Treatment of Eating Disorders (1)

The priority for eating disorder treatment is the management of physical complications relating to undernutrition and compensatory behaviours.

Medical Emergencies in Eating Disorders (MEED): Guidance on Recognition and Management. Royal College of Psychiatrists. May 2022 provides a comprehensive guide to risk assessment in eating disorders.

PHYSICAL PARAMETERS

	Red: High impending risk to life	Amber: Alert to high concern for impending risk to life	Green: Low impending risk to life
Weight loss / week	1kg or more	0.5 – 0.99kg	<0.5kg
%mBMI <18 years	<70%	70 – 80%	>80%
BMI >18 years	<13	13 – 14.9	15 or more
Standing systolic blood pressure <18 years	<0.4th centile for age recurrent syncope	<0.4th centile for age occasional syncope	Normal standing systolic BP for age
Standing systolic blood pressure >18 years	<90 mm Hg recurrent syncope	<90 mm Hg occasional syncope	>90 mm Hg
ECG <18 years	QTc >460ms (female) >450ms (male) + additional ECG abnormality	QTc >460ms (female) >450ms (male) - additional ECG abnormality	QTc <460ms (female) <450ms (male)
ECG >18 years	QTc >450ms (females) >430ms (males) + additional ECG abnormality	QTc >450ms (females) >430ms (males) - additional ECG abnormality	QTc <450ms (females) <430ms (males)
Heart rate; beats / minute	<40	40 - 50	>50
Temperature	<35.5°C	<36 °C	>36 °C
Hydration	Fluid refusal Severe dehydration (10%)	Severe fluid restriction Moderate dehydration (5 – 10%)	Minimal fluid restriction Mild dehydration (<5%)
Abnormal blood results	Life-threatening abnormalities	Non life-threatening abnormalities	None or mild

PSYCHOLOGICAL PARAMETERS

Suicidality	Suicidal ideas with moderate to high risk of completed suicide	Suicidal ideas with low risk of completed suicide	

How does this relate to T1DE?

Additional physical and psychological risks associated with T1DE can be found in Annex 3 of the MEED Guidance; Type 1 Diabetes and Eating Disorders (T1DE).

◀	Appropriate BMI can mask clinical risk associated with the omission of insulin.	◀	Emergence of other eating disorder behaviours as T1DE related compensatory behaviours are addressed.
◀	Hyperglycaemia and raised ketones will occur with reduction or omission of insulin.	◀	Consider other diabetes related aspects of mental health including diabetes-related distress.
◀	**Very high risk** = one or more episodes of DKA associated with deliberate insulin omission.	◀	Increased risk of depression and anxiety in those with Type 1 Diabetes compared to the general population.
◀	Insulin administration is the driver for refeeding syndrome in T1DE, due to starvation at the cellular level.	◀	Suicide occurs more frequently with the coexistence of psychiatric and physical illness.
◀	Hypoglycaemia may occur with carbohydrate restriction, excessive exercise or purging.	◀	Be aware of insulin as an available and lethal means of harm.

Treatment of Eating Disorders (2)

Key nutrition interventions in eating disorders are to safely reintroduce food in those at risk of refeeding syndrome and support ongoing nutrition rehabilitation.

SAFE REFEEDING

Refeeding syndrome is an insulin mediated, potentially fatal shift in fluids and electrolytes that can occur in malnourished patients during the process of reintroducing food.

It usually occurs within 72 hours of beginning refeeding, but it can occur at any point during the refeeding process.

It is managed through a stepwise introduction of food alongside supplementation of thiamine, which is rapidly used by the body during the refeeding process.

Monitoring of electrolytes, specifically potassium, phosphate and magnesium is required.

How does this relate to T1DE?

In patients with T1DE, where insulin has been omitted, the reintroduction of insulin (alongside carbohydrate) will be the key driver for refeeding syndrome. All those with insulin omission are therefore potentially at risk of electrolyte shifts on re-insulinisation/refeeding. The risk is managed by a gradual introduction of insulin (and carbohydrate if this has been restricted).

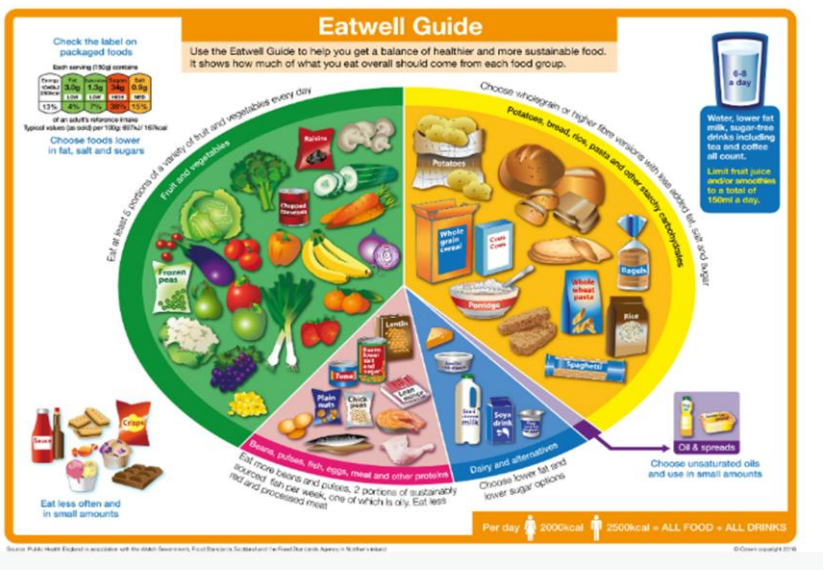
NUTRITIONAL REHABILITATION

Those with eating disorders often:

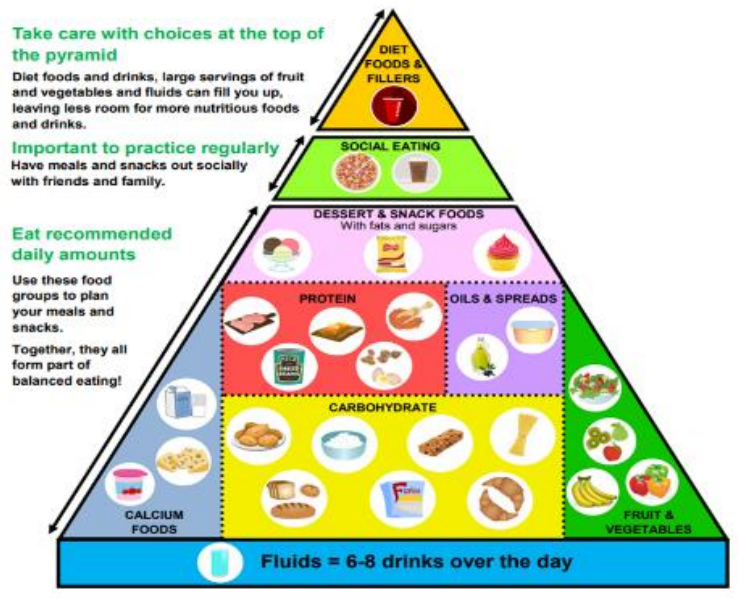
- Place high value on 'healthy' eating, taking recommendations for a healthy diet beyond their intended purpose.
- Have an over-focus on numbers e.g. calories and food labels, imposing strict, food related rules.
- Are influenced by diet culture which moralises food as 'good or bad' and links self worth to the 'thin ideal'.

Some aspects of the Eatwell Plate can be mis-interpreted by those with an eating disorder and reinforce these beliefs.

The Eatwell Guide ☒



The R.E.A.L Food Pyramid ☑



Adapted, with kind permission from Hart et al. J Eat Disord. 2018

The Recovery from Eating Disorders for Life (R.E.A.L.) Food Pyramid is an alternative guide that provides messaging that aims to address the beliefs and concerns common in those with eating disorders. It aims to:

- Promote a healthy balanced food intake
- De-stigmatise foods perceived as 'bad'
- Normalise social eating
- Discourage 'diet' foods and fillers

How does this relate to T1DE?

A healthy diet is a corner stone of management for those with Type 1 Diabetes and optimal management requires a constant focus on food, weight and numbers. In the context of current societal beliefs and culture this may predispose those with Type 1 Diabetes to develop an eating disorder. Those with T1DE may benefit from support to re-evaluate their beliefs and values around food moving away from unhelpful eating patterns and towards a balanced intake that allows them to reconnect with food in a way that promotes good health, enjoyment and social eating.

Treatment of Eating Disorders (3)

PSYCHOLOGICAL INTERVENTIONS

NICE guidance NG 69; eating disorders: recognition and treatment. May 2017, gives recommendations for evidence based psychological therapies for the different eating disorders:

Psychological Therapies

Children and young people

Anorexia nervosa

- Anorexia-nervosa-focused family therapy (FT-AN).
- Individual Eating-disorder-focused Cognitive Behavioural Therapy (CBT-ED).
- Adolescent-focused psychotherapy for anorexia nervosa (AFP-AN).

Bulimia Nervosa

- Bulimia-nervosa-focused family therapy (FT-BN).
- Individual CBT-ED.

Binge Eating Disorder

- Guided self-help.
- Group CBT-ED.

OSFED

- Treat in line with the eating disorder it most closely resembles.

All diagnoses

- Carers skills training

Adults

Anorexia nervosa

- Individual Eating-disorder-focused Cognitive Behavioural Therapy (CBT-ED).
- Maudsley Anorexia Nervosa Treatment for Adults (MANTRA).
- Specialist Supportive Clinical Management (SSCM).
- Eating-disorder-focused focal psychodynamic therapy (FPT).

Bulimia Nervosa

- Guided self-help.
- Individual CBT-ED.

Binge Eating Disorder

- Guided self-help.
- Group CBT-ED.

OSFED

- Treat in line with the eating disorder it most closely resembles.

How does this relate to T1DE?

There are currently no evidence based psychological interventions for T1DE. Eating disorder therapists and psychologists are likely to draw on one or more therapeutic modalities, dependent on the presentation of the client and their own expertise.

PHARMACOTHERAPY

- SSRIs and other antidepressants are used primarily to treat comorbidities e.g. anxiety and depression.
- Atypical Antipsychotics e.g. olanzapine may reduce intrusive ED related thoughts.
- Mood stabilisers e.g. lamotrigine may be used where mood instability is present.

Medication should not be the sole treatment for any eating disorder (NICE 2017).