2018

Eating Disorders Toolkit
for Primary Care Practitioners

Interior Health  
fraserhealth  
ST. PAUL’S HOSPITAL PROVIDENCE HEALTH CARE

island health  
BC CHILDREN’S HOSPITAL  
northern health  
Vancouver Coastal Health

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Purpose of this Document

The aim of this document is to provide a quick reference to primary care practitioners (PCPs) that promotes recognition and prevention of medical morbidity and mortality associated with eating disorders.

This document also aims to clarify the role of the PCP, what to expect with individuals with eating disorders, and how to engage them in necessary treatments.

Many individuals with eating disorders will do well with outpatient support while others may require hospitalization or intensive specialized treatment services.

We believe patients deserve to receive the right treatment, in the right place, at the right time.
Important Things To Know About Eating Disorders

Your Role As A Primary Care Practitioner

Expertise in eating disorders is not a prerequisite to effective screening and early prevention. Despite frequent contact, more than half of eating disorders cases go undetected in primary care settings. By understanding the presentation of these patients, you will be better equipped to screen patients who are at risk or showing common signs or symptoms.

Patients With Eating Disorders In Primary Care

Acute malnutrition is a medical emergency. Malnutrition can occur at any body weight, not just at low weight. Patients with eating disorders are often in denial of the seriousness of their illness or they may not be prepared to begin treatment. Minimizing, rationalizing, or hiding symptoms and behaviours are common and can disguise the severity of the illness. Males can have eating disorders too.

Statistics

Anorexia Nervosa has the highest mortality rate of any other psychiatric illness, up to 20% will die. Almost ½ of deaths in patients with Anorexia Nervosa are related to cardiac failure and medical complications. Up to ⅓ of deaths related to eating disorders are due to suicide. ALWAYS assess for psychiatric risk, including self-harm or suicidal ideation, thoughts, plans, intent, lethality and accessibility of plan.

The Patient’s Experience

Patients with eating disorders experience their behaviours as fulfilling a valued need (e.g. avoid difficult emotions or painful experiences, feel better about oneself, sense of control, feeling special or different). Ambivalence or lack of interest in change is an expected part of the illness. Patients may be reluctant to describe their symptoms or readiness if they fear honest responses will result in judgment, blame or unwanted treatment.
Motivational Interviewing

Website:  https://motivationalinterviewing.org/

Motivational Interviewing is an effective means to building therapeutic alliance and engaging patients who are ambivalent about change. This involves mindful observing, listening and eliciting the patient’s own motivation to change. Therapeutic alliance is foundational to treatment effectiveness.

- Approach with a spirit of acceptance, compassion, and collaboration.
- Express empathy.
- Engage patients with open questions, show interest, make efforts to see the world through their eyes, affirm their strengths and efforts and acknowledge the inherent worth of the patient as an individual.
- Minimize patient-clinician discord: Use reflective listening to disarm resistance and differences; avoid arguing, refuting, or contradicting the patient’s point of view; respond non-defensively and non-judgmentally.
- Listen for underlying emotions, make guesses at what the patient means, validate the emotion so that the patient knows you “get it”:
  - Patient: “I’m not going to the hospital… it was horrible last time!”
  - PCP: “You’re afraid it won’t go well. It makes sense you don’t want to go again. That was horrible for you. And you need help”
- Reflect back discrepancies: Verbalize the discrepancy between the patient’s current state and what they are actually hoping for.
  - Patient: “I’m not going to eat and you can’t make me!”
  - PCP: “You’re so scared to eat and you have no energy. Neither is what you really want. It’s hard to do this on your own…and there is help.”
- Support change:
  - “How would you like things to change?”
  - “How might you go about making this change?”
  - “What have you done before to make things better?”

Therapeutic Boundaries & Non-Negotiables

- Balance therapeutic alliance with therapeutic boundaries.
- Non-negotiables are mandatory treatment components to ensure safety and manage risk. See page 8 for indications for hospitalization.
- Effective non-negotiables require a sound rationale and need to be consistently implemented. Aim to maximize autonomy and collaborate on decisions without surprise.
- For children and youth in outpatient settings, parents are in the best position to set and support treatment non-negotiables with you. Involve school where applicable and with patient consent.

- **Criteria for Involuntary Admission** (BC Practice Guidelines, pp. 127-129):
  
  Website:  https://cfe.keltyeatingdisorders.ca/res/clinical-practice-guidelines-bc-eating-disorders-continuum-services-

  - Eating disorders are mental disorders. There is medical consensus that psychiatric treatment under the Mental Health Act includes any and all treatment, including nasogastric tube feeding and medical stabilization. The Mental Health Act authorizes involuntary psychiatric treatment for people with eating disorders who meet the following criteria:
- Person is suffering from a mental disorder (eating disorder) that seriously impairs ability to react appropriately to circumstance;
- Person requires care, supervision & control in or through a designated facility to prevent the person’s substantial mental or physical deterioration or for the person’s own protection of others;
- Person is not suitable as a voluntary patient; and
- Person requires psychiatric treatment in or through a designated facility.

### Risk Factors & At-Risk Populations

- Early puberty
- Poor or abnormal growth curves in children and adolescents
- Activities and occupations that emphasize body, shape, and weight (e.g., ballet, gymnastics, modeling)
- Low or high BMI, or weight fluctuations
- Type 1 diabetes
- Amenorrhea (primary or secondary)

**WARNING: BCPs/HRTs DO NOT PREVENT BONE LOSS.**

- Family history of eating disorders
- Weight concerns among normal weight individuals

### Early Recognition – Common Signs & Symptoms

#### General
- Marked weight loss, gain, or fluctuations
- Failure to gain expected weight in a child or adolescent
- Cold intolerance
- Weakness, fatigue, lethargy
- Dizziness, syncope
- Hypoglycemia

#### Dermatologic
- Lanugo
- Hair loss
- Carotenemia
- Russell’s sign
- Poor healing

#### Cardiorespiratory
- Chest pain
- Bradycardia
- Hypotension
- Heart palpitations
- Arrhythmias
- Shortness of breath
- Edema

#### Endocrine
- Amenorrhea, irregular menses or unexplained infertility
- Loss of libido
- Low bone mineral density

#### Oral & Dental
- Oral trauma/lacerations
- Dental erosion
- Perimolysis
- Parotid enlargement

#### Gastrointestinal
- Epigastric discomfort
- Early satiety, delayed gastric emptying
- Gastroesophageal reflux
- Constipation

#### Neuropsychiatric
- Seizures
- Memory loss/poor concentration
- Insomnia
- Depression/anxiety/obsessive behaviours
Initial Assessment: History

“S.C.O.F.F.” Screening Tool for Eating Disorders (AGE 14 AND UP)


Over the past three months:
• Do you make yourself SICK because you feel uncomfortably full?
• Do you worry that you have lost CONTROL over how much you eat?
• Have you recently lost more than ONE stone (14 lbs or 6.4 kgs) in a three-month period?
• Do you believe yourself to be FAT when others say you are too thin?
• Would you say that FOOD dominates your life?

Two or more answers of “yes” provides 100% sensitivity for anorexia and bulimia.

Areas of Inquiry to Gain a Thorough Clinical Picture:

• Eating behaviours:
  • Dietary rules or rituals
  • Food avoidance
  • Contents of meals and snacks (food record)
• Compensatory behaviours:
  • Purging
  • Binge/purge cycles
  • Excessive exercise
  • Laxative use
  • Medication use

• Weight history:
  • Lowest and highest weights (at current height)
  • Ideal weight
• Menstrual history
  (Prolonged amenorrhea, consider bone loss)

• Screen for co-occurring psychiatric conditions:
  • Depression
  • Anxiety
  • Personality disorders
  • Self-harm
  • Substance use
  • Suicidal thoughts or ideation

• Family and social history:
  • Family medical and mental health history
  • Status of current relationships

Initial Assessment: Physical Exam

• Vital signs:
  • Supine and standing heart rate and blood pressure
  • Oral temperature
• Measurement of height, weight and BMI (kg/m2)
• For children & adolescents, plot a growth chart
• Sit up-Squat-Stand Test to assess muscle weakness

Ongoing Medical Monitoring is Necessary

• As long as eating disorder symptoms are active
• Frequency will depend on severity and potential risk for decline

DSM5 Severity Specifiers:
• BN: Mild: Average 1-3 episodes/week, Moderate: 4-7/week, Severe: 8-13/week, Extreme: 14 or more/week
### Initial Assessment: Labs And Interpretation Of Results

<table>
<thead>
<tr>
<th>Investigation</th>
<th>If HIGH, may indicate:</th>
<th>If LOW, may indicate:</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBC</td>
<td>Neutrophils may be high with excessive exercise</td>
<td>Leukopenia, anemia (check ferritin and B12), or thrombocytopenia</td>
</tr>
<tr>
<td>Glucose</td>
<td>Insulin omission (with Type 1 Diabetes)</td>
<td>Poor nutrition</td>
</tr>
<tr>
<td>Sodium</td>
<td>Dehydration</td>
<td>Water loading or laxative use</td>
</tr>
<tr>
<td>Potassium</td>
<td>Dehydration</td>
<td>Vomiting, laxative or diuretic use, refeeding</td>
</tr>
<tr>
<td>Chloride</td>
<td>Laxative use</td>
<td>Vomiting</td>
</tr>
<tr>
<td>Bicarbonate</td>
<td>Vomiting</td>
<td>Laxative use</td>
</tr>
<tr>
<td>Blood Urea Nitrogen</td>
<td>Dehydration (High urea and creatinine may indicate excessive use of protein powder with body building)</td>
<td>Low protein intake or muscle mass</td>
</tr>
<tr>
<td>Creatinine</td>
<td>Dehydration, renal dysfunction (Normal results may be considered “relatively elevated” given low muscle mass)</td>
<td></td>
</tr>
<tr>
<td>Calcium</td>
<td>Poor nutrition</td>
<td></td>
</tr>
<tr>
<td>Phosphate</td>
<td>Poor nutrition or refeeding syndrome</td>
<td></td>
</tr>
<tr>
<td>Magnesium</td>
<td>Poor nutrition, laxative use, or refeeding syndrome</td>
<td></td>
</tr>
<tr>
<td>Total Protein / Albumin</td>
<td>Seen in early malnutrition, at expense of muscle mass</td>
<td>Seen in later malnutrition</td>
</tr>
<tr>
<td>Liver Function Test</td>
<td>Liver dysfunction</td>
<td>Poor RBC mass</td>
</tr>
<tr>
<td>Ferritin</td>
<td>Inflammatory marker</td>
<td>Poor iron intake &amp; anemia</td>
</tr>
<tr>
<td>Vitamin B12</td>
<td>Vegan diet</td>
<td>At risk of poor bone health</td>
</tr>
<tr>
<td>25OH Vitamin D</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zinc</td>
<td>Poor nutrition</td>
<td></td>
</tr>
<tr>
<td>Amylase</td>
<td>Vomiting, pancreatitis</td>
<td></td>
</tr>
<tr>
<td>TSH and T4</td>
<td></td>
<td>Sick euthyroid syndrome (may be low to normal)</td>
</tr>
<tr>
<td>ECG</td>
<td><strong>Abnormal Findings:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Bradycardia and / or arrhythmias</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Prolonged QTc interval (&gt; 450 msec.)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• T wave inversion</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Non-specific ST-T wave changes including ST segment depression</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• U waves with hypokalemia or hypomagnesemia</td>
<td></td>
</tr>
<tr>
<td>DEXA Scan</td>
<td><strong>NB: Indicate Hypothalamic Pituitary Suppression on Requisition</strong></td>
<td></td>
</tr>
</tbody>
</table>
### Indications For Hospitalization: 3,7
Consider Consultation To Local Or Provincial EDP

Note: These include indications for involuntary admission under the BC Mental Health Act

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Child / Adolescent</th>
<th>Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temperature</td>
<td>&lt; 35.6°C or 96.0°F</td>
<td>&lt; 35.5°C or 96.0°F</td>
</tr>
<tr>
<td>Heart Rate</td>
<td>&lt; 45 bpm or symptomatic postural tachycardia</td>
<td>&lt; 40 bpm or symptomatic postural tachycardia</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>Systolic &lt; 90 mmHg, or orthostatic change of &gt;20 mmHg coupled with signs of hypovolemia.</td>
<td>&lt; 90/60 mmHg, or orthostatic change of &gt;20 mmHg coupled with signs of hypovolemia.</td>
</tr>
<tr>
<td>Sodium</td>
<td>&lt; 130 mmol/L</td>
<td>&lt; 127 mmol/L</td>
</tr>
<tr>
<td>Potassium</td>
<td>&lt; 3.2 mmol/L</td>
<td>&lt; 2.3 mmol/L</td>
</tr>
<tr>
<td>Magnesium</td>
<td>&lt; 0.7 mmol/L</td>
<td>&lt; 0.6 mmol/L</td>
</tr>
<tr>
<td>Phosphate</td>
<td>&lt; 0.8 mmol/L</td>
<td>Below normal on fasting</td>
</tr>
<tr>
<td>Serum Chloride</td>
<td>&lt; 88 mmol/L</td>
<td></td>
</tr>
<tr>
<td>Blood Glucose</td>
<td>&lt; 3.0 mmol/L</td>
<td>&lt; 2.5 mmol/L</td>
</tr>
<tr>
<td>Weight</td>
<td>&lt; 75% of ideal body weight, &lt; 10% body fat, or ongoing weight loss</td>
<td>Rapid and progressive weight loss</td>
</tr>
</tbody>
</table>

**General Signs And Symptoms:**
- Suicide Risk
- Dehydration that does not reverse within 48 hours
- Cardiac arrhythmias, including prolonged QTc interval (> 450 msec.)
- Intractable vomiting
- Esophageal tears
- Hematemesis
- Syncope
- Severe acrocyanosis
- Muscular weakness or diaphragmatic wasting not accounted for by a correctable deficiency
- Signs of inadequate cerebral perfusion (confusion, syncope, loss or altered level of consciousness, ophthalmoplegia, seizure, tetany, ataxia)
- Poorly controlled diabetes
- Pregnancy with an at-risk fetus
- Failure to respond to outpatient treatment
Goals of Treatment

- Restoration of nutritional status
- Restoration of weight (where applicable)
- Medical stabilization, prevention of serious medical complications
- Resumption of menses (where applicable)
- Cessation of binging, purging & eating disordered ideations
- Restoration of meal patterns that promote health and social connections
- Re-establishment of social engagement
- **For children and youth:** Review pre-pubertal growth & development, prevent stunting, as well as bone loss
- Recovery

Gastrointestinal Discomfort with Refeeding

- Semi-starvation leads to reduced GI motility.
- Expect bloating, stomach pain and constipation during refeeding.
- Reassure the patient that the gut will start working and symptoms will improve over time.
- Medications are usually not necessary. However, treatment of constipation may improve and aid the refeeding process but must be watched carefully to avoid laxative abuse.

Re-feeding Syndrome

- Refeeding syndrome describes a potentially fatal shift of fluid and electrolytes that can occur when refeeding a malnourished patient. If concerned, consult local EDP, SPH or BCCH.
- The following individuals are more at risk:
  - Young age
  - Chronic undernourishment
  - Those who have had little or no energy intake for more than 10 days e.g. prolonged fasting or low energy diet
  - Rapid or profound weight loss, including individuals who present at a normal weight after weight loss
  - Obesity and significant weight loss, including after bariatric surgery
  - Malnourishment, especially if in combination with significant alcohol intake
  - A history of misuse of medications to purge or lose weight
  - Abnormal electrolytes, especially hypophosphatemia

**NB:** Phosphate supplementation (e.g. 500 mg phosphate bid) and regular monitoring of electrolytes are recommended. Consult your local pediatrician/internist for further details.
Provincial Consultation For Eating Disorders

Provincial Adult Tertiary Services for Eating Disorders Program (PATSEDP) St. Paul’s Hospital

- Business Hours (M-F, 9-5), Phone: 604-806-8654 Intake Coordinator, will triage consult requests.
- After hours, phone EDP 4NW Inpatient at 604-682-2344, ext. 62971 contact info for the internist on-call will be provided.

Rapid Access to Consultative Expertise (RACE)

- Business Hours (M-F, 8-5), Phone: 1-877-696-2131 (Toll-free) or 604-696-2131 (Lower Mainland)

Eating Disorder Psychiatry: Option 3, Menu 6
Website: http://www.raceconnect.ca/

BC’s Children’s Hospital Eating Disorders Program

- Phone: 1-604-875-2161 during business hours for the Intake Coordinator or 1-604-875-2345 after hours ask for Adolescent Medicine on-call.

Specialized Intensive Treatment Centres, BC

Provincial Specialized Eating Disorder Program
BC’s Children’s Hospital, Vancouver, BC
Outpatient, day treatment, and inpatient services for children and adolescents up to age 17.
Phone: 1-604-875-2106 (Intake Coordinator)
Website: http://www.bccchildrens.ca/our-services/mental-health-services/eating-disorders#Treatment

Provincial Adult Tertiary Specialized Eating Disorder Program St. Paul's Hospital, Vancouver, BC
Specialized, tertiary care for adults 17 years of age and older:
- 4NW – Specialized inpatient acute care for eating disorders
- Discovery Vista – Residential treatment for eating disorders
Phone: 1-604-806-8347 (Ask for Intake Coordinator)
Website: http://mh.providencehealthcare.org/programs/provincial-adult-tertiary-eating-disorders-program

Looking Glass Residence, Vancouver, BC
A 14-bed youth residential treatment facility for ages 16-24.
Phone: 1-604-829-2585
Website: http://www.lookingglassbc.com/residential-care

Local Referrals

See website for details of services in your locale:
Website: https://keltyeatingdisorders.ca/finding-help/locate-programs-treatment-centres/
Resources and Useful Websites

**Kelty Mental Health Resource Center at BC’s Children’s Hospital (Vancouver, BC)**
Free information, referrals, online resources and drop-in access for individuals and their families with eating disorders (*all ages*). Peer support is also available for individuals of any age struggling with an eating disorder or disordered eating.

**Phone:** 1-800-665-1822  
**Website:** [http://www.keltyeatingdisorders.ca](http://www.keltyeatingdisorders.ca)

**Looking Glass Foundation for Eating Disorders (Vancouver, BC)**
Provincial online support groups for parents/caregivers, adults, and adolescents. Community initiatives including research, annual scholarships, speakers and annual fundraiser.

**Phone:** 1-604-314-0548  
**Website:** [http://www.lookingglassbc.com](http://www.lookingglassbc.com)

**Jessie’s Legacy (North Vancouver, BC)**
Offers education, resources & inspiration in the prevention of eating disorders and addresses disordered eating.

**Website:** [http://jessieslegacy.com/](http://jessieslegacy.com/)

**National Eating Disorders Information Centre (Toronto, Ontario)**

**Website:** [http://nedic.ca/](http://nedic.ca/)

**Clinical Practice Guidelines for the BC Eating Disorders Continuum of Services**

**Website:** [https://cfe.keltyeatingdisorders.ca/res/clinical-practice-guidelines-bc-eating-disorders-continuum-services-1](https://cfe.keltyeatingdisorders.ca/res/clinical-practice-guidelines-bc-eating-disorders-continuum-services-1)

**Excellence in Motivational Interviewing**

**Website:** [https://motivationalinterviewing.org/](https://motivationalinterviewing.org/)

**SCOFF**


**Rapid Access to Consultative Expertise (RACE):**

**Hours:** Monday-Friday 0800 - 1700  
**Phone:** 1-877-696-2131 (toll free) or 604-696-2131 (Lower Mainland)  
**Website:** [http://www.raceconnect.ca/](http://www.raceconnect.ca/)
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References


