

Welcome to UVM/AHEC ECHO: Children's Mental Health

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- RECORDING OF SESSION TO BEGIN



Agenda

- Introductions
- Objectives
- Didactic Presentation (15-20 min)
- Case presentation
 - Clarifying questions
 - Participants – then faculty panel
- Discussion
- Recommendations
- Summary
- Closing Announcements
 - Submission of new cases
 - Completion of evaluations



CME Disclosures

University of Vermont (UVM) Office of Continuing Medical and Interprofessional Education (CMIE) is approved as a provider of Continuing Medical Education (CME) by the ACCME. UVM designates this internet live activity for a maximum of 1.0 AMA PRA Category 1 Credits. Participants should claim only the credit commensurate with the extent of their participation in the activity.

Interest Disclosures:

- As an organization accredited by the ACCME to sponsor continuing medical education activities, UVMCMIE is required to disclose any real or apparent conflicts of interest (COI) that any speakers may have related to the content of their presentations.



Series Objectives

- By the end of this series, the learners should be able to:
 - Feel more comfort and confidence in **identifying, treating, and referring** a variety of complex children's mental health presentations.

Eating Disorders: Brief update

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Session Objectives

- By the end of this activity, the learners should be able to:
- Have increased confidence in screening and diagnosis of eating disorders
- Demonstrate greater familiarity with the various eating disorders and their presentation
- Increase confidence counseling patients with eating disorders with treatment options



What is the data?

- Estimated Prevalence for 13-18 year olds:
 - AN-0.3%
 - BN-0.9%
 - BED-1.6% up to possible 2-4%
- Mean age of onset 12.5 years
- Males make up 25% of cases of ED but often undiagnosed
- Second highest mortality rate second to opioid addiction. Crude mortality rates were 4% for anorexia nervosa; 3.9% for bulimia nervosa;
- Suicide Rates possible 1 in five of deaths related to suicide



Screening for Eating Disorders

- Screening high school students-
 - 1 in 4 female + for at least one symptom
 - 1 in 10 male + for at least one symptom
- All ages, race, and socioeconomic levels at risk
- High risk groups:
 - Sexual minority
 - Transgender up to 16 times higher risk
 - Adolescents with chronic medical diseases such as diabetes
 - Athletes-Relative Energy Deficiency of Sports (new name for Female Athlete Triad)



Talking about Eating Disorders: Language matters

- Consider recommended weight range, not buffer
- Weight restoration not weight gain
- Consider blind weight
- How many times a day or week do you make yourself purge instead of just how often
- And like many other conversations with parents, if she could she would
- Remember the classic question,
 - is there anything else?



Changes with DSM-5

- Addition of Binge Eating Disorder (BED) and Avoidant Restrictive Feed Intake Disorder (ARFID)
- Removal of Eating Disorder Not Otherwise Specified (EDNOS)
- Decrease in frequency of behaviors in criteria for bulimia
- Amenorrhea and specific percentiles removed for dx of AN

Other diagnosis:

- Atypical AN: all of the criteria for AN yet the individual's weight is within or above the normal range despite significant weight loss
- BN or BED (of low frequency and/or limited duration): All of the criteria, but, behaviors occur less than once a week and/or for <3 mo
- Diabulimia- insulin restriction among people with diabetes
- Other specified feeding or eating disorder (OSFED)
- Purging disorder: recurrent purging behavior (eg, self-induced vomiting; misuse of laxatives, diuretics, or other medications) in the absence of binge eating with the intent to influence weight or body shape



Avoidant/Restrictive Feed Intake Disorder (ARFID)

Avoiding and restricting food due to

- Lack of interest
 - Taste, texture or smell issues with food
 - Fear of food after negative experience such as choking
 - Behavior leads to failure to meet nutritional needs
-
- As a consequence of restricting, dx requires one of these
 - Weight loss, poor growth or failure to gain
 - Nutritional deficiency
 - Requires supplement feeding
 - Results in impaired psychosocial function
 - Not due to lack of food available
 - Not due to other mental health or medical condition
 - Not due to anorexia, bulimia or distorted body image



ARFID Treatment

- Very difficult to treat, may not respond to typical eating disorder programs
- Family based treatment
- Often lack of insight or concern of weight loss (overwhelming fear of eating)
- Dietician often plays role of “coach”
- Team communication very important
- Diagnosis difficult, over-exercise may also exist

Binge Eating Disorder (BED)

- Recurrent episodes of binge eating.
 - within a distinct period of time (eg, 2 h), eating an amount of food that is clearly larger than what most individuals would eat during a similar period of time including 3 or more of the following:
 - eating much more quickly than normal,
 - eating until uncomfortably full,
 - eating large amounts of food when not feeling hungry,
 - eating alone because of embarrassment at how much one is eating,
 - feeling guilty, disgusted, or depressed afterward
- Marked anguish is experienced regarding binge eating
- On average, the binge eating occurs at least once a week for 3 months
- The binge eating is not associated with the use of inappropriate compensatory behavior as in BN and does not occur only in the context of BN or AN



Binge Eating Disorder (BED)

- Medication treatments may have more evidence than other eating disorders
 - SSRI
 - Lisdexamfetamine (Vyvanse) approved for binge eating but contraindicated if purging
 - Topiramate (Topamax) off label
 - Zonisamide (Zonegran) off label use



Anorexia Nervosa-DSM-5 Criteria

- Restricted caloric intake relative to energy requirements, leading to significantly low body weight for age, sex, projected growth, and physical health
- Intense fear of gaining weight or behaviors that consistently interfere with weight gain, despite being at a significantly low weight
- Altered perception of one's body weight or shape, excessive influence of body weight or shape on self-value, or persistent lack of acknowledgment of the seriousness of one's low body weight
- Subtypes:
 - restricting type (weight loss is achieved primarily through dieting, fasting, and/or excessive exercise. In the previous 3 mo, there have been no repeated episodes of binge eating or purging);
 - binge-eating/purging type (in the previous 3 mo, there have been repeated episodes of binge eating or purging; ie, self-induced vomiting or misuse of laxatives, diuretics, or enemas)



Anorexia Nervosa-Treatment

- Nutrition and Psychotherapy including family
- Pharmacology
 - Olanzapine (Zyprexa) off label use evidence helps with weight restoration when not responding to first line
 - SSRI shows no significant benefit in reduction of AN symptoms
 - No benefit of, cyproheptadine, cannabinoids, lithium, zinc, omega-3 fatty acid supplementation, pre-meal benzo and testosterone



Bulimia

- Repeated episodes of binge eating characterized by both of the following:
 - Within a distinct period of time (eg, 2 h), eating an amount of food that is clearly larger than what most individuals would eat during a similar period of time
 - Repeated use of inappropriate compensatory behaviors
- On average, the binge eating and compensatory behaviors both occur at least once a week for 3 months
- Self-value is overly influenced by body shape and weight

Mild: An average of 1 to 3 episodes of inappropriate compensatory behaviors per week.

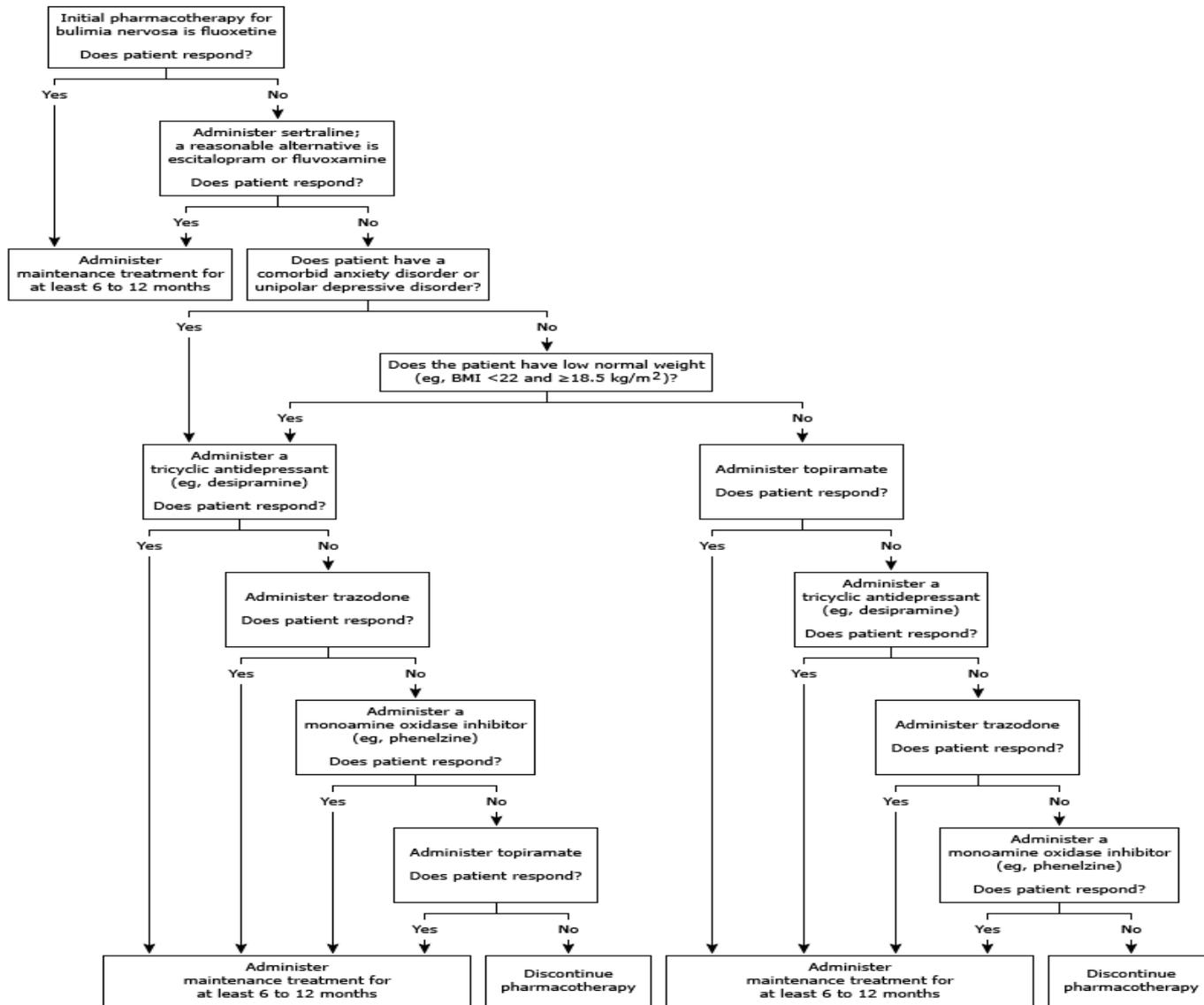
Moderate: An average of 4 to 7 episodes of inappropriate compensatory behaviors per week.

Severe: An average of 8 to 13 episodes of inappropriate compensatory behaviors per week.

Extreme: An average of 14 or more episodes of inappropriate compensatory behaviors per week.



Medication algorithm for bulimia nervosa*



BMI: Body mass index.

* Pharmacotherapy combined with nutritional rehabilitation and psychotherapy is indicated for bulimia nervosa. However, if nutritional rehabilitation and psychotherapy are not available, pharmacotherapy alone is reasonable. In addition, pharmacotherapy is indicated for comorbid anxiety disorders and depressive disorders. Medication choices depend upon the factors addressed in this algorithm, as well as other factors, including past treatment history. Response is often defined as reduction of symptoms $\geq 50\%$. The duration of an adequate medication trial is generally four to eight weeks. Refer to the UpToDate topic on pharmacotherapy for bulimia nervosa for full details of using medications.

Eating Disorder Complications

- Fluids and electrolytes-Dehydration; electrolyte abnormalities: hypokalemia, hyponatremia;
- Psychiatric-Depressed mood; OCD; anxiety; suicide
- Neurologic-cognitive deficits; seizures
- Cardiac-Decreased cardiac muscle mass, cardiac dysrhythmias, pericardial effusion; congestive heart failure; edema
- Hematologic-Leukopenia, anemia, thrombocytopenia,
- GI-Delayed gastric emptying, **gastroesophageal reflux, esophagitis**; Mallory-Weiss tears; esophageal or gastric rupture; laxative dependence
- Endocrine-Growth retardation; euthyroid; hypoglycemia/hyperglycemia, impaired glucose tolerance; night sweats; bone loss
- GU/GYN-polyuria, nocturia, infertility, amenorrhea
- Dental-Dental erosions



Indications for hospitalization

- <75 median BMI for age and sex
- Acute food refusal
- Uncontrollable binge eating and purging
- Acute medical complications
- Comorbid psychiatric or medical conditions
- Failure of outpatient treatment
- Severe bradycardia or hypotension
- Abnormal EKG (prolonged QTc severe brady)
- Electrolyte disturbance



Indications for Residential Treatment vs Partial hospitalization (PHP) and Intensive Outpatient (IOP)

- Poor motivation for recovery
- Need for structure and supervision to prevent unhealthy behaviors (eg, food restriction, compulsive exercise)
- Lack of a supportive family environment
- Absence of outpatient treatment in the patient's locale
- Outpatient interventions having been unsuccessful

Eating Disorder Resources

- National Eating Disorder Association (NEDA)
- ANAD
- Academy for Eating Disorders (AED)
- Renfrew



- RECORDING TO BE STOPPED FOR CASE PRESENTATION



Cases/HIPAA

- Names
- Address
- DOB
- Phone/Fax #
- Email address
- Social Security #
- Medical Record #



The discussion and materials included in this conference are confidential and privileged pursuant to 26VSA Section 1441-1443. This material is intended for use in improving patient care. It is privileged and strictly confidential and is to be used only for the evaluation and improvement of patient care.



Case



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Questions and Concerns/Discussion



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Conclusion

- Volunteers to present cases (this is key to the Project ECHO model)
 - Please submit cases to Michael.Hoffnung@uvmhealth.org
- Please complete evaluation survey after each session
- Claim your CME at www.highmarksce.com/uvmmed
- Please contact us with any questions, concerns, or suggestions
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