/psychologist, etc.).
- **Questions:** The questions in [Table 7](#) provide ideas for engaging patients and their families in meaningful conversations that help you identify eating disorders. Patients and family may not always reveal critical information in this conversation (and the patient may not perceive a problem), but approaching questions in a sensitive way can make the conversation more effective.

**Diagnostic criteria for common eating disorders as recognized by the DSM-5**

TABLE 2: Anorexia nervosa (F50.01 and F50.02 by type) <sup>DSM</sup>		
Diagnostic criteria	Types	Current severity
<p>A. Restriction of energy intake relative to requirements, leading to a significantly low body weight in context of age, sex, developmental trajectory, and physical health. <i>Significantly low weight</i> is defined as a weight that is less than minimally normal or, for children and adolescents, less than minimally expected.</p> <p>B. Intense fear of gaining weight or of becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.</p> <p>C. Disturbance in the way one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.</p>	<ul style="list-style-type: none"> <li>• <b>Restricting type (F50.01):</b> During the last 3 months, the individual has not engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas). This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting, and/or excessive exercise.</li> <li>• <b>Binge eating/purging type (F50.02):</b> During the last 3 months, the individual has engaged in recurrent episodes of binge eating or purging behavior.</li> </ul>	<p><b>For adults:</b></p> <ul style="list-style-type: none"> <li>• <b>Mild:</b> BMI <math>\geq</math> 17 kg/m<sup>2</sup></li> <li>• <b>Moderate:</b> BMI 16–16.99 kg/m<sup>2</sup></li> <li>• <b>Severe:</b> BMI 15–15.99 kg/m<sup>2</sup></li> <li>• <b>Extreme:</b> BMI &lt; 15 kg/m<sup>2</sup></li> </ul> <p><b>For children and adolescents,</b> corresponding BMI percentiles should be used.</p> <p><b>Note:</b> The level of severity may be increased to reflect clinical symptoms, degree of functional disability, and need for supervision.</p>

TABLE 3: Bulimia nervosa (F50.2) <sup>DSM</sup>	
Diagnostic criteria	Current severity
<p>A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:</p> <ol style="list-style-type: none"> <li>1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances.</li> <li>2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).</li> </ol> <p>B. Recurrent inappropriate compensatory behaviors in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.</p> <p>C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least once a week for 3 months.</p> <p>D. Self-evaluation that is unduly influenced by body shape and weight.</p> <p>E. The disturbance does not occur exclusively during episodes of anorexia nervosa.</p>	<p><b>For adults:</b></p> <ul style="list-style-type: none"> <li>• <b>Mild:</b> An average of 1–3 episodes of inappropriate compensatory behaviors per week.</li> <li>• <b>Moderate:</b> An average of 4–7 episodes of inappropriate compensatory behaviors per week.</li> <li>• <b>Severe:</b> An average of 8–13 episodes of inappropriate compensatory behaviors per week.</li> <li>• <b>Extreme:</b> An average of 14 or more episodes of inappropriate compensatory behaviors per week.</li> </ul> <p><b>Note:</b> The level of severity may be increased to reflect other symptoms and the degree of functional disability.</p>

TABLE 4: Binge-eating disorder (307.51/F50.8) <sup>DSM</sup>	
Diagnostic criteria	Current severity
<p>A. Recurrent episodes of binge eating (see Criterion A, Table 3 above).</p> <p>B. The binge-eating episodes are associated with 3 (or more) of the following:</p> <ol style="list-style-type: none"> <li>1. Eating much more rapidly than normal.</li> <li>2. Eating until uncomfortably full.</li> <li>3. Eating large amounts of food when not feeling physically hungry.</li> <li>4. Eating alone because of feeling embarrassed by how much one is eating.</li> <li>5. Feeling disgusted with oneself, depressed, or very guilty afterward.</li> </ol> <p>C. Marked distress regarding binge eating is present.</p> <p>D. The binge eating occurs, on average, at least once a week for 3 months.</p> <p>E. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.</p>	<p><b>For adults:</b></p> <ul style="list-style-type: none"> <li>• <b>Mild:</b> 1–3 binge-eating episodes per week</li> <li>• <b>Moderate:</b> 4–7 binge-eating per week</li> <li>• <b>Severe:</b> 8–13 binge-eating episodes per week</li> <li>• <b>Extreme:</b> 14 or more binge-eating episodes per week</li> </ul> <p><b>Note:</b> The level of severity may be increased to reflect other symptoms and the degree of functional disability.</p>

TABLE 5: Other eating disorders <sup>DSM</sup>	
Other specified feeding or eating disorder (307.59/F50.8)	Unspecified feeding or eating disorders (307.50/F50.9)
<p>Examples of presentations that can be specified using the "other specified" designation include the following:</p> <ul style="list-style-type: none"> <li>• <b>Atypical anorexia nervosa:</b> All of the criteria for anorexia nervosa are met, except that despite significant weight loss, the individual's weight is within or above the normal range.</li> <li>• <b>Bulimia nervosa (of low frequency and/or limited duration):</b> All of the criteria for bulimia nervosa are met, except that the binge eating and inappropriate compensatory behaviors occur, on average, less than once a week and/or for less than 3 months.</li> <li>• <b>Avoidant/Restrictive Food Intake Disorder:</b> An eating or feeding disturbance (e.g., apparent lack of interest in eating or food; avoidance based on the sensory characteristics of food, concern about aversive consequences of eating ) as manifested by persistent failure to meet appropriate nutritional and/or energy needs. (See DSM-5 criteria for full criteria.)</li> <li>• <b>Binge-eating disorder (of low frequency and/or limited duration):</b> All of the criteria for binge-eating disorder are met, except that the binge eating occurs, on average, less than once a week and/or for less than 3 months.</li> <li>• <b>Purging disorder:</b> Recurrent purging to influence weight or shape (e.g., self-induced vomiting; misuse of laxatives, diuretics, or other medications) in the absence of binge eating.</li> </ul>	<p>This category applies to presentations in which symptoms characteristic of a feeding and eating disorder that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning predominate but do not meet the full criteria for any of the disorders in the feeding and eating disorders diagnostic class. The unspecified feeding and eating disorder category is used in situations in which the clinician chooses <i>not</i> to specify the reason that the criteria are not met for a specific feeding and eating disorders, and includes presentations in which there is insufficient information to make a more specific diagnosis (e.g., in emergency room settings).</p>

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**TABLE 6: Labs and tests for eating disorder evaluation**

Lab / test	When to use
Basic blood chemistry: serum electrolytes; renal function (BUN, Cr); calcium; liver function tests; TSH; CBC and differential; urinalysis	All patients with suspected eating disorders
Additional blood chemistry: iron studies; vitamin D; vitamin B12; magnesium; phosphorous	Malnourished and severely symptomatic patients
Additional blood chemistry: serum luteinizing hormone; follicle-stimulating hormone; prolactin; estradiol; consider urine pregnancy test	Patients with delayed menarche — no menses by age 15; absence/delay of secondary sexual characteristics by age 13; secondary amenorrhea (no menses for 3 consecutive months)
Toxicology screen	Patients with suspected substance use
Tissue transglutaminase (TTG)	Patients with suspected celiac disease
Serum amylase	Patients with suspected surreptitious vomiting
Stool for guaiac	Patients with suspected gastrointestinal bleeding
C-reactive protein; fecal occult blood; qualitative fat; calprotectin	Patients with suspected inflammatory bowel disease/malabsorption
Radiologic imaging: DXA, radiographs, advanced imaging	DXA for patients with amenorrhea for 6 months or more of prolonged oligomenorrhea (<6 periods in 24 months); radiographs to evaluate for stress fractures
EKG	For patients with syncope; chest pain; suspected or detected lab abnormalities (hypokalemia, hypomagnesemia, or hypophosphatemia)
Cortisol; TSH/FT4	Patients with suspected endocrinologic disease (Addison's disease, thyroid disease)

**TABLE 7: Conversation guide for diagnosis of eating disorders (for more information see page 5)**

Topic	Questions
<b>Questions to start the conversation</b>	<ul style="list-style-type: none"> <li>• How have you been feeling in general?</li> <li>• How do you feel about yourself?</li> <li>• Do you mind if we talk about your eating habits?</li> </ul>
<b>Initial critical questions</b>	<ul style="list-style-type: none"> <li>• Are there foods or food groups that you avoid eating?</li> <li>• How do you feel about dieting in general?</li> <li>• How do you feel about your body size?</li> <li>• In what ways does your weight affect the way you think about yourself?</li> <li>• What percentage of your waking hours do you spend thinking about weight, food, and body image?</li> </ul>
<b>Diet and dieting</b>	<ul style="list-style-type: none"> <li>• Do you worry that you have lost control of how much you eat?</li> <li>• Are you happy with your eating behavior?</li> <li>• Do you eat in secret?</li> <li>• What did you have for breakfast today/yesterday? Lunch? Dinner? Snacks?</li> <li>• Do you count your calories? Watch fat grams? Avoid certain foods and/or food groups?</li> <li>• Do you ever eat a lot in one sitting — enough that you feel sick afterward?</li> <li>• Are you worried because sometimes you can't stop eating?</li> </ul>
<b>Vomiting/purging</b>	<ul style="list-style-type: none"> <li>• Do you make yourself vomit because you feel uncomfortably full?</li> <li>• Do you use diuretics, laxatives, enemas, or diet pills?</li> </ul>
<b>Weight and self-perception</b>	<ul style="list-style-type: none"> <li>• When you look in the mirror, what do you see?</li> <li>• What do you think you should weigh? What are you doing to reach or maintain that weight?</li> <li>• Do you weigh yourself regularly? If so, how often?</li> <li>• Have you recently lost or gained a lot of weight in a short period of time?</li> <li>• What was your lowest weight in the last 2 years? Your highest weight?</li> </ul>
<b>Exercise</b>	<ul style="list-style-type: none"> <li>• How much do you exercise? How often? How intensely?</li> <li>• Do you feel anxious if you miss a workout?</li> </ul>
<b>Family and support</b>	<ul style="list-style-type: none"> <li>• Does your family have any history of obesity, eating disorders, depression, mental illness, or substance abuse (parents or other family members)?</li> <li>• Who are your primary sources of emotional support? How do they support you?</li> <li>• Has your family shown any concerns about your eating?</li> </ul>
<b>Health</b>	<ul style="list-style-type: none"> <li>• Female patients: When did you have your first period? Are your periods regular? When was your last period?</li> <li>• Do you have constipation? Diarrhea?</li> <li>• Are you ever dizzy? Weak? Tired? Have you ever fainted?</li> <li>• Do you bruise easily? Bleed easily?</li> <li>• Do you get cold easily?</li> <li>• Have you lost any hair? Grown new hair? Do you have dry skin?</li> <li>• Do you ever feel bloated? Have abdominal pain? Burning?</li> <li>• Do you ever have muscle cramps? Joint pains? Chest pain?</li> </ul>

## Diagnosis: eating disorder

After diagnosing an eating disorder, do one of the following according to the severity of the case (see algorithm and notes, [pages 4 and 5](#)):

- If the patient is **medically unstable or there is a suicide risk**, send the patient to the ED or other care facility.
- Binge eating disorder (BED) is the most prevalent eating disorder. It is more prevalent than anorexia nervosa and bulimia nervosa combined, and is often under recognized and not always screened for. BED affects men and women more equally than any other eating disorder. Coordinated care is key for psychological and medical support; many individuals suffering from BED concurrently suffer from other psychiatric disorders. Individuals with BED experience high levels of body dissatisfaction, shame, and embarrassment. Binge eating is typically done in secret and individuals are not always forthcoming with information. Great care should be taken to reduce the shame associated with binge eating and with body image. Primary focus needs to be on reduction and abstinence from bingeing, with weight loss as a secondary goal once bingeing is controlled.
- If the patient is **not medically unstable or at risk for suicide**, assemble a multidisciplinary team and educate the patient and family. A multidisciplinary team approach is the standard of care for patients with eating disorders. This team provides medical treatment, psychotherapy, and nutrition support in a coordinated approach (see [pages 9 to 13](#) for details). You can assemble a team that you will lead, refer the patient to a multidisciplinary team, or consult with another physician.
  - If you have MHI resources at your clinic, consider referral for further evaluation, treatment, and/or triage to a community-based provider for ongoing, longer-term psychotherapy.
  - If a dietitian is not available at your facility, order “nutrition individual counseling outpatient dietitian adult/pediatric” in iCentra or contact your local hospital and ask for a dietitian with experience working with patients with eating disorders.
  - Reach out to your professional contacts.
  - If a team is not available in your area, see Team communication on [page 18](#) for virtual team ideas.
  - Educate the patient and/or parents and family members about the importance of the multidisciplinary team.

Intermountain has a goal to identify multidisciplinary care teams within each geographic region. In addition, SelectHealth has identified a list of providers who treat eating disorders. Call 801-442-1989 to find resources near you.

For patients who don't meet the criteria for an eating disorder, but show signs of disordered eating or are at risk for developing an eating disorder, provide information and close monitoring.

- **Provide educational materials.** See Patient and Family Resources on [page 27](#) for ideas.
- **Follow up.** Depending on the severity of the risk, follow up in 4 to 8 weeks.
- **Reassess at each visit.** Perform the diagnosis steps outlined on [pages 6 and 7](#) during each visit to assess the patient's health and mental state.

**Bring in a mental health professional.** If the patient seems at high risk or you don't have a high level of comfort, consult a mental health professional or other specialist.

## BODY DYSMORPHIC DISORDER (BDD)

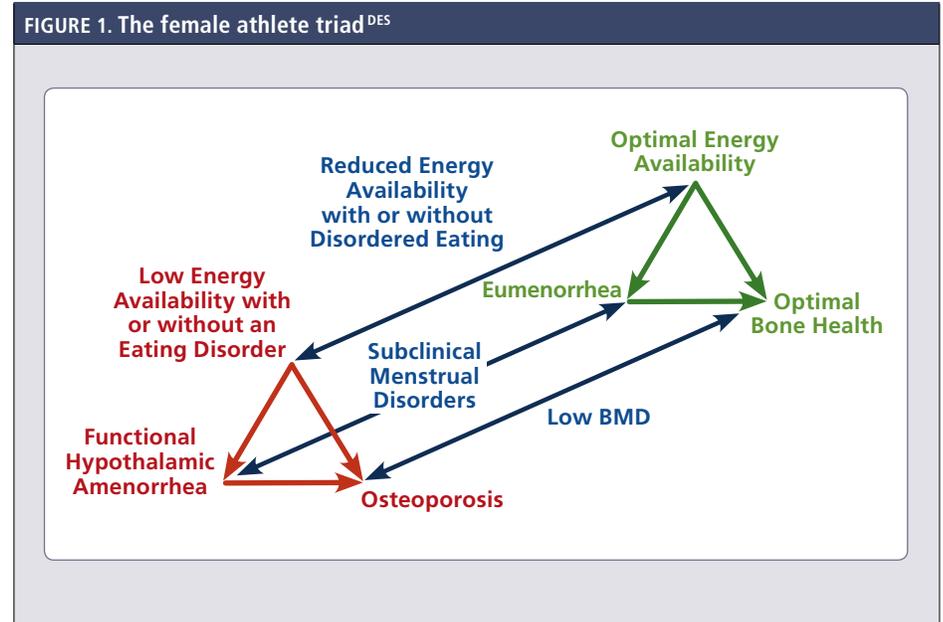
BDD is a relatively common yet underdiagnosed psychiatric disorder. Patients with BDD:

- Are preoccupied with 1 or more perceived physical defects or flaws that others don't see, or see only as slight defects.<sup>DSM</sup>
- Perceive minimal or nonexistent flaws to be unattractive or devastating and the cause of much anxiety or distress.
- Are more concerned if they have slight physical anomalies.
- Have significant distress or impairment in functioning as a consequence of distorted body image.
- Do not sway from their views, even when a physician reassured them that they look fine.<sup>PHI</sup>

If an eating disorder patient is seeing a **plastic surgeon**, this may be a sign of BDD.

## The female athlete triad

Three clinical conditions are often associated with female athletes with eating disorders — the female athlete triad, below. These conditions pose significant health risks and potentially irreversible consequences.



## Diagnosis challenges and indicators

- **Recognize the challenges of diagnosing eating disorders.** For example, a patient may have recently lost significant weight (e.g., moving from obese to normal BMI). Although this is usually a healthy change, certain key indicators can be early signs of an eating disorder. It is important to review the growth chart when evaluating children and adolescents. Crossing two or more major centile lines on the growth chart, and weight that is below the third or above the 97th percentile for weight/BMI should prompt further assessment.
- **Key indicators of eating disorders:** Dramatic weight change (more than 8 to 10 pounds per month), low weight combined with excessive exercise (more than 60 minutes per day most days of the week), and a significant imbalance between energy intake vs. expenditure.
- **Continually evaluate your comfort level throughout the diagnosis and treatment process and reach out to other medical professionals as needed.** A positive outcome for the patient should be the primary driver in the process.

**✓ KEY PRINCIPLES**

- A **multidisciplinary team** should be brought together to promote the best outcome for eating disorder patients. Each team member brings special skills and different perspectives to the case.
- **Communication** among team members is critical.
- Although the **cost of multidisciplinary care** can be high (because of regular appointments with the team), inpatient or residential care is much more costly.

**TEAM COORDINATION**

The medical care team member typically serves as team coordinator and works closely with members of the multidisciplinary team:

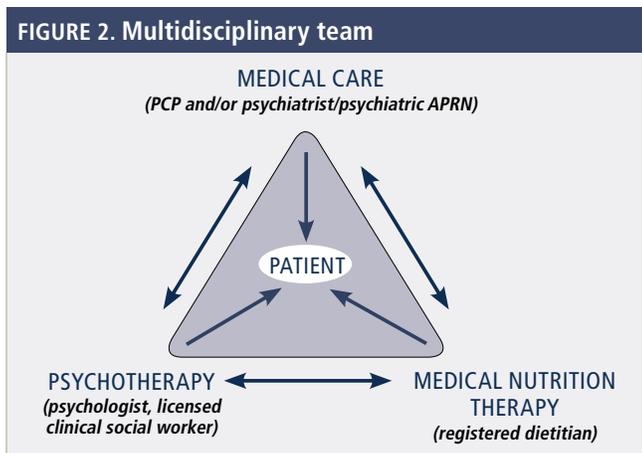
- **Assembles and coordinates the team**, which may include a care manager in addition to the multidisciplinary team.
- **Defines a method for exchanging information about each patient** through team meetings, notes in the patient record, etc. (see page 13).
- **Further works with the team to refine team roles** as needed — roles often overlap in team-based care and may evolve in the course of a patient’s treatment.

**▶ MULTIDISCIPLINARY TEAM**

A multidisciplinary team approach is widely recognized as the best practice to treating patients with eating disorders. This CPM advocates for **PCPs to create multidisciplinary teams** for treating patients with eating disorders and establishing methods of team communication.

Each provider in the multidisciplinary team plays a pivotal role in the patient’s recovery. Core areas of focus for the team members include **medical care** (mental and physical health), **psychotherapy**, and **nutrition support**. While all team members should be experienced in eating disorder diagnosis and treatment, each team member has unique skills and responsibilities with respect to patient care. That said, there may be considerable overlap in what each member of the treatment team does to promote recovery from disordered eating.<sup>10Y</sup>

It is important to note that this model is fluid and continuous; a multidisciplinary team works together throughout the course of care to achieve the best possible outcome.



**Establishing roles**

The multidisciplinary team’s first step is to establish the role of each team member. These roles may vary, depending on the team available. For example, a PCP in a rural environment may not have immediate access to a dietitian, and so might work with a dietitian in another location to gather ideas and work with the patient directly.

<b>TABLE 8: Overview of multidisciplinary team member roles</b>			
<b>Role</b>	<b>Who fills the role?</b>	<b>What does this team member do?</b>	<b>How often does he/she meet with patient?</b>
<b>Medical care</b>	<ul style="list-style-type: none"> <li>• Primary care provider</li> <li>• Psychiatrist</li> <li>• Psychiatric APRN</li> </ul>	<ul style="list-style-type: none"> <li>• Evaluates overall health of the patient (weight, nutrition, mental health, functional ability)</li> <li>• Manages the medical consequences of the eating disorder</li> <li>• Advises the patient on healthy levels of exercise</li> <li>• Prescribes medication</li> <li>• Recommends mental health and nutritional interventions</li> </ul>	1 to 4 times monthly, depending on severity
<b>Nutrition support</b>	<ul style="list-style-type: none"> <li>• Registered dietitian</li> </ul>	<ul style="list-style-type: none"> <li>• Provides information on a healthy diet and meal planning</li> <li>• Establishes healthy eating and exercise patterns</li> <li>• Addresses behaviors related to food and eating</li> <li>• Monitors physical symptoms</li> <li>• Implements nutritional treatment plan</li> </ul>	1 to 4 times monthly, depending on severity
<b>Psychotherapy</b>	<ul style="list-style-type: none"> <li>• Mental health professional (psychologist, licensed clinical social worker, psychiatrist)</li> </ul>	<ul style="list-style-type: none"> <li>• Performs cognitive behavior, interpersonal, or family therapy</li> <li>• Monitors mental health issues</li> </ul>	4 times monthly or more depending on severity

## OTHER MEDICAL PROFESSIONALS

As needed, other team members may treat the patient, for example:

- **Gastroenterologists:** digestive system concerns that have contributed to the development of or are the consequences of disordered eating behaviors
- **OB/GYNs:** menstrual dysfunction (delayed menarche, oligomenorrhea, and amenorrhea), pregnancy
- **Sports medicine physicians:** evaluation and management of the female athlete triad (see page 9)
- **Orthopedic surgeons:** bone health issues (e.g., high-risk stress fractures)
- **Endocrinologists:** growth and menstrual disturbance and concurrent conditions (e.g., thyroid disease)
- **Adolescent medicine specialists:** medical and emotional issues of teens
- **Developmental and behavioral pediatricians:** medical and emotional issues of children, adolescents, and their families
- **Plastic surgeons:** awareness of BDD (see below) if patients present for recurrent aesthetic interventions; referral to appropriate physicians when eating disorder suspected

## LEAD, REFER, OR SEEK CONSULTATION? FACTORS TO CONSIDER

You may lead a multidisciplinary team yourself, refer the patient to another physician, or consult with another physician about the patient. Consider these factors when making this decision:

- Your level of comfort with the patient/case
- Level of complexity of the case
- Comorbid conditions and personality disorders
- The patient's family support and family structure
- History of hospitalizations

Throughout the treatment process, continually re-evaluate the team and bring in other team members as needed.

## Medical care (PCP and/or psychiatrist/psychiatric APRN)

The primary goal of the physician is to ensure that the patient is stable, then work toward improving the patient's physical and mental health. **The physician covers many of the same topics as the dietitian and the therapist; all team members need to support what the other team members have told the patient.**

A psychiatrist or psychiatric APRN is sometimes involved if the patient has significant comorbid mental health issues that require complex psychotropic medications or mental health issues that significantly compromise ability to function.

**TABLE 9: Medical care focus and strategies**

Focus
<ul style="list-style-type: none"> <li>• <b>Function (PCP and/or psychiatrist)</b> — assessment of day-to-day functioning by asking questions, such as: <ul style="list-style-type: none"> <li>– How have you been doing since your last visit?</li> <li>– Is there a time of day that your behaviors are better or worse?</li> <li>– What helps you succeed (with changing behaviors, with treatment, etc.)?</li> <li>– Are you taking your medications as prescribed?</li> <li>– Additional questions to develop rapport and further assess patient functioning (e.g., “How is school? Work? Family?” and “What are you eating for breakfast, lunch, dinner, and snacks (describe amounts)?”).</li> </ul> </li> <li>• <b>Mental status (PCP and/or psychiatrist)</b> — assessment of the patient's mental health with a standard mental status examination (MSE) and discussion of various topics, such as body image, stressors, and mental health issues.</li> <li>• <b>Physical health exam (PCP)</b> — checking and recording the following: <ul style="list-style-type: none"> <li>– Vital signs — blinded weight, height (review growth chart for pediatric individuals), BMI, BP, HR, temp, PAVS (see sidebar page 6)</li> <li>– Change in weight since last visit</li> <li>– Physical exam if necessary — throat, heart, lungs, extremities, etc.</li> <li>– Repeated tests/exam items from diagnosis as necessary (see the <i>Comprehensive Medical Evaluation</i> section on page 5)</li> </ul> </li> <li>• <b>Physical health discussion (PCP)</b> — health-related topics, such as: <ul style="list-style-type: none"> <li>– A targeted symptom review: sleep, bowel habits, energy, urination, palpitations, syncope, near syncope, other issues or concerns</li> <li>– Exercise — PAVS (see page 5 sidebar)</li> <li>– Eating behaviors — restriction, bingeing, purging, etc.</li> <li>– Exercise behaviors — healthy and unhealthy levels of exercise</li> </ul> </li> <li>• <b>Medications (PCP and/or psychiatrist)</b> — prescribing and managing medications as needed. <ul style="list-style-type: none"> <li>– Psychotropic medications have a limited value in the treatment of eating disorders.</li> <li>– Fluoxetine has an FDA indication for the treatment of bulimia nervosa.</li> <li>– Lisdexamphetamine has an FDA indication for the treatment of binge eating disorder.</li> <li>– Psychotropic medications may be most beneficial for the treatment of co-morbid psychiatric disorders, especially mood disturbance.</li> <li>– Additional medications classes, may be beneficial in the treatment of eating disorder related health problems (e.g. gastrointestinal dysmotility, gastroesophageal reflux, menstrual dysfunction, low bone mineral density, etc.)</li> <li>– Please see Eating Disorder CPM Medication Supplement for further detail</li> </ul> </li> <li>• <b>Other health needs as necessary (PCP)</b> — menstrual function, digestive issues, bone health, endocrinology manifestations, etc.</li> <li>• <b>Determining the level of care (PCP and/or psychiatrist)</b> and where the patient is on the spectrum of care.</li> <li>• <b>Consulting (psychiatrist)</b> — working closely with the physician to manage psychotropic medications and the impact of mental health disorders on the patient's health and well-being.</li> </ul>

## CHRONIC HEALTH CONDITIONS AT RISK

Diet related chronic health conditions may influence the development of disordered eating patterns. Diseases such as type 1 diabetes mellitus, cystic fibrosis, celiac disease, eosinophilic esophagitis, inflammatory bowel disease, and irritable bowel syndrome require heightened focus on dietary choices, along with dietary elimination of trigger foods in certain situations.

The increased focus on dietary and/or growth needs may increase the risk of the development of disordered eating patterns. Screening for disordered eating patterns can help in identifying concerning behaviors in patients with diet related chronic health conditions.

**TABLE 9: Medical care focus and strategies – Continued**

### Strategies

- **Health and eating behaviors** — teach about and encourage healthy behaviors with a focus on dietary intake needed for health (in relation to energy expenditure).
- **Follow up** — initiate and drive care plan; follow up with patient regularly; ask the patient about meetings with the therapist and the dietitian.
- **Psychotherapy (psychiatrist)** — see [page 16](#) for details.

## MEAL PLANNING TECHNIQUES

The goal of meal planning is to return the patient to normal eating and behavior by:

- Reintroducing foods the patient avoided
- Challenging food fears and phobias
- Avoiding a “perfect” diet that eliminates or restricts some foods

Meal planning is individualized for the patient — there is no right or wrong way. Dietitians use a number of methods for meal planning.

Typically, dietitians discourage counting calories and weighing/measuring food for these patients.

## FOOD & FEELINGS JOURNAL

The Intermountain *Food & Feelings one-day journal* connects emotions to eating behaviors; it has words on the back that help patients express how they’re feeling — about food and their lives.



## INTUITIVE EATING

As the patient begins to recover, the dietitian may help the patient move toward intuitive eating. With intuitive eating, patients learn to:

- Respond to inner body cues.
- Distinguish between physical and emotional feelings.
- Listen to their hunger and fullness cues.

The 10 principles of intuitive eating are described here: [intuitiveeating.org/content/what-intuitive-eating](https://www.intuitiveeating.org/content/what-intuitive-eating).<sup>IEP</sup>

Patient handouts for use nutrition consultations include:

- [Ten Principles of Intuitive Eating \(English\)](#)
- [Ten Principles of Intuitive Eating \(Spanish\)](#)

## Medical nutrition therapy

The overall goal of nutrition support is to help the patient resume normal eating behavior through realistic goals and behavior change. The focus should be more on the patient’s **relationship with food** and **how and why to eat** than on what to eat. A **registered dietitian nutritionist (RDN)** can help the patient make connections between food behaviors and emotions. Additional strategies, approaches, and tools are used in supporting nutritional changes in children and adolescents affected by eating disorders.

**TABLE 10: Dietitian focus and strategies**

### Focus<sup>OZI</sup>

- **Function and physical health discussion** — see descriptions in Table 9 on the previous page.
- **Eating disorder history and potential causes** — current and past eating behaviors, history of weight fluctuations, situations that may have triggered the start of the eating disorder, and the patient’s goal weight (if applicable).
- **Appropriate exercise and eating patterns** — current patterns; behaviors to avoid such as skipping meals, restricting a specific food group, and obsessively counting calories, carbohydrates, and fat; and appropriate and inappropriate exercise (based on the physician’s recommendations).
- **Body image issues** — disordered feelings about body image, self image, and self esteem.
- **Stressors** — social, emotional, and family factors that prompt the behavior.
- **Food fears and challenges** — emotional and physical hunger, relationship with food, fear/challenge foods, food phobias, and food myths.
- **Energy (food) and fluid intake** — the amount, timing, and routine of intake; the importance of adequate intake; the benefits of carbohydrates, proteins, and fats; the effects of inadequate intake; nutrient deficiencies; blood sugar; and supplement/medication use.

### General strategies

- **Coping mechanisms:** Replace stress responses with healthier coping mechanisms.
- **Strategies to normalize food patterns:**
  - Use food feeling diaries to help patients notice thoughts that lead to behaviors and identify triggering foods or environments.
  - Identify ways to avoid binge/purge behaviors, such as avoiding triggers, seeking support when vulnerable, staying busy, and postponing the behavior as long as possible.
  - Create meal plans based on the individual patient, but generally starting with minimum meal plans, using safe foods as a foundation and slowly increasing intake of ‘challenge’ foods (to help patients move to intuitive eating over time).
- **Working with family members:**
  - Listen to the family’s concerns and answer questions.
  - Educate the family about realistic treatment expectations
  - Ask for the patient’s input: What can your family do to help you? What helps and what doesn’t help?
  - Have the family plate food for the patient, remove labels from cans or cross out calories and fat on labels, observe the patient eating, and stay with the patient after meals.
- **Intuitive eating:**
  - Encourages the patient to eat based on internal physical cues (hunger/fullness) rather than eating based on food rules they create for themselves.
  - Components of intuitive eating can be implemented as a patient moves away from the structure of meal planning.
  - Indicators that a patient is ready to move toward intuitive eating include:
    - Physiological restoration (weight restoration, ability to recognize and respond to hunger/fullness cues, period of regular eating patterns)
    - Cognitive awareness
    - Ability to recognize how the eating disorder influences one’s eating patterns
    - Willingness to challenge food rules/beliefs

**TABLE 10: Dietitian focus and strategies – continued****General strategies – continued**

- **Family-based therapy (Maudsley):**
  - There is no specific meal plan in the traditional family-based treatment model.
  - Encourages the parents to assume control in feeding their child. Parents take on the responsibility for determining what, when, and how much the child eats based on how they fed their child prior to the eating disorder.
  - Throughout the treatment process, the goal is to have the patient assume more control of eating, with the goal of establishing healthy adolescent identity, behaviors, and health.
- **Enteral nutrition:**
  - May be necessary when a patient is unable to orally consume adequate calories to meet energy needs.
  - May be used in conjunction with oral intake as a patient works towards increasing their intake to meet their nutritional needs.
  - May be used to offset the elevated energy needs often needed to promote weight restoration.
  - May be used in an outpatient setting but may require initiation in an inpatient setting.
  - May be titrated down with improvement in oral intake.
- **Estimating target weight range in children and adolescents:**
  - The identification of a minimum target weight is essential in the treatment of eating disorders as one means of determining the state of optimal health.
  - Target weight is often associated with the resumption of menstruation (as applicable).
  - Children and adolescents who are still growing may exhibit minimal, or no weight loss; however, they may have a drop in their BMI percentile as they are not gaining adequate weight with linear growth. Several methods have been used to determine the target weight including the use of historical growth trends, BMI method, McLaren Method, and the Moore Method.
    - The **McLaren Method** compares weight and height (length) to the individuals' age on the growth chart. It is calculated by plotting the height on the growth chart for age, extending a horizontal line to the 50th percentile for height, and then drawing a vertical line to meet with the 50th percentile for weight. This is identified as the target weight.
    - The Moore Method identifies target weight by matching the weight percentile for age to the height percentile.
- **Individual growth chart:**
  - The use of a comprehensive growth chart allows for the clinician to better assess the patient's individual growth trends. To assess the patient's target weight, multiple data points are required (weight, height, and BMI) to best assess historical growth trends.
  - The use of these points allows for the determination of growth history and to identify a target weight based on the patient's individual trajectory.
- **BMI method:**
  - Healthy body weight is determined with the use of the Centers for Disease Control and Prevention growth charts.
  - Target weight is determined by calculating the BMI at the 50<sup>th</sup> percentile for age and gender based on the patient's current height, taking into consideration growth trajectories prior to the onset of disordered eating behaviors.
- **Eating disorders in pediatrics:**
  - Disordered eating and eating disorders are being identified in school age and pre-adolescent individuals.
  - Nutrition management of disordered eating and eating disorders in the pediatric population requires parental inclusion for successful implementation. Parental involvement allows for increased understanding of the family norms with eating, including influences on dietary preferences and habits, as well as the role of cultural, ethnic, and religious background.
  - Special consideration with school age, pre-adolescent, and adolescent individuals needs to focus on ensuring appropriate nutrition to promote growth and development during the periods of increased growth.

**TABLE 10: Dietitian focus and strategies – continued****General strategies – continued**

- **Meal planning:** Can comprise of an array of different approaches. The specific approach needs to take into account the patient and family needs. Dietary recommendations need to take meal schedules, volume tolerance, need for supervision, and eating behaviors into account when creating meal and snack recommendations. Common meal planning strategies with eating disorders include:
  - **Select menu:** A specific menu including portion sizes that is created by a registered dietitian with a patient or family. The patient and/or caregiver select meals and snacks based on the patient's needs. This is ideal for an individual who needs structure but is not ready to add a wide variety to their dietary intake, or someone who needs specific snack or meals determined for them.
  - **Exchange system:** Foods with like nutrient values are grouped into units. In an exchange system, a patient is provided a certain number of exchanges based on their energy needs. Exchanges provide a more structured approach to eating and de-emphasizes calories. An exchange plan creates some autonomy in food choices because foods can be substituted for others. There are different ways to provide an exchange plan – some are based on 100 calories per serving, while others may be based on grams carbohydrate, protein, or fat per serving.

**Dietitian's role in binge eating disorder**

Primary focus needs to be on reduction and abstinence from bingeing, with weight loss as a secondary goal once bingeing has been controlled.

The dietitian's primary role is to assist in improving the patient's eating relationship. Initial strategies include working towards consistent eating patterns, neutralizing food, and reducing/eliminating bingeing. Long-term strategies include working towards intuitive eating, preventing weight gain/promoting weight loss, and improving overall health.

- **Strategy 1: Meal plans and neutralizing food**

- Consistent eating throughout the day is crucial for this population. Binges may be a result of physical and/or psychological triggers and eating regularly and avoiding extremes in hunger help regulate hunger and fullness cues as well as blood sugars. Create a meal plan with 6 opportunities (or 3 meals + 3 snacks). Make the plan as simple as possible so that the foods they are currently eating can fit easily into the plan (i.e. protein + carbs + color, or plate method, or mains and sides, etc.). Calorie counting is generally not the best route to start with. When using calorie counting, calorie levels need to be very realistic and not restrictive.
- When neutralizing food, make sure to be consistent and legalize all foods. Help the patient identify food rules and be cautious about introducing any food rules. Any plans or guidelines with "rules" run the risk of inducing more shame.

- **Strategy 2: Reducing and eliminating binges**

- Maintaining the meal plan throughout treatment is extremely important. Work with the patient to identify triggers (physiological and emotional) and overall behavioral patterns that lead to bingeing.
- This population likely has experienced judgment and shame regarding their intake and being in a larger body, your job is not to judge at all. It's to be their ally, because they may not have anyone else. On that note, weight loss may be very slow or nonexistent (patients may even gain some weight initially). Keep the big picture in mind and remind patient that stopping bingeing is the most important and initial first step.

- **Strategy 3: Mindfulness and intuitive eating**

- Introduction of different Intuitive eating principles can be made throughout the process. Use the LiVe Well handout on Intuitive Eating to introduce the principles and encourage patient to read the Intuitive Eating book. Use the Food & Feelings Journal to help the patient identify hunger/fullness cues and work through some of the emotions/situations that may trigger overeating. Throughout this process, the dietitian must act as the voice of reason, reassuring patient that he/she can eat all foods and that he/she is not a bad person for choosing certain types of foods over others.
- Moderate physical activity is recommended and is beneficial for this population. Again, aim to neutralize activity and include activity that he/she enjoys and does not induce shame. Activity focus is on how the patient feels, not how it may affect the number on the scale. Reinforce active at any size and every step counts. Consider a step or activity counter to help with accountability and motivation.

- **Gastric Bypass**

- Special consideration should be taken in regards to bariatric surgery candidates and patients who have undergone bariatric surgery. Patients with BED experience lower amounts of weight loss following bariatric surgery. Individuals with disordered eating experience higher rates of psychological stress and weight regain than individuals who don't. Individuals with binge eating or loss of control eating need to be treated and monitored prior to surgery in order to increase surgical effectiveness, especially long-term.
- Post operatively, disordered eating issues may lead to restriction or binge eating. For both issues, create a meal plan with the eating schedule: 4-6 small meals. Individuals who have had bariatric surgery need an adequate amount of protein and with limited stomach volume, meal plans should make protein intake a priority. If the patient is struggling to get adequate protein, a supplement is indicated.
- Especially in the first couple of years after surgery, patients cannot eat 'typical' portion sizes, small meals and snacks are indicated. Liquids must be consumed between meals and nutrient-rich foods are a priority. Compliance with supplements is often lacking, see the [Metabolic and Bariatric Surgery CPM](#) for supplement needs and indications. Be familiar with which surgery the patient underwent to better understand his/her volume and supplement needs.
- Mindless/emotional eating is particularly problematic for this population. For many, food has been used as a coping mechanism for years and having that coping mechanism removed may have physical and psychological ramifications. Regular psychotherapy is recommended.

## PATIENT PROGRESS AND REGRESSION

Often, a patient progresses in one area while regressing in another. For example, during periods of intense psychotherapy, a patient may inappropriately restrict caloric intake and lose weight to cope with the increased psychological risk. Or, when taking caloric risks at meals, a patient may be agitated and hopeless and may push away the therapist. Working with other members of the team to clarify the spotty nature of progress can help provide a more realistic picture of the patient's current needs. Recovery takes time — there are no quick fixes.

## WHAT DEFINES SUCCESS?

Success can be challenging to define in eating disorder patients. Success may include the following:

- Reduction or resolution of eating disorder behaviors
- Eating enough to support growth and activity
- Improved function in school, work, relationships, etc.
- Reduction of thought disturbances related to food and body image
- Attainment of healthy weight
- Normalization of lab abnormalities
- Engagement in healthy physical activity
- Diminished comorbidity symptoms

## WORKING WITH SUPPORT SYSTEMS

When appropriate, engage family and friends to support treatment:

- **Help families understand** eating disorders, and give them realistic expectations regarding recovery.
- **Trust family concerns.**
- **Empower parents** to listen to their children and find solutions that will be best for them.
- **Teach parents** about the warning signs of eating disorders (*see resources on page 27*).

## Psychotherapy (psychologist, licensed social worker)

The overall goal of the psychotherapist is to develop a trusting interpersonal relationship with the patient.<sup>JOY</sup> The techniques that follow are customized to the patient based on the style of the therapist, the presentation and needs of the patient, and the availability of community resources. Note that a psychiatrist or psychiatric APRN may fill this role.

**TABLE 11: Psychotherapy focus and strategies**

Focus
<ul style="list-style-type: none"> <li>• <b>Body image:</b> The function of certain body image tendencies (obsessive-compulsive tendencies, self esteem, gender roles, social anxiety, etc.).</li> <li>• <b>Psychosomatic reactions:</b> The interrelationship between body and mind; the effects of environmental or emotional stress on how the patient experiences physical symptoms, sensations, or urges; and the physical sensations that occur naturally after eating.</li> <li>• <b>Physiology:</b> Reinforcement of positions established by other team members about fat metabolism, factors influencing body composition changes, fat vs. lean weight, frequency of weighing, appropriateness of and/or comfort with goal weight, etc.</li> <li>• <b>Psychological trauma:</b> Past trauma (abuse, abandonment, injuries, etc.).</li> <li>• <b>Current situation:</b> Current life circumstances and coping mechanisms.</li> <li>• <b>Psychological therapies for comorbid conditions:</b> Anxiety, depression, substance abuse, etc.</li> <li>• <b>Care approach:</b> Validation of care plan, level of care, etc.</li> </ul>
Strategies
<ul style="list-style-type: none"> <li>• <b>Cognitive behavioral therapy (CBT):</b> The most thoroughly researched treatment in the evidence-based psychotherapy category, CBT combines the theories and strategies of both behavior therapy and cognitive therapy models. The goal of CBT is to change problematic behavior and affect by identifying, challenging and changing maladaptive thought patterns in an individual.</li> <li>• <b>Mindfulness based therapies:</b> Mindfulness is the state of being more “fully present” in the current moment. Paying attention to any of the physical senses or noticing thoughts and feelings without judgement or pressure are skills that have been proven to lower anxiety and enhance mood. Adding mindfulness strategies to other conventional psychotherapies has proven to add substantial benefit to therapeutic progress. Mindfulness Based Cognitive Therapy (MBCT) and Mindfulness Based Stress Reduction (MBSR) are examples of therapeutic strategies that can effectively treat symptoms associated eating disorders.</li> <li>• <b>Dialectical behavior therapy (DBT):</b> DBT is a specific and highly structured type of CBT. Originally designed to treat chronically suicidal people, DBT has shown effective as an intervention for patients with eating disorders, possibly due to its focus on mindfulness, interpersonal effectiveness, distress tolerance and emotion regulation. The focus on group skills training, individual therapy and coaching combined help patients learn and develop confidence in new coping skills.</li> <li>• <b>Feminist therapy (FT):</b> Focusing on the unique challenges women face due to gender bias, discrimination and related inequalities of Western culture, FT has become an essential component in the treatment of eating disorders. FT is designed to help patients strengthen their individual identity and empower them to cope more effectively with stressors in their lives, both personal and societal. It is particularly valuable in the treatment of body image disturbance.</li> <li>• <b>Interpersonal therapy (IPT):</b> Another standard of the evidence-based psychotherapies, IPT focuses on helping patients to experience relief from disordered eating symptoms by improving satisfaction and confidence in interpersonal relationships. The importance of a strong, trusting therapeutic relationship along with focus on effective communication patterns and strengthening healthy attachments are essential to patient progress.</li> <li>• <b>Psychodynamic psychotherapy:</b> Developing a better understanding as to the subconscious functions of behavioral patterns and symptom clusters is the main goal of psychodynamic therapy. Patients experience therapeutic change when they can recognize recurring patterns and the potential functions of these patterns related to thoughts, emotions, physical sensations and attachment history.</li> </ul>

**TABLE 11: Psychotherapy focus and strategies – continued****Strategies – continued**

- **Psychoeducation:** When a patient better understands their illness, they are more likely to make better decisions regarding their care. Because eating disorders tend to be complex and misperceptions are common, educating patients is essential to effective treatment. Examples of diverse areas for patient education include nutrition, medical effects of disordered eating behaviors, metabolism, exercise physiology, body image, and many psychological and societal factors.
- **Desensitization therapy:** Systematic desensitization is a behavioral strategy used within many different therapeutic modalities. Utilizing relaxation techniques and gradual exposure to situations that trigger an anxiety response, the patient learns to tolerate and adapt to circumstances that tend to trigger an avoidant response. Dietitians may gradually introduce “trigger” or “forbidden” foods so the patient can reduce the fear associated with stigmatized foods. Psychotherapists may encourage gradual exposure to uncomfortable situations that trigger symptoms in order to practice new skills and better tolerate the stimulus.
- **Eye movement desensitization and reprocessing (EMDR):** This highly structured therapy was originally used to treat traumatic reactions (PTSD) and phobias. Its use of bilateral sensory stimulation (eye movements, tapping hands or auditory sounds) combined with cognitive focus are a unique combination that have shown to produce effective therapeutic effects where other therapies have failed. Targeting specific traumatic historical events, current avoidant tendencies or future triggering situations help a patient to tolerate anxiety and practice new skills.
- **Family based therapy (FBT):** This is a front line treatment for children/adolescents struggling with anorexia nervosa. Putting the immediate focus on supporting parents/caregivers in feeding their child, FBT works to get the patient nutritionally stable and return them to a normal developmental trajectory. Once the patient’s weight is restored and their functional baseline is established, any contributing mental health concerns are addressed. It is currently being studied as a front line intervention for treating bulimia nervosa in adolescents as well as for anorexia nervosa and bulimia nervosa in young adults. FBT is a 3 phase protocol:
  - **Phase 1:** Parents take responsibility for feeding the child/adolescent with the support of their clinician. All food decisions are made by the parent. The patient’s job is to eat.
  - **Phase 2:** As the patient becomes weight restored, he or she begins to slowly take over their eating with the guidance of parents and therapist. This is a practice phase.
  - **Phase 3:** The patient is eating on their own with general observation of parents. Therapeutic objectives move toward the continued support of developmentally appropriate eating and addressing any contributing mental health factors.

## VIRTUAL TEAM OPTIONS: EATING DISORDER EXTENSION FOR COMMUNITY HEALTH OUTCOMES (ECHO)

Intermountain has assembled a team of eating disorder specialists — physicians, therapists, and dietitians — during a monthly telepresence meeting. The goal is to educate providers about working with these patients.

- The Eating Disorder ECHO is a collaborative model of medical education geared toward primary care clinicians, dietitians, and mental health professionals who are linked to expert clinical teams from Intermountain Healthcare via video, which acts like virtual grand rounds and combines mentoring and patient case presentations. This allows front-line clinicians to obtain the knowledge and support they need to manage patients who have complex conditions, to better determine when referrals to specialists and sub-specialists are medically appropriate, and to improve relationships and networks they have with specialists in a variety of areas of care.
- To find information on schedules, registration, the case presentation form, the didactic presentations, and the Intermountain Eating Disorder Hub Team, visit [intermountainhealthcare.org/about/transforming-healthcare/innovation/project-echo/eating-disorders](http://intermountainhealthcare.org/about/transforming-healthcare/innovation/project-echo/eating-disorders).

### To learn more:

Visit [intermountain.net/Eating-Disorders](http://intermountain.net/Eating-Disorders) or [intermountainphysician.org/Eating-Disorders](http://intermountainphysician.org/Eating-Disorders).

## VIRTUAL TEAM OPTIONS FUTURE PLAN: SCHEDULED VIDEO VISITS

Intermountain plans to provide tools for specialists at Intermountain referral centers to conduct audio and scheduled video consults with referring physicians or care for patients in remote TeleHealth Suites. This technology is under development.

### A NOTE ABOUT HIPAA

While you don't need a signed release form for the members of the team to communicate, it is best to keep the patient informed about the team and the information you share.

## Establishing team communication methods

Each multidisciplinary team member **personalizes the approach** for each patient. This makes regular communication between team members critical. The initial contact between team members is critical to establish roles and a communication plan.

Team members should communicate at least monthly (weekly for complex patients) to share information about the patient. Patients and families should be informed that treatment team members will discuss their case to comprehensively address recovery care and goals, while providing a cohesive treatment plan.

- What the patient is reporting to each team member (*see Team splitting below*)
- General medical condition and mental health
- Specific medical risks
- Current status of associated behaviors
- Medication adjustments
- Effectiveness and side effects of medications
- Changes in relationships, support system, living situation, work and/or school

### Communication methods

The team should work together to determine how they're going to communicate.

The team can communicate in any way that works, including:

- **In person.** This is the ideal. The team could set up a weekly meeting over lunch or meet at someone's office.
- **By phone.** Team members should call each other as needed with updates, questions, and so on.
- **Virtually.** If resources are not available to form a multidisciplinary team, the team should consider virtual options (*see sidebar*).
- **By email.** Email is not ideal because it may not be secure. If you do need to email, type "PHI" (Protected Health Information) in the subject line; this prevents others from seeing the email. Also, delete the email from your sent box immediately.

### Team splitting

Patients may attempt to divide treatment teams by forming an alliance with one member of the team against the others. Communication among the treatment team members can identify the presence of team splitting and allow the team to quickly isolate its impact on treatment. The team can implement a plan to normalize and use the splitting behavior to improve the patient's trust with the treatment team.

**✓ KEY PRINCIPLES**

- Maintaining an environment that is appropriate for patients with eating disorders vastly improves the patient experience.
- All team members should follow these guidelines to support effective treatment for the patient.

**MAINTAINING A WEIGHT-SENSITIVE OFFICE**

- **Face the patient away from the scale while weighing** (blinded weights), and keep scales out of public view.
- Don't talk about a person's weight except in private.
- Avoid weight-related comments (see table at left).
- Be aware that patients may put weights in pockets or take other actions to increase weight during weigh-ins.
- Dietitians and mental health professionals may not need to weigh the patient if the PCP is doing this — not facing another weigh-in can make appointments for psychotherapy or nutrition support more pleasant for the patient.
- If weight is a considerable trigger for eating disorder behaviors, consider additional strategies to eliminate direct discussion of weight with the patient (e.g. not documenting weight in vital sign section of EHR, or indicate "not in patient portal" within iCentra).
- For pediatric patients, privately review growth curve progress with parents/guardians.
- For adolescent patients, consider both patient maturity, and the degree to which weight is a trigger for behaviors when considering discussion of weight and growth curve progression.

**PATIENT EDUCATION**

Education is a critical element of the treatment plan. Use Intermountain resources (which also provide links to other materials) to educate patients and their families:



Eating Disorders



Eating Disorders: Conversation Tips for Friends and Family

**▶ GENERAL TREATMENT GUIDELINES**

Follow the guidelines below, whether managing a patient with disordered eating or working with a multidisciplinary team to treat a patient with a diagnosed eating disorder.

**General approach**

- For **Clinical Nutrition**, do not enter weight in vital signs or put patient note in patient's portal.
- For **Medical Group**, consider:
  - Blinded vs. unblinded weights at provider discretion and patient recovery status
  - Provider discretion regarding note in the patient portal
- **Maintain a weight-sensitive office.** Respect patients' feelings, keep scales out of public view, and don't comment on a person's weight except in private (see sidebar).
- **Respect the power of the illness.** Understand that it can be very challenging to change eating-related thoughts and behaviors. Simply providing advice to eat more is not likely to result in improvement.

**Talking to the patient**

Approaching conversations with patients in a sensitive way can result in more honest answers. For example, patients with eating disorders may hear something different than other patients when they hear a comment about appearance (e.g., "You look good today" sounds like "You're getting fatter" to a patient with anorexia). Follow these guidelines when talking to patients with eating disorders:

- **Avoid overemphasis on weight** as an indicator of general health. Eating disorder diagnosis is not defined by weight alone. Do not refer to body weight or overall appearance. Instead, compliment patients in ways that do not refer to the body.

**TABLE 12: Conversational DO's and DON'Ts with eating disorders**

DO say (if true)	DON'T say (even if true)
<ul style="list-style-type: none"> <li>• It looks like you are having a good day.</li> <li>• I see you have a University of Utah logo on your shirt (or a BYU keychain). Do you or someone in your family go there?</li> <li>• What does your day look like today?</li> <li>• What have you been doing for relaxation (or fun or vacation) since we saw you last?</li> <li>• Your eyes look very bright today.</li> <li>• Your hair looks nice today.</li> <li>• That's a great color on you.</li> </ul>	<ul style="list-style-type: none"> <li>• You look like you have gained weight.</li> <li>• You look good today.</li> <li>• You look better today.</li> <li>• You look more recovered.</li> <li>• You look like you have been following the (meal/therapy/nutrition) plan.</li> <li>• You are making progress in treatment.</li> <li>• You must like how much better you look.</li> <li>• You look so much better not being so thin.</li> </ul>

- **Present your concerns to patients** (and their families when appropriate) in a sensitive and caring way.
- **Communicate the importance of nutritional intake.** See page 11.
- **Discuss the dangers of restriction** — cognitive dysfunction; decreased BMI; fat storage; impacts on physical, psychological, and emotional functioning; and risk of bingeing.
- **Encourage patients to educate themselves and be proactive.** For any patient with a diagnosed or suspected eating disorder, it is helpful to provide the patient and family with information on the nature, course, and treatment of eating disorders (see page 20).

**✓ KEY PRINCIPLES**

- Eating disorders are surprisingly common in adolescents in the ED; weight is not always a reliable sign.
- Some emergency symptoms can be signs of an eating disorder, and some emergency treatments can be dangerous for patients with eating disorders.
- If an adolescent or young adult patient presents with symptoms of eating disorders, check for admit orders from the PCP and/or screen for eating disorders.
- Amongst children and adolescents, the growth chart should also be reviewed. Crossing 2 lines or more on the weight and/or BMI growth chart should raise concerns for an eating disorder.

**MEDICAL RECORD REVIEW**

- The electronic record may provide clinical **notes from the patient’s physician** with reasons for admission and recommended emergency room and/or inpatient management strategies.
- If an Intermountain patient presents with symptoms of an eating disorder, **check the problem list in the patient’s electronic record** for anorexia nervosa, bulimia nervosa, binge-eating disorder, or another eating disorder.

**TREATMENT TIPS**

- **Avoid rapid infusions of large volumes of fluid;** they can precipitate heart failure in patients with compromised heart size and reduced cardiac index. Even in patients with normal cardiac function, rapid infusion may result in significant edema.<sup>MAS</sup>
- Watch for **serious dysrhythmia** in patients below 70% of ideal body weight. Risk is high due to magnesium and phosphorus depletion, which can precipitate sudden cardiac risk and torsades de pointes.<sup>MAS</sup>
- Consider giving **spironolactone** rather than thiazide or loop diuretics for edema.

**DISCHARGE GUIDELINES**

See the table on the next page for discharge criteria and the sidebar on page 21 for discharge guidelines.

**▶ EMERGENCY TREATMENT**

Eating disorders are surprisingly prevalent among adolescent patients in the emergency department (ED). A study of emergency patients aged 14 to 20 showed that 16% screened positive for an eating disorder on a validated questionnaire.<sup>600</sup> Patients with eating disorders don’t always present with low weight; the same emergency study showed that 19.3% of the emergency room patients who screened positive for an eating disorder were overweight, and 11.5% were obese.

- **Patients currently under treatment:** Some eating disorder patients will arrive at the ED with **admit orders** from a primary care or specialty care physician, and/or treatment recommendations from another member of the multidisciplinary team. However, patients may not always volunteer this information, so it’s important to review the patient record or call the patient’s PCP if patients present with symptoms that may be signs of an eating disorder.
- **Patients who have undiagnosed eating disorders:** Especially with teenagers and young adults, watch for symptoms that may be signs of an eating disorder. If there is no diagnosis in the patient record but you suspect an eating disorder based on the patient’s symptoms, use the **Modified ESP** for screening (see Table (b) on page 5). For more information on diagnosis, see pages 6–7.

If an admit order is not present, the **admission criteria** on the following page can guide this decision.

**TABLE 13: Signs of eating disorders in the ED<sup>MAS</sup>**

	Symptoms	Notes
<b>Restricting (anorexia)</b>	Vitals: low BP or decreased heart rate	<ul style="list-style-type: none"> <li>• Consider admitting for <b>telemetry</b> or for close monitoring and management of symptoms (dizziness, fatigue, syncope).</li> <li>• <b>Avoid rapid infusions of fluid</b>, which can lead to heart failure in very low-weight patients.</li> </ul>
	Arrhythmia signs: weakness, fainting, palpitations	<ul style="list-style-type: none"> <li>• Order baseline ECG; if it reveals <b>prolonged QT</b>, identify cause beyond simple malnutrition (often hypokalemia or hypomagnesemia; may be medication-induced).</li> </ul>
	Chest pain	<ul style="list-style-type: none"> <li>• Order an ECG to evaluate for <b>acute coronary syndrome</b>. Chest pain may also be a sign of mitral valve prolapse, seen in 30% to 50% of patients with severe anorexia (usually benign unless accompanied by arrhythmia).</li> </ul>
	Musculoskeletal complaints	<ul style="list-style-type: none"> <li>• Consider a physical exam to exclude <b>spontaneous or low-impact fractures</b> in patients with anorexia nervosa, especially if the patient has hip or low back pain.</li> </ul>
	Signs of refeeding syndrome	<ul style="list-style-type: none"> <li>• Risk factors include &lt;70% of ideal body weight, abnormal electrolytes, and little or no intake (&lt;500 kcal per day) for 10 days.</li> <li>• See notes on refeeding syndrome in the sidebar on page 17.</li> </ul>
	Hypoglycemia, which can lead to seizures	<ul style="list-style-type: none"> <li>• May be a sign of <b>liver dysfunction</b>; order liver function tests.</li> <li>• Check <b>medication list</b> for medications affected by decreased liver function.</li> </ul>
<b>Purging (anorexia or bulimia)</b>	Lower GI: pain, diarrhea, abdominal cramping, constipation	<ul style="list-style-type: none"> <li>• Consider using a <b>nonstimulant laxative</b> to combat constipation/bloating and keep the patient hydrated.</li> <li>• <b>Superior mesenteric artery (SMA) syndrome</b> can result from loss of visceral fat associated with restricted eating and weight loss.</li> </ul>
	Blood: hypovolemia, hypokalemia, metabolic alkalosis	<ul style="list-style-type: none"> <li>• <b>Adjust IV boluses (if warranted) of fluid to the patient’s weight;</b> rapid infusions of fluids can cause edema (purging causes patients to retain salt and water). These patients can gain 10 pounds of edema if purging is abruptly stopped, and edema can be a trigger for eating disorder behaviors.</li> <li>• <b>Vomiting or diuretics</b> lead to dehydration, increased sodium and bicarbonate absorption and decreased potassium and hydrogen absorption.</li> <li>• <b>Normal saline</b> is a key component when treating for <b>potassium</b> deficiency. When the patient is hydrated, the patient will need much less potassium to replenish stores than would be predicted for the serum potassium level.<sup>MAS</sup></li> </ul>
	Upper GI: hoarseness, dysphagia, heartburn, hematemesis	<ul style="list-style-type: none"> <li>• Order an ECG to evaluate for <b>arrhythmia</b>.</li> <li>• Self-induced vomiting can cause <b>gastric reflux symptoms</b>.</li> <li>• Hematemesis can be a sign of Mallory-Weiss syndrome (tearing in the esophagus or stomach from self-induced vomiting).</li> </ul>
	Lower GI: pain, diarrhea, abdominal cramping, constipation	<ul style="list-style-type: none"> <li>• Consider using a <b>nonstimulant laxative</b> to combat constipation/bloating and keep the patient hydrated.</li> <li>• Symptoms may be caused by <b>laxative abuse</b>; detoxing can be difficult.</li> <li>• Consider using a proton pump inhibitor for gastro-esophageal reflux symptoms resulting from self-induced vomiting.</li> </ul>

## ✓ KEY PRINCIPLES

- Some treatments can be dangerous for patients with eating disorders.
- Closely monitoring patients is critical to care for patients with eating disorders.
- Severe malnutrition, regardless of its underlying cause, can be a medical emergency.
- Focus on oral intake for patients with eating disorders (instead of enteral feeding).

**TABLE 14: Identifying patients at high risk of refeeding problems** <sup>MEH</sup>

### Patient has one or more of the following:

- Body mass index (kg/m<sup>2</sup>) < 16
- Unintentional weight loss > 15% in the past 3–6 months
- Little or no nutritional intake for more than 10 days
- Low levels of potassium, phosphate, or magnesium before feeding

### Patient has two or more of the following:

- Body mass index (kg/m<sup>2</sup>) < 18.5
- Unintentional weight loss > 10% in the past 3–6 months
- Little or no nutritional intake for more than 5 days
- History of alcohol misuse or drugs, including insulin, chemotherapy, antacids, or diuretics

## ► OVERVIEW OF INPATIENT TREATMENT

Patients with eating disorders are admitted to inpatient treatment either from the emergency department or based on the recommendation of the multidisciplinary team. The multidisciplinary team should take an active role in inpatient treatment if possible.

The most objective and measurable feature of the patient presenting to a health care facility with a medically actionable eating disorder is the risk or fact of undernutrition. This can be characterized as the absolute BMI percentile (e.g. crossing two or more lines on the growth curve), an acute change in weight with a concerning trajectory, and cardiac abnormalities (e.g. arrhythmia, hypotension, orthostasis), oftentimes accompanied by significant psychological distress.

One of the most reliable indicators for outcome or prognosis during hospital-based care is ability to intake sufficient calories and fluid by mouth, and associated change in weight if clinically indicated. <sup>REB</sup>

Failure to achieve improvement in behaviors or body weight is associated with increased relapse and readmission. Conversely, restoration of normal body composition as represented by BMI or weight (while not expected in the hospital) portends a better prognosis.

### Refeeding syndrome

Refeeding syndrome is the potentially fatal shifts in fluids and electrolytes that may occur in malnourished patients receiving artificial refeeding (whether enterally or parenterally). These shifts result from hormonal and metabolic changes and may cause serious clinical complications.

The hallmark biochemical feature of refeeding syndrome is **hypophosphatemia**. The syndrome is complex and may also feature abnormal electrolytes (sodium and potassium) and fluid balance; changes in glucose, protein, and fat metabolism; thiamine deficiency; and hypomagnesemia.

Most nutritional resuscitation is done orally at first and monitored for adequacy, veracity, and safety from refeeding complications. In patients assessed to be capable of behavioral intervention augmenting voluntary eating, the care team (physician, registered dietitian, and behavioral health professionals) will set up a meal menu and schedule structure, and implement other elements of a supportive / therapeutic milieu.

A decision will be made after an oral observation period and care conference with providers and family (if appropriate) about future inpatient medical management, including escalation of nutrition support to nasogastric non-contingent enteral feeding.

Patients with severe acute malnutrition and progressive weight loss indicating pathophysiologic decompensation with catabolic injury to the brain, viscera, skeleton, and lean body mass should be considered in medical crisis and receive secure nutritional resuscitation by nasogastric route, in contrast to uncomplicated chronic undernutrition (see Table 14 at left).

Non-contingent nasogastric feedings, if elected based on algorithm criteria and failure of oral feeding challenge, will be instituted and advanced according to standard protocol. For vomiting and intolerance of intra-gastric feeding, GI consultation will be sought. Patients should be monitored for signs and symptoms of refeeding for 10 days after initiation of enteral or parenteral nutrition.

## RESIDENTIAL TREATMENT

For patients unable to function in their environments, residential treatment provides a highly structured environment that promotes healthy eating and weight gain (if indicated), changes destructive behaviors, and provides insight and coping skills.

## PARTIAL HOSPITALIZATION / INTENSIVE OUTPATIENT TREATMENT

After residential treatment, patients often undergo full-day, partial hospitalization / intensive outpatient treatment. This is a transitional program out of residential treatment back into free living. The patient continues multidisciplinary care if needed.

## FOLLOW-UP

The multidisciplinary team should follow up with the patient after discharge from inpatient treatment:

- **Physician:** within 1 week of discharge
- **Dietitian:** within 1 week of discharge
- **Therapist:** within 1 or 2 days of discharge

## DISCHARGE GUIDELINES

It is critical to discharge patients with eating disorders to knowledgeable providers. When patients meet the discharge criteria outlined in Table 15 on the previous page, do one of the following:

- **If the patient has a multidisciplinary team,** inform the patient's physician and therapist that the patient is being discharged.
- **If the patient does not have a multidisciplinary team:**
  - For SelectHealth patients, call SelectHealth at 801-442-1989 for a list of providers.
  - Non-SelectHealth patients, recommend close follow-up with the patient's primary care provider

## Team member roles in inpatient care

The patient's **multidisciplinary team** should communicate with the emergency department and/or inpatient care team if possible. This section provides additional guidelines for physicians, nurses, mental health professionals, and dietitians at the facility.

**Nursing staff** should perform the following during inpatient treatment:

- Check orthostatic vitals every morning.
- Monitor enteral feeding volume closely to ensure there has not been any manipulation of the pump or feeding material.
- Ideally, observe mealtimes; encourage completion of meals.
- Prohibit the patient from locking the bathroom door. If possible, ask housekeeping to turn off water to the sink. Remove the trash can from the room. These are strategies to discourage self-induced vomiting, or manipulation of enteral feeding. .
- Restrict physical activity (generally not allowed off unit unsupervised).
- Offer calorie-containing liquids (soda, juice, milk) rather than water and diet soda.

A **mental health professional** should be involved in treatment. The patient's own therapist should be notified of admission, and the inpatient team should outreach to discuss the plan of care as well as discharge plans. Additionally, the team can involve unit social workers and religious personnel as needed.

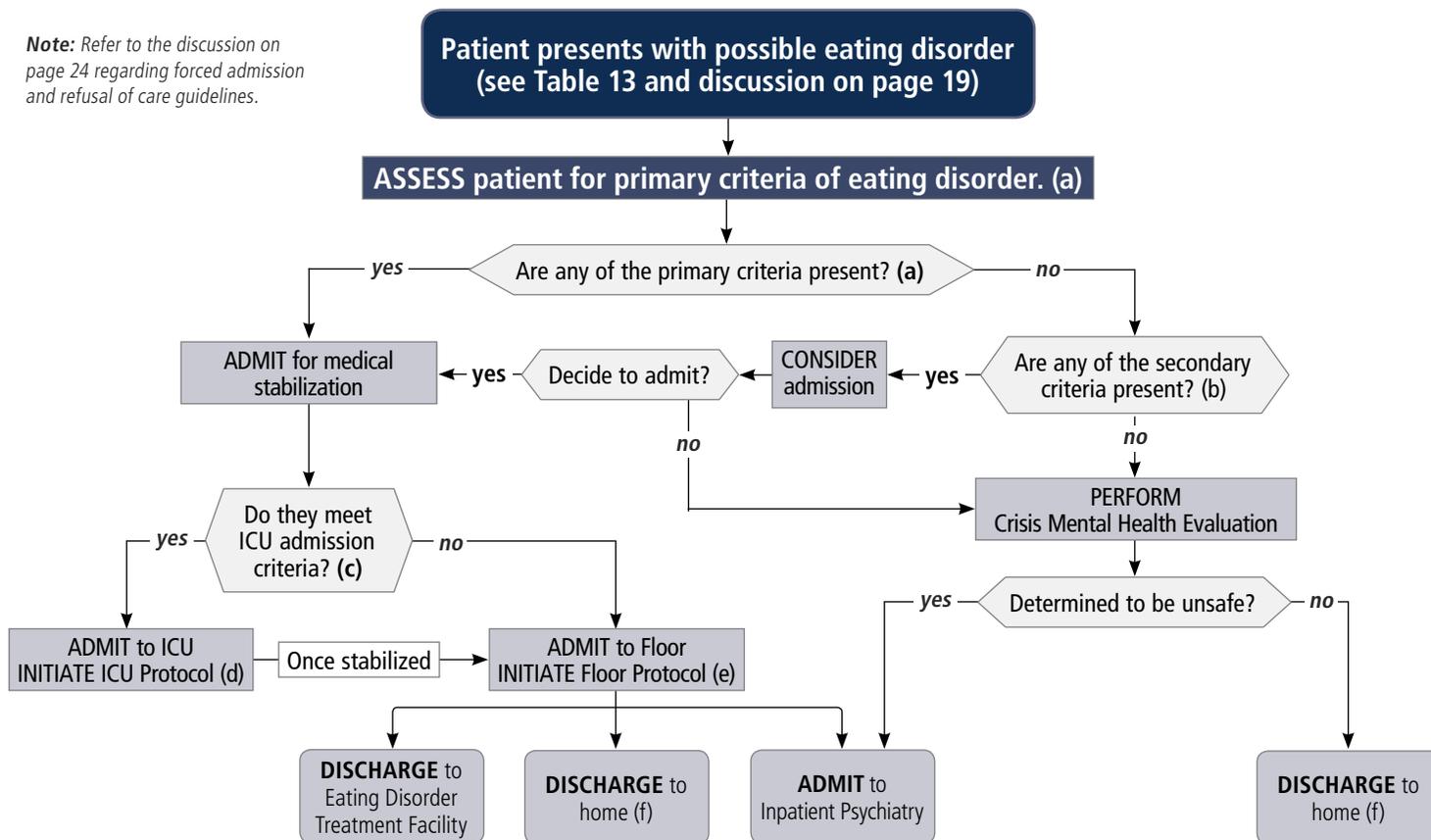
A **psychiatry consult** should be considered in patients with comorbid mental health conditions (e.g., depression, anxiety, bipolar disorder, obsessive compulsive disorder) that are complicating and/or exacerbating the eating disorder.

An **inpatient dietitian** calculates nutrition needs, provides recommendations regarding enteral / parenteral feeding (if necessary), and coordinates daily calories counts.

The patient's **outpatient dietitian** should be available to talk with hospital staff and the patient, and coordinate the outpatient dietary plan if possible.

# ▶ INPATIENT ALGORITHM: DIAGNOSIS AND EARLY MANAGEMENT OF PATIENT WITH SUSPECTED EATING DISORDER IN THE HOSPITAL

*Note: Refer to the discussion on page 24 regarding forced admission and refusal of care guidelines.*



## ALGORITHM NOTES

**(a) Primary criteria**

- Acute food refusal and significant weight loss defined as any one of the following:
  - BMI below 2nd percentile for age (pediatric patients)
  - 10-15% weight loss over 30 days
  - Repeated syncopal episodes
- AND** one of the following:
  - Vital sign abnormalities including bradycardia (HR < 50), QTC prolongation, orthostatic hypotension, or hypothermia (< 35 C degrees)
  - Metabolic disturbances including hypokalemia, hypophosphatemia, hypomagnesemia, hypoglycemia

**(b) Secondary criteria**

Consider admission with any of the following:

- Significant signs of malnutrition or dehydration
- Inability to maintain nutritional input and/or failure of other levels of care
- Inability to ensure a clear disposition plan with multi-disciplinary follow-up
- High psychiatric comorbidity (including suicidal ideation) and not appropriate or unable to provide direct psychiatric hospitalization
- High level of psychosocial distress or in the case of pediatric patients, parental/child discomfort with other options

**(c) ICU admission criteria**

The patient is a high risk for refeeding syndrome. Admit if any of the following:

- BMI < 13
- Previous history of severe refeeding syndrome
- Vital sign abnormalities including (HR < 40), hypotension (SBP < 80), serious cardiac arrhythmia
- Severe metabolic disturbances including K < 2.5, glucose < 55, Na < 115, magnesium < 1.0, phosphorous < 1.0

**(f) Discharge criteria**

The patient must meet all discharge criteria prior to discharge:

- No additional weight loss and no longer having purging behavior (if applicable)
- Stable vital signs, normalized electrolytes
- Normal QTC; resolution of serious cardiac arrhythmia
- Tolerating adequate PO intake +/- enteral feeds (total intake meets nutritional goal)
- Evaluated by behavioral health or crisis team
- Clear disposition plan in place including follow-up with physician, dietitian, and mental health therapist

### INPATIENT ALGORITHM NOTES – CONTINUED

#### (d) ICU protocol

- Initiate IV Fluid replacement
- Initiate IV Thiamine replacement
- Twice daily labs (PO4, Magnesium, BMP) If hypoglycemic, QID BS
- Initiate Nasogastric (NG) feeding (NJ for patients with severe gastroparesis or SMA syndrome)
- Start with low calories (5–10 kcal/kg/day) but build up as swiftly as twice-daily monitoring of K and PO4 allows
- If patient refuses NG feeding:
  - If labs or vital signs critical, (review Patient Refusal of Care Guidelines)
  - If not critical, consider 24-hour trial of PO intake, followed by NG placement if PO intake < 10 kcal/kg
- Obtain Nutrition Consult
- Obtain Behavioral Health Consult
- Increase enteral feeding by 20 kcal/kg/day within 2 days if stable labs, vital signs
- Once BMR intake is established and the patient is physically stable, it is recommended that 10% is added if bed-bound

#### (e) Inpatient floor protocol

- Daily multidisciplinary rounding (provider/hospitalists, nursing, nutrition, and behavioral health)
- Discharge planning to include outpatient follow-up with:
  - Medical provider
  - Mental health provider
  - Registered dietitian

Roles	Tasks
<b>Provider/hospitalists</b>	<ul style="list-style-type: none"> <li>• Telemetry bed (if indicated [e.g., risk of refeeding, arrhythmia, severe electrolyte abnormalities])</li> <li>• Twice daily labs (Mg, PO4, BMP) (if indicated); otherwise daily labs</li> <li>• Nutrition and Behavioral Health Consults</li> <li>• Additional Consults as indicated (e.g. GI)</li> <li>• Initiate feeding plan</li> <li>• Initiate meal plan with 3 scheduled meals and 2-3 snacks/day.                             <ul style="list-style-type: none"> <li>– Meals should be supervised by hospital personnel and are to be limited to 25 minutes with no food or drink in between</li> <li>– Expectation is for 100% completion, noting that food is medicine</li> </ul> </li> <li>• Consider NG or NJ placement when PO is inadequate.                             <ul style="list-style-type: none"> <li>– If PO intake is &lt; 50% of calculated needs during the first 24 hours, place NG/NJ tube</li> <li>– If PO intake is &lt; 80% of calculated needs in 48 hours, place NG/NJ tube</li> <li>– If NG/NJ is placed, feeds will run overnight, providing 50% of needs initially and adjusted per oral intake and weight gain trends                                     <ul style="list-style-type: none"> <li>– 1.2 kcal/cc formula (Pediatrics)</li> <li>– 1.5–2.0 kcal/cc formula (Adults)</li> </ul> </li> <li>– NG may be removed after 2 days of no use</li> </ul> </li> <li>• If patient is assessed to be extremely medically unstable, consider placing feeding tube immediately.</li> </ul>
<b>Nursing</b>	<ul style="list-style-type: none"> <li>• Vital signs (in addition to routine): daily blinded weights in hospital gown; daily orthostatic BP and HR</li> <li>• Bed rest on admission, transitioning to walks in room, then walks on unit as compliance with dietary intake, vitals, labs, and weight improves</li> <li>• Bathroom door locked</li> <li>• Supervise meals and snacks. Document meal completeness</li> <li>• Consider 1:1 supervision</li> </ul>
<b>Nutrition</b>	<ul style="list-style-type: none"> <li>• Determine calorie goal (enteral + oral)</li> <li>• Daily calorie counts</li> <li>• Document malnutrition in EHR</li> <li>• Assist in transition from enteral to oral, then to discharge</li> </ul>
<b>Behavioral health</b>	<ul style="list-style-type: none"> <li>• Psychosocial assessment and diagnosis</li> <li>• Meet daily with patient for psychoeducation, motivational interviewing, and psychotherapy</li> <li>• Help to resolve concerns, conflicts, and behavior problems while in the hospital</li> <li>• Along with medical team, determine appropriate discharge plan (e.g., home, transfer to inpatient psychiatry, discharge to eating disorder treatment facility)</li> </ul>

## Patient refusal-of-care guidelines

Severely underweight persons with an eating disorder very often meet criteria for serious bodily injury and substantial danger. In a situation where a patient has an acute and potentially life-threatening eating disorder, decisions must be made regarding the degree to which the patient should be involved in medical decision making. Two distinct guidelines come into play in this situation: [Medical Involuntary Hold](#) and [Psychiatric Involuntary Commitment](#).

When a patient is experiencing a medical emergency and is refusing treatment, and there is no one available to make medical decisions for the patient, the patient should be assessed to determine if an involuntary medical hold and involuntary treatment is appropriate. Utilize the [Intermountain Healthcare Involuntary Medical/Treatment Hold Worksheet](#) in these circumstances.

**Psychiatric involuntary commitment** differs from medical involuntary hold in that it is the process of safely detaining the patient in a controlled location. It requires the filing of a written application. Refer to the Intermountain [Psychiatric Involuntary Commitment Guideline](#).

- **Blue Sheet:** This is an emergency application for involuntary commitment with certification. It allows an adult to be temporarily held (safely detained in a controlled location) for 24 hours, excluding weekends and holidays. A blue sheet requires certification by a licensed physician or a designated examiner and the applicant.
- **White Sheet:** This is an application for "order of involuntary commitment." It is a court order that allows for an individual to be detained prior to a hearing or for continued commitment, specifying treatment.

The second guideline involved in this difficult situation is the [Utah Psychiatric Involuntary Commitment policy](#). Involuntary commitment is the process of being safely detained in a designated location and requires a filing of a written application (a blue sheet or white sheet). Involuntary patients can be held under reasonable measures until an evaluation has been completed and a decision regarding the treatment has been made. An involuntary patient continues to maintain their sovereignty and ability to make choices about their medical care and treatment and may refuse medications and tests, with the exception of emergency intervention required where there is substantial danger exists and a medical involuntary hold has been initiated.

**Involuntary medication.** To administer a medication against a patient's will, the patient must either meet the criteria for Emergency Medical Treatment or the criteria of Intermountain Healthcare's [Intermountain Healthcare's Involuntary Medical Administration Policy](#). Medication may be administered involuntarily in emergency situations without a court order. Involuntary medications may be given for emergency treatment if the patient's behavior presents substantial danger to themselves.

**Involuntary feeding** is a medical procedure that qualifies as emergency medical treatment when the person being treated lacks capacity, their surrogate decision maker agrees with the proposed treatment, or a surrogate decision maker is absent, and it is determined by the physician or APP that there is imminent risk of serious bodily harm if feeding (enteral or parenteral) is not administered.

*Continued on page 26.*

## SELECTHEALTH MEDICAL POLICY: FORMULAS AND OTHER ENTERAL NUTRITION (POLICY #534)

Enteral nutritional support is used for members with medical conditions that result in nutritional risk. Nutritional risk is considered having a potential for developing malnutrition as shown by clinical indicators. Enteral nutrition is providing sufficient nutrients to maintain weight, strength, and overall health status. Enteral nutrition involves the use of special formulas or medical foods that are administered orally or through a tube placed in the gastrointestinal tract. Enteral nutrition is used when a person cannot maintain sufficient nutrition to support health. The policy can be found at the link below:

[https://phy.intermountain.net/selecthealth/policies-procedures/selecthealth%20policies%20%20procedures/534\\_new.pdf](https://phy.intermountain.net/selecthealth/policies-procedures/selecthealth%20policies%20%20procedures/534_new.pdf)

### *(Refusal-of-care guidelines, continued.)*

**Every effort should be made to enlist the patient's trusted family members and support of recommended medical interventions.** This is often an ongoing process with both the patient and family members throughout the course of care. If a patient is determined to not have health care decision-making capacity and there is no legally-authorized individual available to provide substituted consent as described above, and Emergency Medical Treatment is necessary to preserve the life of the patient or to prevent serious bodily injury to the patient, then a patient may be held against the patient's will to provide emergency medical treatment under the theory of implied consent.

The physician or APP should reassess capacity to consent frequently, but no less often than every 24 hours. If the patient regains capacity to provide informed consent, then the patient's wishes must be followed even if the patient refuses to continue medical treatment. The physician or APP must carefully document their findings in the patient's medical record.

## ► MEDICATION MANAGEMENT SUPPLEMENT

In general, medications are prescribed to patients with eating disorders to treat comorbid conditions, manage physical complications, and reduce anxiety. Target symptoms should be established with the patient and monitored carefully. Ineffective medications should be discontinued after an adequate trial.

- A majority of patients with eating disorders will have comorbid mood disturbance and/or other psychiatric conditions which may benefit from psychotropic medications. In addition, the health consequences of eating disorders may warrant pharmacologic intervention.
- Females with prolonged amenorrhea may benefit from hormone replacement therapy to support bone health, or to address infertility.
- Gastrointestinal consequences of either dietary restriction or binge purge behavior can significantly impact health and quality of life. Examples include GERD as a consequence of self-induced vomiting, constipation from restriction of food and fluid, and bloating from the reintroduction of food, enteral feeding, and the avoidance of purging behaviors.
- Low bone mineral density as a consequence of malnutrition, and hypogonadism may warrant not only hormone replacement therapy, but additional bone health medications such as bisphosphonates.
- Providers should also collaborate with registered dietitians in regard to dietary supplements, vitamins, and mineral replacements.

For specific medication recommendations, please see the Eating Disorder Medication Management Supplement, **Table 9: Medical Care Focus and Strategies** on [page 11](#).

## ► REFERENCES

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## ► RESOURCES

### Patient and family resources



***Eating Disorders.*** This 4-page fact sheet provides an overview of eating disorders, diagnosis, and treatment.



***Eating Disorders: Conversation Tips for Friends and Families.*** This 2-page fact sheet provides key information for friends, family, and partners in how to best communicate with and support a person with an eating disorder.



***Food & Feelings 1-day Journal.*** This patient tool helps patients track how their emotions affect their eating habits.

#### PATIENT RESOURCES ON THE WEB

***Intermountain web resources.*** Patients can also access information about eating disorders directly from Intermountain's Health Resources: [intermountainhealthcare.org/health](https://www.intermountainhealthcare.org/health), Health Topic Library.

#### ***Other web resources:***

- The National Eating Disorders Association (NEDA): [nationaleatingdisorders.org](https://www.nationaleatingdisorders.org)
- Parent Toolkit provided by NEDA: [nationaleatingdisorders.org/parent-toolkit](https://www.nationaleatingdisorders.org/parent-toolkit)
- Eating Disorders booklet provided by the National Institute of Mental Health: [nimh.nih.gov/health/publications/eating-disorders/eating-disorders.pdf](https://www.nimh.nih.gov/health/publications/eating-disorders/eating-disorders.pdf)
- Center for Change: [centerforchange.com](https://www.centerforchange.com)
- Avalon Hills Residential Eating Disorder Program: [www.avalonhills.org](https://www.avalonhills.org)

### Provider resources

Access this CPM and other resources from:

- [intermountainphysician.org/Eating-Disorders](https://www.intermountainphysician.org/Eating-Disorders)
- [intermountain.net/Eating-Disorders](https://www.intermountain.net/Eating-Disorders)

#### Intermountain Eating Disorder ECHO

A team of eating disorder specialists provides support for healthcare providers during this monthly meeting. Visit the following link for more information on joining the Intermountain Project ECHO for Eating Disorders: [intermountainhealthcare.org/about/transforming-healthcare/innovation/project-echo/eating-disorders](https://www.intermountainhealthcare.org/about/transforming-healthcare/innovation/project-echo/eating-disorders)

#### Eating disorders materials

- [Eating Disorders CPM Reference List](#)
- [Eating Disorders eConsult Patient Information Form](#)
- [Eating Disorders Best Practice Flash Card](#)

#### Mental Health Integration (MHI) materials

- [MHI CPM](#)
- [MHI Scoring and Tracking Sheet](#) and other tools

#### Other related materials

- [Depression CPM](#) and associated tools
- [Bipolar Disorder CPM](#) and associated tools

This CPM presents a model of best care based on the best available scientific evidence at the time of publication. It is not a prescription for every physician or every patient, nor does it replace clinical judgment. All statements, protocols, and recommendations herein are viewed as transitory and iterative. Although physicians are encouraged to follow the CPM to help focus on and measure quality, deviations are a means for discovering improvements in patient care and expanding the knowledge base. Send feedback to Mark Foote, MD, Intermountain Healthcare, Behavioral Health Medical Director ([Mark.Foote@imail.org](mailto:Mark.Foote@imail.org)).