Child Mental Health CoP Session 4: Eating Disorders

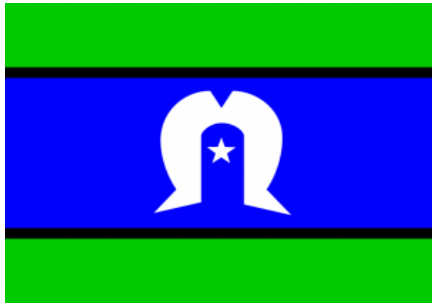
Tuesday 6 August 2024

The content in this session is valid at date of presentation

Acknowledgement of Country

North Western Melbourne Primary Health Network would like to acknowledge the Traditional Custodians of the land on which our work takes place, The Wurundjeri Woi Wurrung People, The Boon Wurrung People and The Wathaurong People.

We pay respects to Elders past, present and emerging as well as pay respects to any Aboriginal and Torres Strait Islander people in the session with us today.

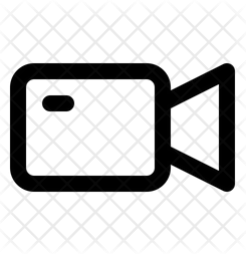


CoP guidelines
We agree to…

Stay on **mute** unless speaking

Raise your **hand** to speak

Keep conversations **confidential**



If possible, keep **camera on**

Introduce yourself and your role when speaking

Share **ideas** & promote everyone's **participation**

Acknowledge that we have **varied learning needs & interests**

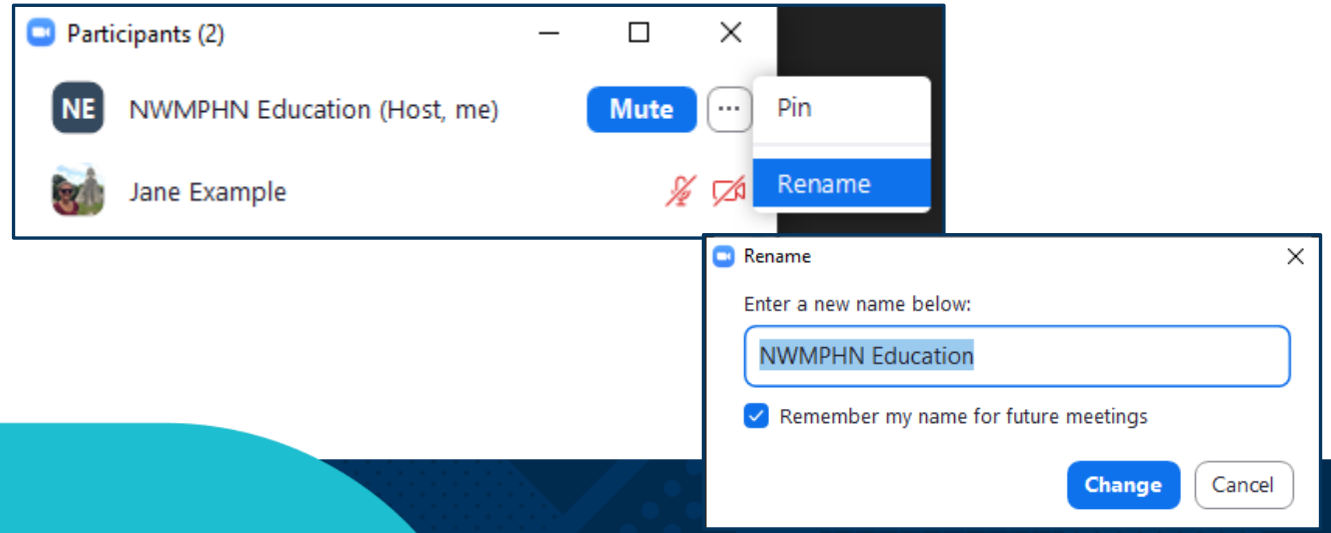
Ask **questions**

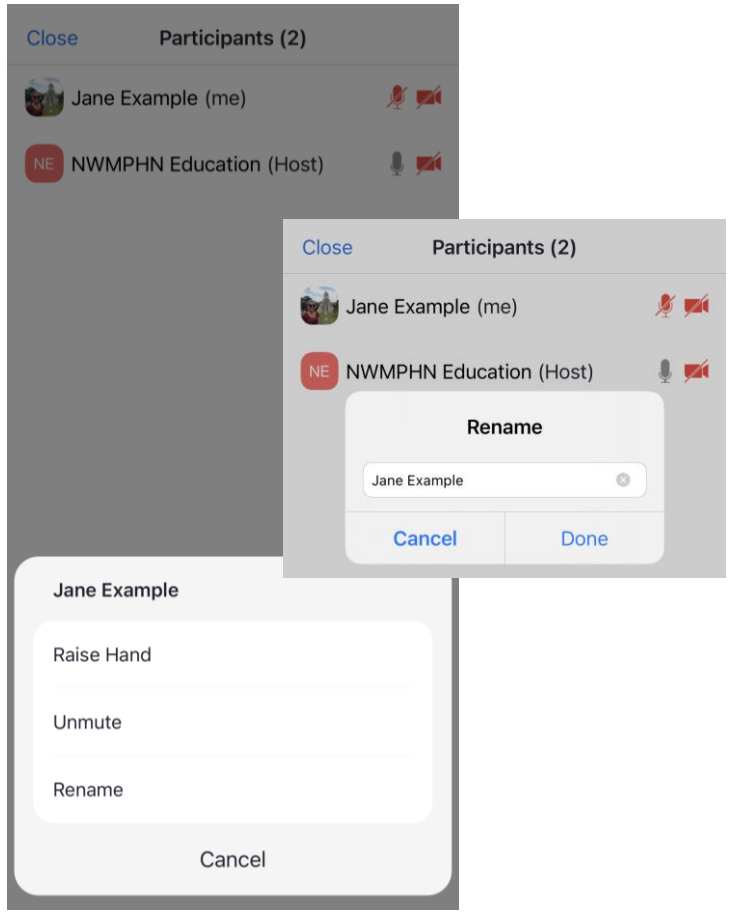
No question is silly

Please ensure you join the session using the same name you registered with and add your role next to your name

How to change your name in Zoom Meeting

1. Click on ***Participants***
2. **App:** click on your name
   Desktop: hover over your name and click the 3 dots
   Mac: hover over your name and click *More*
3. Click on ***Rename***
4. Enter the name you registered with and click
   Done / Change / Rename





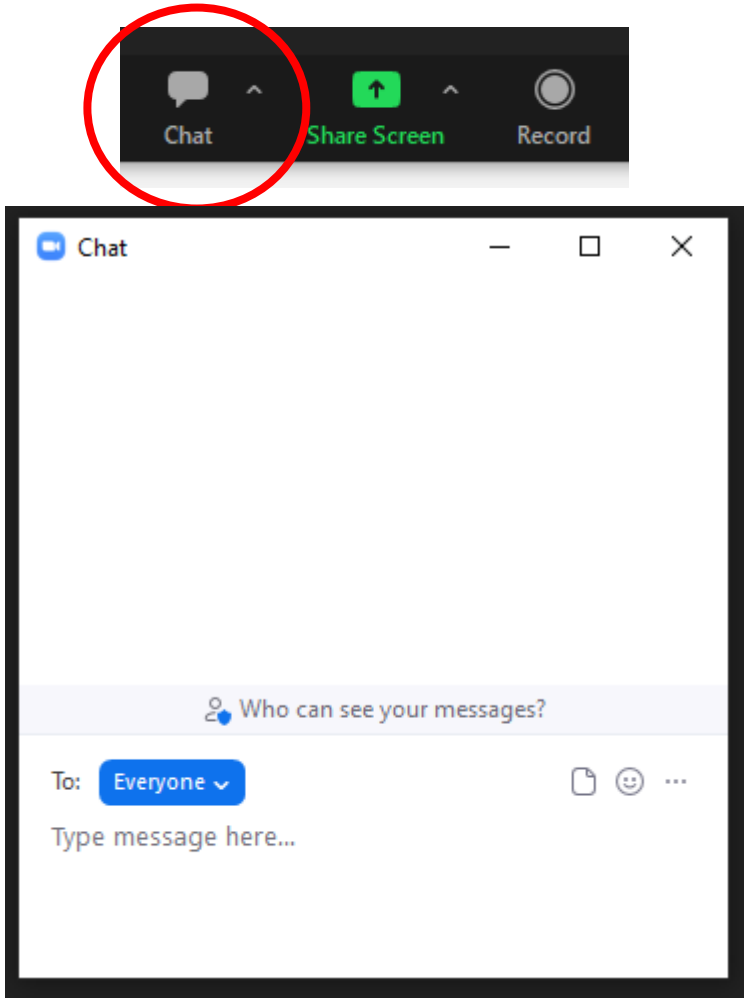
Housekeeping – Zoom Meeting

During the education component, please ask questions via the Chat box

This session is being recorded

Please ensure you join the session using the name you registered with so we can mark your attendance

Certificates and CPD will not be issued if we cannot confirm your attendance



Psychiatrist – Dr Chidambaram Prakash

- Dr Chidambaram Prakash is a senior consultant child and adolescent psychiatrist at the RCH with over 20 years' experience.
- Prakash has worked in, and managed, general and specialist clinics within child psychiatry in metropolitan and regional public mental health services.
- Prakash has worked with children and adolescents from 4 to 18 years of age assessing and managing a variety of mental health issues.

GP Facilitator - Dr Sahar Iqbal

- Practicing as a GP at Goonawarra Medical Centre for the past 11 years

- Sahar's areas of interest are child and adolescent mental health and chronic disease management

Guest Speakers

Dr Michele Yeo, Royal Children's Hospital

Michele is a paediatrician and physician in adolescent medicine. She has a longstanding interest in eating disorders and is the medical lead for the RCH ED Service. She enjoys working with in a multidisciplinary team and opportunities. Her other interests include chronic illness and health risk behaviours.

Matt Hogbin, Royal Children's Hospital

Matt Hogbin is a paediatric dietitian working within the Adolescent Medicine Department and the Children's Cancer Centre at The RCH. He has worked in the area of eating disorders for the past 7 years with experience in regional community health and metropolitan inpatient care with adults and adolescents. He takes particular interest in the nutritional rehabilitation of young people beginning their recovery pathway and providing education to families on how best to support their young person experiencing an eating disorder using a food first approach.

Agenda

Introduction and housekeeping	5 minutes
Education component and Q&A *Paediatric dietician - Matt Hogbin* *Peadiatrician and adolescent medicine physician - Dr Michele Yeo*	35 minutes
Health Pathways	5 minutes
Case discussion Part 1 – Breakout room	12 minutes
Breakout room discussion	9 minutes
Case discussion Part 2 – Breakout room	12 minutes
Breakout room discussion	9 minutes
Conclusion	2 minutes

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Education component: Eating Disorders

MICHELE YEO AND MATT HOGBIN


UGLY
think
Ugly

Screening for Eating Disorders

Screening tools not particularly sensitive/ specific for adolescents

Hornberger,

Pediatrics 2020

Nagata, Jama Int Med 2022

"The most effective screening device probably remains the health professional thinking about the possibility of an eating disorder."

(NICE, 2004)

What disorders will you see? DSM 5

Anorexia Nervosa

Bulimia Nervosa

Binge Eating Disorder

Avoidant Restrictive Food Intake Disorder (ARFID)

Other Specified Feeding and Eating Disorder (OSFED)

- **Atypical Anorexia Nervosa**

Pica

Rumination Disorder

Epidemiology

Adolescence peak age of onset
3rd most common chronic illness in female teenagers (asthma, obesity)
Affects all ethnicities and social groups

AN

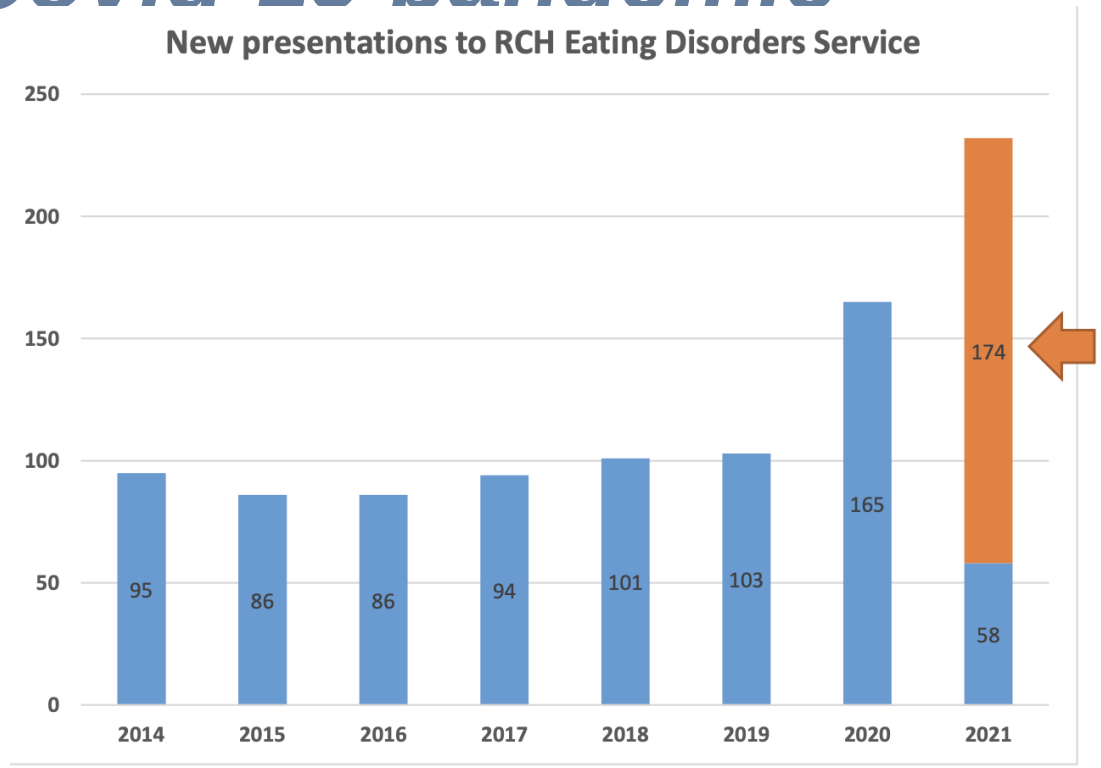
- Lifetime prev 0.9-2.2% females; 0.2-0.3% male
- Overall incidence stable but increasing in adolescent females
- Earlier onset than BN

BN

- Lifetime prev 1.5-2% (0.5% male)

Keski-Rahkonen Eat Disord Rev 2018
Hoek, Curr Op Psych 2016

Impact of Covid-19 pandemic



Numbers replicated in studies worldwide

Increased numbers presenting to emergency departments, outpatients and hospital admissions

Phillipou A, Int J Eat Disord 2020

Lin J, J Adol Health 2021

Devoe D, Int J Eat Disord 2023

Anorexia Nervosa

A.Restriction of energy intake relative to requirements leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal, or, for children and adolescents, less than that minimally expected.

B.Intense fear of gaining weight or becoming fat, or persistent behavior that interferes with weight gain, even though at a significantly low weight.

C.Disturbance in the way in which 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.

- **Restricting subtype**
- **Binge/Purge subtype**

Atypical Anorexia Nervosa

- Individuals meet all criteria for AN with exception of the weight criterion: individual remains within or above normal weight despite significant weight loss

Bulimia Nervosa

- **Recurrent binge eating**
- **Inappropriate compensatory weight control behaviours**
- **Frequency ≥ 1 / week for 3 months**
- **Self-evaluation unduly influenced by body weight/shape**
- **Absence of Anorexia Nervosa**

- **Binge eating = eating in a discrete period an amount of food that is definitely larger than most would eat in a similar situation & time period + a sense of lack of control over eating during episodes**

Avoidant Restrictive Food Intake Disorder

What ARFID IS

A persistent problem with feeding or eating leading to an inability to take in adequate nutrition/coupled with one of the following:

- substantial weight loss or failure to gain weight in growing children/adolescents
- major nutritional deficiency
- dependence on oral nutritional supplement or nasogastric tube feeds
- marked interference with psychosocial functioning

What ARFID is NOT

Associated with body image disturbance

Due to scarcity of food (eg neglect) or related to culturally sanctioned practice (eg fasting)

Explained by another medical problem or psychiatric disorder, such that the eating problem resolves with the treatment of the medical or psychiatric disorder

Avoidant/Restrictive Food Intake Disorder (ARFID)

Heterogenous disorder: 3 major types of presentations

1) Sensory food aversions, very restricted range of foods

2) Lack of interest in eating

- Low appetite, early satiety

3) Fear of aversive consequences

- Phobia of vomiting/choking/ anaphylaxis
- Gastrointestinal symptoms, abdominal pain, functional dysphagia
- Tend to present more acutely with weight loss

Can present with a mix of rationales for not eating

Thomas JJ, et al. *Curr Psychiatry Rep*. 2017

ARFID - prevalence

- **Tertiary North American paediatric centres - ED programs- 5-14%**
- **Swiss community-based study – 3%**
- **Australian population based >15y – 0.3%**

Ornstein 2013, Fisher 2014, Forman 2014, Kurz 2014, Hay 2017

- **Males > females**
- **Younger**
- **Comorbid medical and psychiatric disorder**
  - Anxiety disorder in 50% of ARFID in 1 study
  - OCD, ASD also common

Can be as malnourished as AN

Norris, J Eat Disord 2014, Fisher, J Adol Health 2014, Nicely , J Eat Disord 2014

Comparison of Eating Disorders

	Anorexia Nervosa/Atypical AN	Bulimia Nervosa	ARFID
Significant weight loss/ failure to gain	Yes	No	Maybe
Underweight	Yes/Not yet	No	Maybe
Body image disturbance	Yes	Yes	No
Binge eating	Maybe	Yes	No
Fasting/laxatives/ exercise/vomiting[1]	Maybe	Yes	No

Best Practice Approach in Primary care

Early recognition, assessment and appropriate referral

Establish rapport

Assess current physical and psychological state

Establish safety - Physical and psychological

Exclude underlying physical illness

Appropriate referral

Co-ordinate treating/care team

Ongoing monitoring of medical / psychological state

History – Helpful questions

Hx of eating behaviour over time

- Fussy/ selective eating/ dieting

Current intake (24h dietary history)

Pattern of avoidance

- Restricting: skipping meals/ snacks / reducing portion sizes

Binge eating

Purging

Max and min weight

Body image

Exercise

- Private exercise , walking

Periods

HEADSS – Context

Fhx of EDs/ psychopathology

Mental health assessment

Important to look for comorbidity

- Depression
- Anxiety Disorder: unusual rules, rituals, fear of judgement
- ASD

Taking a diet history

Vital information to gain knowledge on how a person is eating and how this has changed

Can be useful in diagnosis and escalation of care

Ask specific question on current intake

Food recall, generally

24hr recall

Ask for quantities and portions

Diet products including those that are low in fat, carbs and high in protein etc

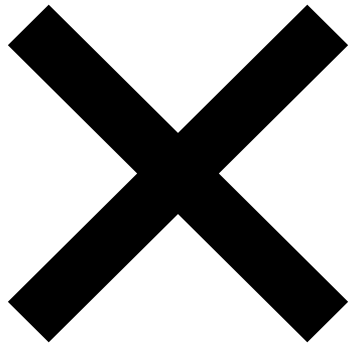
Important to ask when intake changed, and what diet was like prior to change

Current vs premorbid diet

Per 100g

Energy: 35 KJ

Carbs: 1g



Per 100g

Energy: 1440 KJ

Carbs: 70g

Per 100ml

Energy: 123 KJ

Carbs: 3.6 g

Protein: 0.6g

Fat: 1.4g

Calcium: 120mg

Per 100ml

Energy: 259 KJ

Carbs: 4.4g

Protein: 3.4g

Fat: 3.4g

Calcium: 118mg

Diet Hx example 1

Restrictive intake

Bfast)

Espresso coffee shot

25g oats made with water into porridge with 4 raspberries

MT)

Nil

Lunch)

Nil

AT)

Nil

D)

65g chicken/salmon/turkey - nil oil

Raw vegetables with no dressing

Meal time behaviors to be aware of

- Regimented inflexible eating
- Cutlery/crockery
- Weighing food
- Particular focus on macro/micronutrients to the exclusion of others
- Observations of parental cooking
- Increased distress around meal times

Diet Hx example 2

BF/ 9.00 - 2x salada crackers with 1/4 tsp or less butter + 1 gerkins (slice), no sugar cordial/lemonade 1 cup

MT/ Nil

L/ Nil

AT/ Nil

D/ 2x sushi rolls with avocado and tuna

S/ NIl

Premorbid diet hx:

BF/ 2 butter toast

MT/ snacks

L/ 2 sml bread rolls (butter), pretzels, grapes, string cheese, yoghurt

AT/ cherries, sandwich (vegemite + butter)

D/ ravioli pasta (ricotta/spinach), salad, fish, avocado and toast with PE, potatoes- butter/chives and cheese/ sour cream and caulslaw, baked beans

S/ 2 rows peckish crackers

Fluids/ water bottle throughout day, juice occasionally, milk before bed

Things to look out for

High protein products, that are low in energy/carbohydrates

Low carbohydrate products (noodles etc)

Dairy restriction and plant milks

High vegetable and fruit intake

Newly vegetarian/vegan/pescatarian diets

"Air" or "filler foods" like rice cakes and puffer rice cereal etc

Excessive caffein intake including coffee and energy drinks that are low sugar

Excessive water intake

Total elimination of discretionary foods

Limited variety that continues to reduce

Australian Guide to Healthy Eating

Requirements in adolescents

Food groups (serves per day)

Vegetables: 5 serves

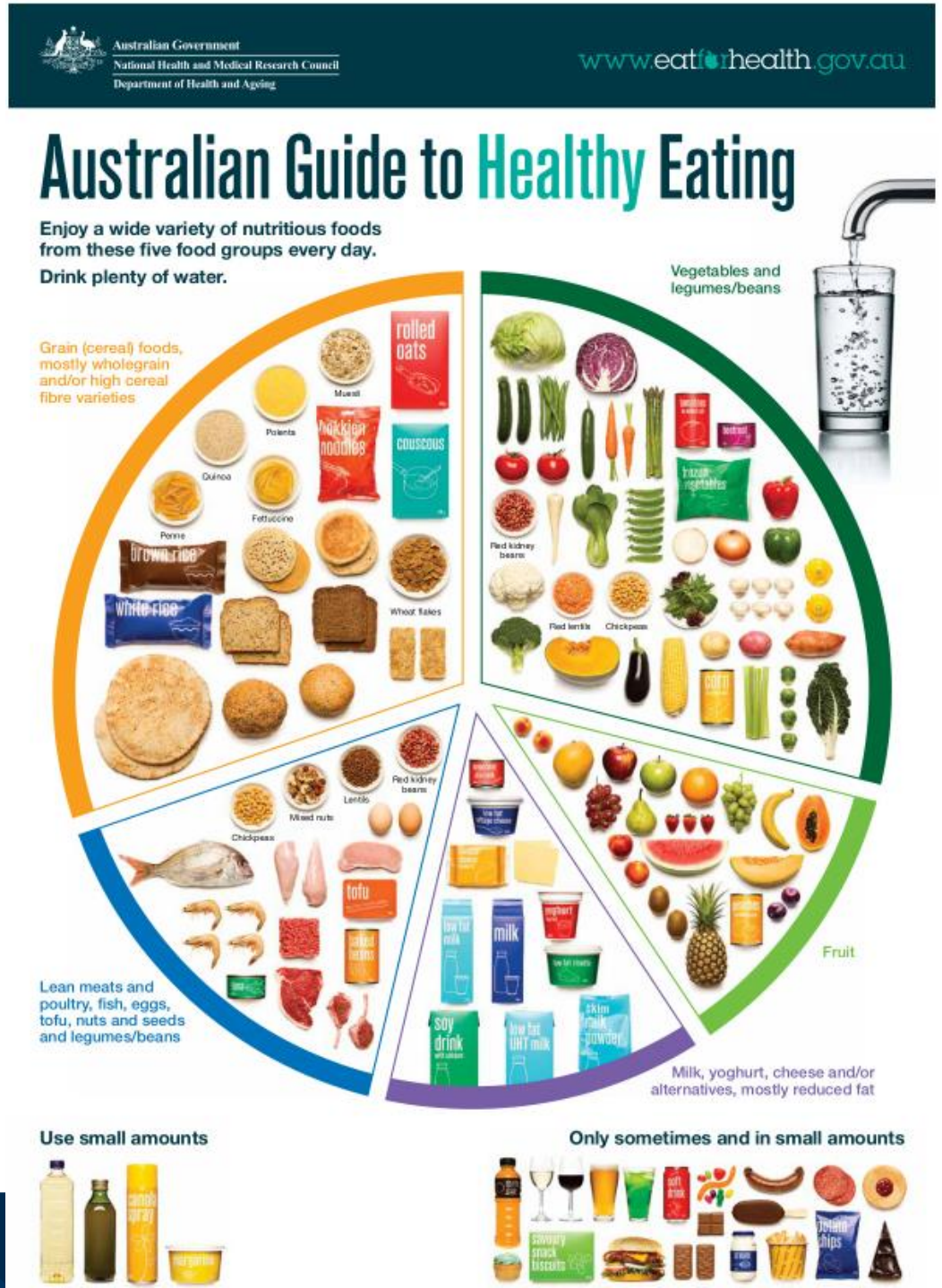
Fruit: 2 serves

Grains: 5-7 serves

Meat + alternatives: 2.5 serves

Dairy + alternatives: 3.5 serves

Discretionary food: <u>sometimes and in small amounts</u>



Refeeding syndrome

Potentially life threatening condition that occurs when aggressive nutrition is recommenced in someone who has metabolically adapted to starvation

Lean tissue breakdown releasing intracellular K+, Po4, Mg and Zn cleared by urinary excretion = net body deficit

Occurs over the first 3-10 days of starvation

Treated by reintroducing intake and monitoring condition

Refeeding syndrome

Reintroduction of nutrition can cascade and see an affect of abrupt metabolic changes

Reintroduction of intake

- Increase HR, BP, metabolic rate and change hormone levels increasing insulin
- Increases protein synthesis and replenishes body stores of ATP and glycogen

Electrolyte changes

- Sudden increase in thiamine consumption
- Sodium moved out of cells into serum
- Intracellular electrolytes shift from serum back into cells resulting in reduced serum levels
- potassium/phosphate/magnesium/calcium

Outcomes if not addressed

- Oedema, ECG changes
- Can cause thiamin deficiency and if significant can alter muscle, nerve and brain function

Examination

- Weight, Height (nb growth chart)
- BMI, BMI centile & % Median BMI (% of 50th centile BMI)
- Temperature
- Lying and standing PR (2 mins lying, 2 mins standing)
- Lying and standing BP
- Capillary refill
- Tanner staging
- Signs of severity – cognitive slowing, cachexia, peripheral oedema, inability to sit up/ squat –stand (SUSS)
- Signs of purging

Relevant investigations

Exclude organic disease – Diabetes, Thyroid disease, Inflammatory bowel disease, Coeliac disease etc

- ESR, TSH, Coeliac screen, FWTU, BSL

Check for complications

- Iron/ B12/ folate levels
- Vit D levels
- UEC, Ca/ Mg/PO4
- FSH, LH and Oestradiol
- Bone age
- Bone mineral densitometry -DEXA

Review of psychological interventions

Evidence Based Psychosocial Interventions for Eating Disorders in Adolescents (James Lock Jan 2015)			
	Anorexia Nervosa/Atypical AN	**Bulimia Nervosa**	**ARFID**
Level 1 Well established Treatment	FBT		
Level 2 Probably efficacious treatment	Systemic Family Therapy CBT-E Adolescent Focused Treatment (AFT)		
Level 3 Possibly efficacious treatment	Multi Family therapy Temperament Based Treatment	FBT, CBT,	FBT – Unified Protocol CBT-AR
Level 4 Experimental treatment		CBT, Individual psychotherapy	
Level 5 Questionable efficacy			

What makes us worry?

Rapid weight loss over a short period

- More likely to become bradycardic

Period of starvation/ very low intake followed by increased eating

- Development of the refeeding syndrome

Frequent vomiting

- Hypokalaemia

Safer Care Victoria / RCH Guidelines

Consider medical admission for those with:

Significant electrolyte disturbance (K < 3.0)

- **HR ≤ 50bpm**
- **Postural HR increase ≥30 bpm**
- **Resting systolic BP ≤80 mmHg**
- **Postural systolic drop ≥ 20mmHg**
- **Hypothermia <35.5C**
- **Dehydration**
- **Arrhythmia or prolonged QTc >0.45s**
- **Weight <75% of their expected body weight or rapid weight loss (>10-15% in 3-6 months is significant)**
- **Out of control ED compensatory behaviours eg prolonged fasting/ inability to eat at home/ uncontrolled purging and exercising**
- **Admission may be appropriate in rare circumstances where community management is not effective**

Useful resources

RANZCP Guidelines

- https://www.ranzcp.org/clinical-guidelines-publications/clinical-guidelines-publications-library/eating-disorders-cpg-and-associated-resources

RCP Medical Emergencies in Eating Disorders (MEED)

- https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2022-college-reports/cr233

Resources for parents/carers

EDV Carer Support

- Carer Coaching
- Carer Courses
- Telehealth counselling for carers
- https://www.eatingdisorders.org.au/for-family-and-friends/edv-services-for-carers/

Butterfly Program

- https://butterfly.org.au/get-support/support-programs/

Eating Disorder Families Australia

- https://edfa.org.au/

Pathways are written by GP clinical editors with support from local GPs, hospital-based specialists and other subject matter experts

- clear and concise, evidence-based medical advice
- Reduce variation in care
- how to refer to the most appropriate hospital, community health service or allied health provider.
- what services are available to my patients

HealthPathways – Child Eating Disorders

Relevant and related pathways

Relevant pathways

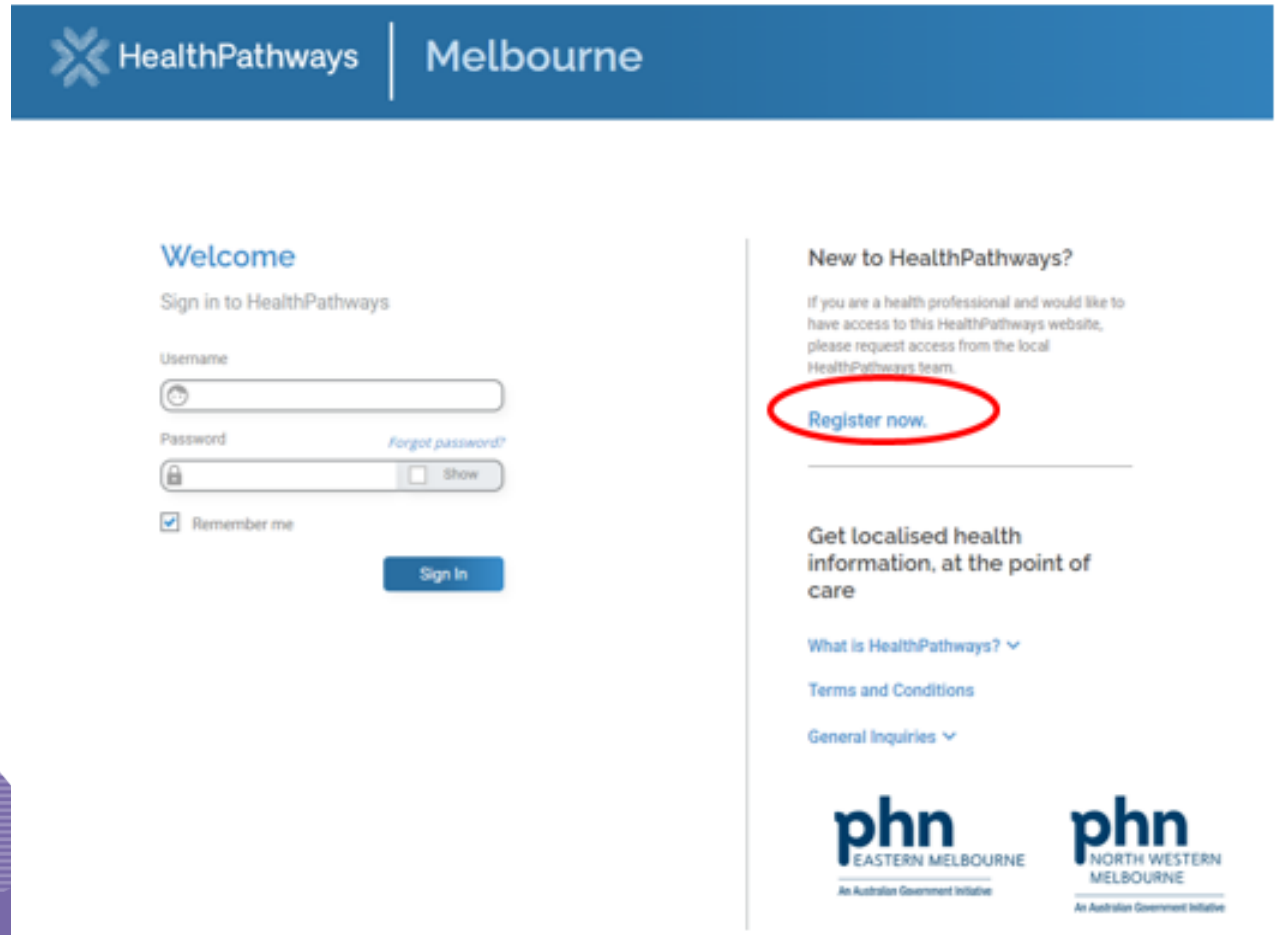
- ADHD in Children and Youth
- Anxiety in Children and Adolescents
- Borderline Personality Disorder (BPD)
- Depression in Children and Adolescents
- Eating Disorders
- Self-harm
- Psychological Trauma in Children

Referrals

- Acute Child and Adolescent Psychiatry Referral or Admission (Same-day)
- Non-acute Child and Adolescent Psychiatry Referral (> 24 hours)
- Paediatric Psychology and Counselling Referral
- Child and Youth Online Mental Health Therapy
- Child and Adolescent Eating Disorders Specialised Referral
- Child and Youth Mental Health Support Services

CPD Hours for HealthPathways Use

Accessing HealthPathways: Go to melbourne.healthpathways.org.au



Register via QR code

info@healthpathwaysmelbourne.org.au

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Case studies

Breakout 1 – Case study "Lorenz"

Lorenz is a 13-year-old who lives at home with his mother and older sister, he also sees his father on weekends.

Lorenz presents with increasingly restricted eating and weight loss of 5kg over 6 months. He has a long history of being a fussy eater and not being interested in food - does not like vegetables or fruit, mushy foods, squishy textures, strong tastes.

He has also had a difficult transition to Year 7 this year where he struggled with friendships and going to school and has missed most of the school year

Physically, Lorenz reported that he was just tired but his mother reported that he was also up late playing on the computer. He was always cold, no dizziness.

Examination revealed a thin boy, tall for age. He was polite but shy, mostly looked down at his lap and tended to fidget. Height was 165cm (just above 50th centile). His weight was 32kg (<1st centile)

His PR was 88 lying and 100 standing, BP was 105/60 lying and 98/60 standing. He had a mild thoracic scoliosis and the rest of his physical examination was normal.

Take a photo

Breakout 2 – Case study "Lorenz"

History from Mum

- Separation anxiety in kinder, prep.
- Settled somewhat in later primary school years but always quite anxious
- Teachers reports Lorenz struggles to concentrate
- Family history of anxiety – herself, and her own mother
- Has noticed Lorenz eating much less at mealtimes, refusing meals and getting anxious with eating + needing to push him to eat
- Has also seen him pinching his sides and his stomach
- Has not seen him exercising

History from Lorenz

- Attends local secondary school – doesn't like school - has found it too loud and intimidating
- Always worrying
- Worries about what others think of him, about schoolwork, finds it hard to concentrate
- Has 1 good friend from primary school
- Likes playing with his cat and enjoys gaming
- Has never been interested in food
- Lately has been worried about being fat and being called fat by others

Take a photo

Session Conclusion

Next session on neurodiversity in children and young people

– Tuesday 27th August (same time)

You will receive a post session email within a week which will include slides and resources discussed during this session.

Attendance certificate will be received within 4-6 weeks.

RACGP CPD hours will be uploaded within 30 days.

To attend further education sessions, visit,

https://nwmphn.org.au/resources-events/events/

This session was recorded, and you will be able to view the recording at this link within the next week.

https://nwmphn.org.au/resources-events/resources/

We value your feedback, let us know your thoughts.

Scan this QR code