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Eating Disorder Assessment & Management in Young People Presenting at Primary Care

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With **all of us** in mind.

NATIONAL
COLLABORATING
CENTRE FOR
MENTAL HEALTH

NHS
England

Access and Waiting Time Standard for Children and Young People with an Eating Disorder

Commissioning Guide

Version 1.0

July 2015

What are eating disorders?

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CAMHS provides input for children and young people with

- Anorexia nervosa
- Bulimia nervosa
- Atypical forms of the above disorders
- Binge eating disorder

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Diagnostic features of an eating disorder

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- Refusal to maintain body weight or failure to gain weight during a period of growth
- Intense fear of gaining weight
- Disturbed body perception
- Undue influence of body weight or shape on self-esteem
- Denial of seriousness of current low body weight
- Recurrent episodes of binge eating

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- Rapid exclusion of other conditions e.g. DM, IBD, Tumours
- Physical examination weight, height, cardiovascular and bloods
- Do not delay referral in order to arrange blood tests and an ECG

Height measurement

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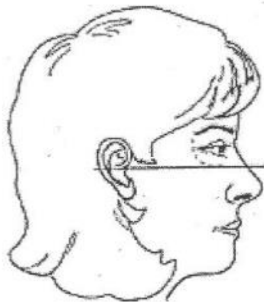
The child is instructed to

- stand erect (stand up straight and look straight ahead). The child’s position should be verified from both the FRONT and from the LEFT side of the body.
- Next, the child’s head is positioned in the Frankfort Horizontal Plane. In this position, an imaginary line can be drawn from the bottom of the eye socket (orbital margin) to the external opening of the ear (external auditory canal).



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Weight

- Weighing in the same way and at the same time of day will help to minimise fluctuations in weight from non-nutritional reasons
- This means weighing on the same scales, in the morning before breakfast and after emptying the bladder, in light clothing and without shoes
- Advise patients to wear top tank, and light trousers, and preferably the same clothing at each visit. Ask them to remove any heavy object e.g. mobile, belt

Calculating percentage weight for height

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- Plot height on a standard growth chart and note the centile
- Read off **expected weight** from the same centile on the weight portion of the chart

- $\% \text{ weight for height} = \frac{\text{Measured weight}}{\text{Expected weight}} \times 100$

- calculate BMI (weight(kg)/height^2(m)) and plot onto BMI centile chart

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Weight 4 Height

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Date of birth: 11/12/2003   sex: female

Date of visit	Weight (kg)	Height (cm)	BMI	Weight centile	Height centile	BMI centile	Weight for height
11/02/2018	43.50	156.00	17.87	16.13	25.98	23.81	91.69
11/06/2018	42.00	156.00	17.26	7.88	21.12	13.32	87.68
11/09/2018	41.50	156.00	17.05	5.09	18.20	9.86	86.03
11/10/2018	39.00	156.00	16.03	1.65	17.42	2.75	80.67
11/11/2018	38.00	156.00	15.61	0.88	16.72	1.35	78.42
12/12/2018	36.50	156.00	15.00	0.32	16.04	0.38	75.15

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Key clinical assessment parameters

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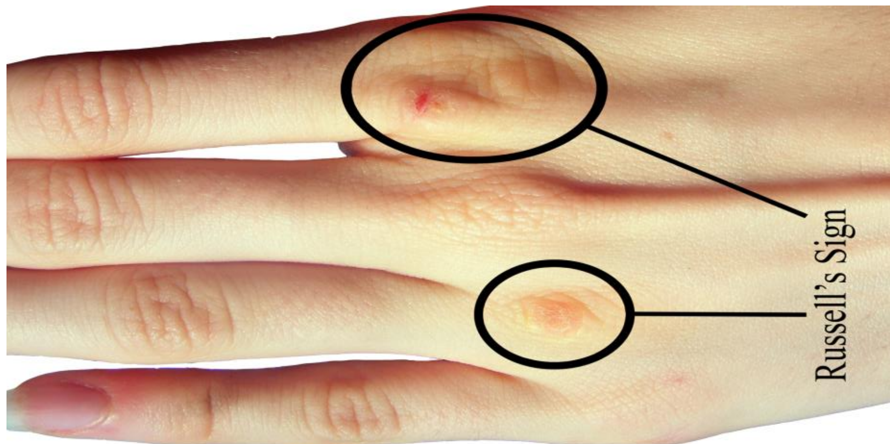
- Heart rate to look for Bradycardia, postural tachycardia
- Blood pressure to look for Hypotension or postural drop of more than 15 mmHg
- Assess for dehydration
- Other features of severe malnutrition look for Lanugo hair, dry skin, skin breakdown and/or pressure sores
- Evidence of purging look for enamel erosion, swollen parotid glands, calluses on fingers



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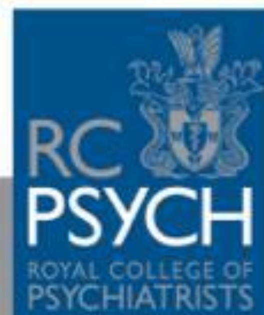

Junior MARSIPAN: Management of Really Sick Patients under 18 with Anorexia Nervosa

January 2012

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Is ECG monitoring needed?

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Assess based on the following risk factors (NICE 2017)

Rapid weight loss

Bradycardia

Hypotension

Prescribed or non-prescribed medications

Electrolyte imbalance, severe purging behaviours, such as laxative or diuretic use or vomiting

Previous abnormal heart rhythm

Excessive caffeine (including from energy drinks)

Muscular weakness

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Urgent or routine?

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- Rapid weight loss over a short period of time i.e. 15 % of body weight lost within 3 months
- Percentage median BMI
- Severe restriction of dietary and fluid intake
- Degree of physical risk
- Excessive exercise/loss of periods/laxative abuse/induced vomiting
- Intense suicidality
- Family's ability to manage the disordered eating

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Single Point of Access (SPA)

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SPA will request for all young people to have:

- Height
- Weight
- Blood Pressure
- Pulse

- All children should have a routine blood screen including full blood count, electrolytes, liver function, renal function, including calcium, **phosphate** and magnesium, iron status, coeliac antibody screen, inflammatory markers, and thyroid function (Junior Marisiapn)

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Access and Waiting Time Standard

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- Routine referrals : This group receive a mental health assessment where possible within 15 days with a view of starting a NICE concordant treatment within 4 weeks

- Urgent referrals : This group receives a mental health assessment within 1 week

- Emergency referrals: Comprehensive assessment will take place within 1 working day

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Role of Primary Care where referral has been from another source

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- GP will be asked to endeavour to undertake the physical health check within 2 days of a urgent referral being received (by CAMHS) and within 5 days for a routine (AWTS, 2015)

- After diagnosis the GP will receive a comprehensive care plan following the assessment detailing CAMHS treatment plus the GP's role in the child's on-going care

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Role of primary care prior to CAMHS assessment

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- Monitor weekly to review BP, pulse and weight and repeat any abnormal bloods until seen by CAMHS
- Liaison with locality paediatrician where uncertain re any physical health concerns or test results

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Role of primary care post diagnosis

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- Monitor physical health for low risk patients , and for follow up (AN and BN should have follow up for 12 months following end of treatment)
- Manage medical problems unrelated to the Eating Disorder diagnosis
- Bring any deterioration in mental or physical health to the attention of the CAMHS

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CAMHS assessment & Interventions

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- Psychiatry for diagnosis and pharmacological treatment (if indicated)
- Dietician to advise a graded meal plan, to reduce risk of refeeding syndrome
- Nursing for care coordination and physical monitoring supported eating
- Family therapy (anorexia-nervosa-focused family therapy)
- Individual therapy – Psychotherapy/CBT

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Referral to inpatient psychiatric unit

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- **Referral criteria for consideration to Tier 4/acute medical ward admission:**
- Medical indications of significant physical compromise eg low potassium, abnormal ECG, recurrent syncope
- Refusal of virtually all food and drink
- Suspected re-feeding syndrome
- Failure of prolonged outpatient treatment
- Risk of suicide
- Before Tier 4 referral consideration should be given to involvement of home based treatment via crisis team if not already involved

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When to refer to Paediatrician

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- Refer to paediatrics any child who has one or more criterion of a high risk with simultaneous referral to CAMHS
- HR<50, QTc>460 in girls, and QTc=400 in boys
- History of recurrent syncope
- T<35.5 (Tympanic temperature)
- Sever biochemical abnormalities including Hypokalaemia, Hypophosphataemia, Hypo-albuminaemia, Hypoglycaemia, Hypo-natraemia, Hypocalcaemia

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Re-feeding Syndrome

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- Re-feeding syndrome is a serious potential complication of commencing feeding
- There is an increased requirement for phosphate as the body switches back to carbohydrate metabolism
- Phosphate levels in the blood begin to fall, and cardiovascular and neurological squela may follow
- Re-feeding syndrome is most likely to occur in the first few days of re-feeding but may occur up to 2 weeks after

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Refeeding syndrome

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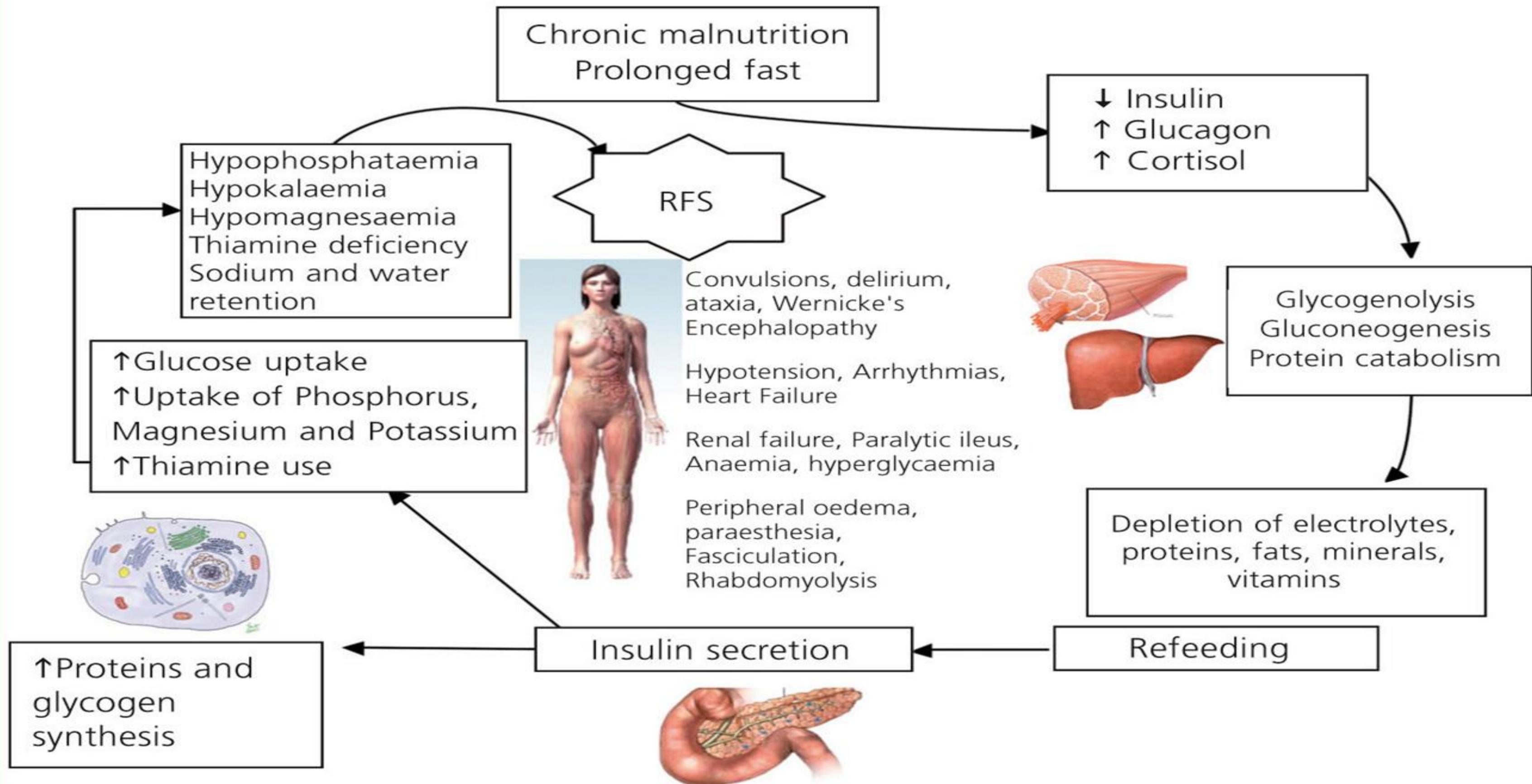

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Support Services

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- South Yorkshire Eating Disorder(SYEDA), one to one therapeutic and practical support for people experiencing eating disorders and for families and friends. We also facilitate support groups, offer a befriending service
- www.b-eat.co.uk
- http://anorexiafamily.com/
- http://www.maudsleyparents.org/

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Reference:

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- *Junior MARSIPAN – management of really sick patients with anorexia nervosa, http://www.rcpsych.ac.uk/publications/collegereports/cr/cr168.aspx*
- https://www.nice.org.uk/guidance/ng69/resources/eating-disorders-recognition-and-treatment-pdf-1837582159813
- Access *and Waiting Time Standard for Children with an Eating Disorder, NHS England 2015*
- Community Eating Disorder Pathway for Barnsley, Wakefield, Calderdale and Kirklees, SWYT, 2017

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Following the appropriate risk pathway (AWT Standard 2015)

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- If the pathway has been classified as urgent, the GP should be notified for urgent consultation within 1 day and the child or young person should be seen by the CEDS-CYP within 5 days from the clock starting

- If the pathway has been classified as routine and the child or young person has not seen their GP within the past 2 weeks, they should be directed to their GP for a consultation within the next 2 days. The CEDS-CYP should liaise with the GP by day 5 following the clock starting. (please see figure 2 of AWT Standard 2015)

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