Eating Disorder Treatment
in the Outpatient Setting

Behavioral Health ECHO
Rachele McCarthey, MD
University of Utah Department of Psychiatry
Medical Director UNI Behavioral Health Outpatient Clinics
Objectives

Gain a better understanding of outpatient treatment for anorexia nervosa and bulimia nervosa
Treatment for Anorexia

- **Multi-modal Treatment Approach**
  - Nutritional rehabilitation and treatment of medical complications
  - Nutritional counseling to restore healthy eating behavior
  - Individual therapy
  - Group therapy
  - Family counseling or therapy
  - Treatment of co-morbid disorders
  - Ideally all providers are in frequent contact
Anorexia Management

- **Medical Management**
  - Monitor for refeeding syndrome
    - Occurs when phosphate, mg, and k homeostasis is disrupted and serum levels decrease.
    - Change from fat metabolism to carbohydrate metabolism
    - Increased basal metabolic rate
    - Disorder and confusion in electrochemical membrane potential, arrest of enzyme systems
    - Can result in heart failure, seizures, rhabdomyolysis, respiratory failure, encephalopathy, etc
  - Monitor ECG
    - Watching for bradycardia, prolonged Q-T, changes in contractility
Refeeding Syndrome

Risk factors

- BMI <16
- Weight loss >15% in past 3-6 months
- Little to no intake for >10 days
- Reduced K, Mg, Phos prior to refeeding
- Recent problematic use of alcohol, drugs, insulin, antacids, diuretics
- Chemotherapy
Treatment for Anorexia

- **Nutritional Rehabilitation**
  - Restoration of normal body weight
    - Start calories slowly with goal of 2200-2500kcal/d
    - Goal weight gain 1000-2000g/wk
    - Some role for NG tube feeding if oral intake insufficient
    - Daily blinded weights in am, post-void in gown
  - Laboratory monitoring 3x daily to weekly
    - Basic Metabolic Panel, magnesium, phosphate, ionized calcium, urinalysis
Pharmacotherapy for Anorexia

- No FDA approved agents for anorexia
- Atypical Antipsychotics
  - Obsessions, anxiety, near delusional thinking
  - Short-term use
  - Should disclose risk of metabolic syndrome, wt gain and monitor for extrapyramidal symptoms
  - Non-compliance common
  - Olanzapine most studied with a few positive studies
  - No difference when risperidone added
Pharmacotherapy in Anorexia

- Anxiolytics
  - Helpful before meals
  - Short-term use
  - Higher potential for side effects

- Antidepressants
  - SSRIs may help prevent relapse
    - Used after weight restoration
    - Use for anxiety/OCD symptoms
  - Mirtazapine used occasionally
    - Higher risk of neutropenia
  - Avoid bupropion, TCAs due to seizure risk and prolonged Q-T interval

- N-acetylcysteine
  - Helps with compulsive behaviors
  - OTC 1000-1200mg daily for 3 months
Pharmacotherapy in Anorexia

- **Adjunct Medications**
  - **Anti-Nausea Medications**
    - Ondansetron
  - **Pro-motility agents decrease bloating and early satiety**
    - Metoclopramide
    - Erythromycin
  - **Decrease constipation**
    - Colace
    - Miralax
    - Avoid abusable laxatives
  - **Treatment/Prevention of osteopenia/osteoporosis**
    - Calcium and Vit D replacement
    - Oral contraceptives not shown to improve osteopenia
  - **Multi-vitamin**
    - No need for zinc replacement or every single B vitamin unless at risk for B12 deficiency
Anorexia Treatment

- Family Based Treatment
  - For children and adolescents living at home with parents
  - No fault approach
  - Manualized Therapy
    - Three stages, about 20 sessions, outpatient
    - Therapist supports parents in how best to refeed their child at home
  - Has best rates of long-term recovery in teens
    - Evidence Based for children and adolescents
    - 85% recovery vs. 35% recovery in 5 year study
Other Therapeutic Treatments for Anorexia

- **Therapies**
  - Cognitive Behavioral Therapy (CBT-E)
    - Has good data for adults
  - Group Therapy
  - Dialectical Behavioral Therapy (DBT)
  - Education About Eating Disorders
  - Supportive Therapy
    - Mentors: recovered ED patients
      - [www.mentorconnect-ed.org](http://www.mentorconnect-ed.org)
Anorexia Outcomes

- Chronic course in 20% of cases
  - All ages of onset

- Age at onset and early treatment matter
  - Onset in adolescence protective
  - Onset in prepubertal years and in adulthood = chronic

- Co-morbid psychiatric illness in 50% of cases
  - Depression most common psychiatric diagnosis
  - Anxiety disorders also common
  - Cluster C personality disorders

- 10-20% mortality rate over time
  - High rate of suicide
    - **Most common cause of death in long term follow up**
  - Other causes of premature death including malnutrition and cardiac causes
Bulimia Signs and Symptoms

- Dental enamel erosion
- Salivary gland enlargement
- Knuckle abrasions: Russell’s sign
- Esophagitis
- Pancreatitis
- Poor GI motility
- Hypokalemia
- Hyponatremia
- Metabolic alkalosis
  - Severe purging
Bulimia Comorbidity

- Depression
- Suicidal Ideation and Attempts
  - 25-35% of patients with bulimia reported a history of attempt
- Substance Abuse
- ADHD
  - Combined type most common
- Anxiety Disorders
  - OCD
  - Social Phobia
- Borderline Personality Disorder
Pharmacotherapy in Bulimia

- **SSRIs**
  - Reduce core symptoms and improve mood and anxiety
  - Fluoxetine FDA approved for bulimia
  - Need higher doses than for depression
  - Relapse is common
  - Need long-term treatment: minimum one year

- **Topiramate**
  - Reduces binging and purging
  - Seems to help with impulse control
  - Weight loss is common
  - Use cautiously in someone who is underweight or restricts more frequently than b/p
  - Cognitive difficulties and sedation can reduce compliance
Pharmacotherapy in Bulimia

- **Ondansetron**
  - Reduces binge-purge frequency
  - Decreases patient’s ability to vomit
  - Using more routinely but more studies needed

- **Naltrexone**
  - Reduces binge-purge frequency

- **Mood stabilizers/SGAs**
  - Used for treating co-morbid symptoms that may be interfering with eating disorder recovery
Therapeutic Models for Bulimia

- CBT
  - Treatment of choice
  - Several studies showing efficacy
- Family-based treatment
  - Some evidence
  - Requires even more family monitoring to ensure not only eating but no purging
- Motivational Interviewing
  - Good place to start to get a sense of motivation to stop b/p behaviors
  - Some research shows promise
- DBT
  - Effective method. Patients often have co-morbid self-harm behaviors or use b/p behaviors to cope with strong emotions
- Group Therapy
- Behavior Therapy
Resources

Books

- Life Without Ed Schaefer and Rutledge
- Goodbye Ed, Hello Me Jenni Schaefer
- Intuitive Eating Tribole and Resch
Resources

- **Websites**
  - [www.aedweb.org](http://www.aedweb.org)
    - Resource guide at [www.aedweb.org/Resources_for_professionals/2920.htm](http://www.aedweb.org/Resources_for_professionals/2920.htm)
  - [American Psychiatric Association Practice Guidelines](http://psychiatryonline.org/content.aspx?bookid=28&sectionid=1671334)
  - [www.maudsleyparents.org](http://www.maudsleyparents.org)
  - [www.nationaleatingdisorders.org](http://www.nationaleatingdisorders.org)
  - [www.feast-ed.org](http://www.feast-ed.org)
  - [www.something-fishy.org](http://www.something-fishy.org)
Questions...