Letter to General Practitioners Regarding

Paediatric Eating Disorders During the COVID-19 Pandemic

Dear colleague,

As you may be aware, there has been a considerable rise in the incidence of eating disorders within the community during the COVID-19 pandemic.

Possible reasons behind this observed clinical trend include unintended negative impacts on mental health from social distancing measures necessary in the containment of COVID-19. These have disrupted key aspects of the lives of children such as onsite school engagement, extracurricular activities including sport, and opportunities for in person social interaction with friends and extended family. There has been an increase in the use of social media, and families have been under considerable strain in trying to manage home schooling with altered work circumstances, whilst being acutely worried about the wellbeing of loved ones, and their own financial security and the future overall.

Observed rates of eating disorders have been particularly high in Victoria, in the setting of extended lockdown measures implemented to contain COVID-19 outbreaks. We are grateful more than ever for your support and collaboration in providing safe clinical care for these patients during this pandemic, and we hope that you and your colleagues find the following medical guidance on the assessment and management of young patients with eating disorders helpful.

Eating Disorders

Eating disorders including Anorexia Nervosa, Atypical Anorexia Nervosa, Avoidant Restrictive Food Intake Disorder and Bulimia Nervosa are serious mental illnesses with significant medical and psychiatric sequelae and carry the highest mortality rate of any psychiatric disorder. They can impair the workings of all organ systems of the body, as well as school and family functioning. Individuals with an eating disorder may not recognize the seriousness of their illness and/or may be ambivalent regarding treatment and recovery. Early identification and timely intervention are crucial, as shorter duration of illness is associated with increased rates of recovery and greatly improved patient outcomes.

Initial evaluation is aimed at establishing the patient's diagnoses, excluding alternative causes for the clinical features present, performing a nutritional and psychosocial assessment, appraising for medical complications, with determination of the severity of malnutrition, and overall medical and psychiatric risks for the young person.

It is essential that in children and adolescents, failure to gain expected weight or height, and/or delayed or interrupted pubertal development, be investigated for the possibility of an underlying eating disorder.

Assessment

History

- History of weight loss or change and how it was achieved. Reviewing past photos can additionally assist in appraising premorbid growth and development
- Growth and feelings regarding weight & shape as a child and teenager
- Body image – including importance of weight and shape on self-evaluation, body checking, fear of being fat / weight gain. Patient's desired weight
- Nutritional history including typical food and fluid intake over a 24-hour period detailing quantity and variety of foods and fluids consumed, restriction of specific foods or food groups, calorie counting, usual shopping and cooking arrangements, family meals
- Abnormal eating behaviours including mealtime rituals, difficulties with eating in social settings
- Compensatory behaviours and their frequency - fasting or dieting, self- induced vomiting, exercise, laxative, diuretic and insulin misuse, use of diet pills and/or other over-the counter supplements. Last dental check
- Exercise type, frequency, duration and intent (for enjoyment / compulsion / manage weight)
- Physical symptoms (e.g., palpitations, dizziness, syncope, dyspnoea, nausea, abdominal discomfort, early satiety, bloating, reflux, constipation, cold intolerance, insomnia, weakness and lethargy)
- Menstrual history, including presence of amenorrhoea, oligomenorrhoea, use of hormonal contraceptives
- School and academic functioning
- Developmental history, including temperament, attachment, relationships and early feeding difficulties
- Mental health history including symptoms of mood, anxiety and substance use disorders, difficulties with concentration and memory
    - History of trauma (physical, sexual or emotional)
    - Individual assessment including mental state examination, risk assessment including risk of self-harm and suicide
    - Family history including symptoms or diagnoses of eating disorders, obesity, mood & anxiety disorders, and substance use disorders
    - Family assessment including parenting style and consistencies, strengths and resources, impact of the illness, current level of concern, understanding of eating disorders and treatment and available social supports

Examination

- Measure and plot weight (post void and in light clothing), height, BMI, mid parental height
- Supine and standing blood pressure and pulse rate
- Temperature
- Hydration
- Lanugo, alopecia, oedema, hypercarotenemia, skin and nail health
- Stigmata of purging - dorsal finger abrasions, parotidomegaly, oral and dental health
- Tanner staging
- Muscle size and strength

Investigations

- ECG – including rate, rhythm, QTc
- Bloods
    - Full blood examination, electrolytes, calcium, magnesium, phosphate, glucose, liver function tests, thyroid function (TSH, FT3, FT4), iron studies, active vitamin B12, folate, vitamin D, zinc, ESR, coeliac screen, FSH / LH / oestradiol or testosterone

    - Electrolytes, calcium, magnesium, phosphate and glucose need to be monitored in an ongoing way to help identify the refeeding syndrome
    - It is vital to note however that investigations may be normal and falsely reassuring even in very ill patients
- Radiology
    - Bone age x-ray and bone densitometry

Patients at particular risk of significant medical and psychiatric complications from their illness require regular (up to twice weekly) medical reviews.

Management

Management is based on evidence-based, developmentally appropriate and multidisciplinary team-based approach in the outpatient setting whenever possible, with mental health, medical and dietetic input recommended to optimise patient care and outcomes.

Medicare item numbers for GPs are available for Eating Disorder Treatment and Management Plans to assist in funding an adequate treatment course.

Family Based Treatment (FBT) is the internationally recognized first line treatment for eating disorders in children and adolescents with a duration of illness of less than three years. FBT is divided into three phases of treatment. In Phase 1 the focus is on renourishing the body and weight restoration. In Phase 2 the control of eating is progressively handed back to the young person, and the adolescent is supported in developing independence in self-care. In Phase 3 adolescent issues which impede appropriate adolescent development are addressed, with the goal of assisting the family and young person to return to normal life without an eating disorder. There are a number of other evidence-based treatments for patients with eating disorders.

Research indicate that early weight restoration positively predicts longer term physical and psychological recovery. In order to achieve this, diligent meal support and supervision by caregivers is required. Parents often need to take time off work to facilitate this, and children may require some time off school to reestablish healthier mealtime behaviours.

Inpatient medical care is sometimes necessary to ensure patient safety.

Criteria for admission to the paediatric medical ward include the following:

- Cardiac and hemodynamic instability
    - Bradycardia
        - <50bpm in 12-18yo children
        - <60bpm in <12yo children
    - Systolic hypotension
        - <90mmHg in 12-18yo children
        - <80mmHg in <12yo children
    - Orthostatic systolic hypotension >20mmHg
    - Recurrent syncope
    - Cardiac arrhythmia
    - ECG abnormality, e.g., prolonged QTc > 450msec
    - Hypothermia <35.5^{0}C
    - Postural tachycardia >30bpm

- Metabolic derangement
    - Hypokalaemia
    - Hyponatraemia
    - Hypophosphataemia

    - Hypoglycaemia
    - Dehydration

- Weight and growth
    - Rapid weight loss of >500g-1kg per week over consecutive weeks
    - Weight ≤ 75% median BMI for age and sex
    - Arrested growth and development

- Acute food and fluid refusal for >48 - 72hrs

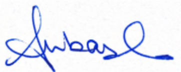
Criteria for admission to the child and adolescent psychiatric unit include the following:

- Suicidality, severe self-harm
- Uncontrolled eating disorder behaviours

We value your feedback, and please be in contact with any queries or if any further information or guidance would be useful.

Thank you for taking the time to read this letter. We greatly appreciate your partnership and collaboration in the care of our eating disorders patients during these extraordinary times.

Warm regards,



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