Eating Disorders in Youth
Evaluating and Treating in the Medical Home

February 27, 2017  Rebecca Marshall, MD, MPH
Outline

- Anorexia Nervosa
- Bulimia Nervosa
- Binge Eating Disorder
- Avoidant Restrictive Food Intake Disorder
- Screening
- Treatment
- References
Anorexia Nervosa (AN)

- Restriction of energy intake leading to low body weight
- Fear of gaining weight or behavior that interferes with weight gain
- Self-evaluation unduly influenced by weight and body shape
  - Restricting type
  - Binge-eating/purging type
it's not a diet
it's a lifestyle.
Epidemiology of AN

- 1-2% among females
- Prevalence in teenage girls 0.3-.7%
- Prevalence of AN in males not clear
- Peak incidence occurs at 14-28 years
- Chronicity (having AN > than 5 years) 7-15%
- Mortality 5-7%; resulting from medical complications of starvation (50%) or suicide (50%).
Bulimia Nervosa (BN)

• Recurrent binge-eating, where binge is defined as consuming a very large amount of food in a discrete period of time, such as within two hours; plus a sense of loss of control over eating
• Recurrent compensatory behavior such as vomiting, fasting, exercise, laxative use, diuretic use, taking diet pills
• Self-evaluation unduly influenced by weight and body shape
• The binge-eating and compensatory behaviors occur at least once a week for three months and do not occur exclusively during AN
BN Epidemiology

• Incidence increasing in urbanized areas and countries undergoing rapid Westernization
• Between 1-2% of adolescent females and 0.5% of adolescent males
• Male : female ratios between 1:10 – 1:3
• Typically begins in adolescence between 14-22 and for some may arise after an episode of AN
Binge Eating Disorder (BED)

- Recurrent binge eating episodes accompanied by a sense of loss of control over eating during the episode.
- In BED, episodes associated with at least three of the following:
  - Eating more rapidly
  - Eating until uncomfortably full
  - Eating when not hungry
  - Eating alone because of embarrassment about the amount of food consumed
  - Feelings of disgust, depression or guilt
- Occur on average at least once a week for three months
- Associated with marked distress
BED Epidemiology

• Likely most common eating disorder
• Affects 3.5% of females and 2% of males among adults
• Affects 2.3% of adolescent females and 0.8% of adolescent males
Avoidant Restrictive Food Intake Disorder (ARFID)
ARFID

- Food restriction or avoidance without shape or weight concerns or intentional efforts to lose weight that results in significant weight loss, nutritional deficiencies, and is associated with disturbances in psychological development and functioning
- Some patients present with highly selective eating, neophobia (fear of new things) related to food types
- Hypersensitivity to food texture, appearance and taste.
- For others involves fear of swallowing or choking; a specific event can sometimes be identified as triggering fear.
Screening

• AAP recommends PCPs screen for eating disorders as part of annual health supervision or during sports exams by monitoring weight and height longitudinally and paying careful attention to potential signs and symptoms of disordered eating

• All preteens and adolescents should be asked about eating patterns and body image

• SCOFF questionnaire
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes/No</th>
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<tr>
<td>Do you make yourself <strong>SICK</strong> because you feel uncomfortably full?</td>
<td></td>
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<tr>
<td>Do you worry that you have lost <strong>CONTROL</strong> over how much you eat?</td>
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<td>Have you recently lost more than <strong>ONE</strong> stone (14 lb) in a 3-mo period?</td>
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<td>Do you believe yourself to be <strong>FAT</strong> when others say you are too thin?</td>
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<td>Would you say that <strong>FOOD</strong> dominates your life?</td>
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Each “yes” equals 1 point; a score of 2 indicates a likely diagnosis of anorexia nervosa or bulimia. Abbreviation: SCOFF, sick, control, one, fat, food. Morgan JF, et al.\textsuperscript{12}
Screening

- PCP should provide additional assessment / monitoring if:
  - concern for excessive weight concern, inappropriate dieting, or pattern of weight loss
  - primary or secondary amenorrhea
  - failure to achieve appropriate increases in weight or height
AACAP Recommendations

1. Mental health clinicians should screen all child and adolescent patients for eating disorders
2. A positive screening should be followed by a comprehensive diagnostic evaluation, including labs and imaging as indicated
3. Treat severe acute physical signs/ medical complications
AACAP Recommendations

4. Psychiatric hospitalization, day programs, partial hospitalization programs and residential programs for ED in children and adolescents should be considered only after outpatient interventions have been unsuccessful.

5. Treatment of eating disorders in youth usually involves a multidisciplinary team that is developmentally aware, sensitive and skilled in the care of children and adolescents with eating disorders.
AACAP Recommendations

6. Outpatient psychosocial interventions are the initial treatment of choice for children and adolescents with eating disorders.

7. The use of medications, including complementary and alternative medications, should be reserved for comorbid conditions and refractory cases.
Treatments for AN

• No evidence for SSRIs in adults or adolescents
• Atypical antipsychotics have shown no benefit in small RCTs though some case reports claim success with olanzapine and other atypicals for weight gain and dysfunctional thinking
• Family-based “Maudsley” Therapy
  – Three phase interventions
Three Phases of FBT

**Phase 1**
(Sessions 1-10)
- Parents in charge of weight restoration

**Phase 2**
(Sessions 11-16)
- Parents transition control over eating back to the adolescent

**Phase 3**
(Sessions 17-20)
- Discuss adolescent developmental issues
Treatments for BN

- In adults, SSRIs have good evidence base.
- Fluoxetine FDA approved for BN in adults (high dose – 60 mg).
- Other SSRIs, SNRIs (venlafaxine) and tricyclic antidepressants have been shown to decrease binge-eating and purging in BN.
- Topiramate has been shown to decrease binge eating – can use for those who do not respond to or cannot tolerate SSRIS.
- CBT superior to antidepressants – current recommendations support the use of medications for patients who refuse CBT or do not have optimal response to CBT.
Additional notes

- Evaluate for comorbid disorders (anxiety, depression).
- When patients are starved, lower levels of available serotonin may limit the effectiveness of SSRIs and other antidepressants until weight partially restored.
- Obsessionality / depressed mood often improve with weight gain alone.
References

