

Guidelines

Guidelines for the Admission of Children and Young People with an Eating Disorder

This document is designed to be used by clinicians located in hospitals or wards without specialist eating disorder facilities, to guide in indicators for admission of children and young people with an eating disorder.

Introduction

This document is designed to be used by clinicians located in hospitals or wards without specialist eating disorder facilities, to guide in the assessment of eating disorders, indicators for admission, and management strategies.

This guideline was produced by the NSW Statewide Committee of Eating Disorder Medical Lead (SCEDML) Subcommittee which reports to the NSW Service Plan for People with Eating Disorders Implementation Steering Committee.

Purpose of the Guidelines

To provide local health staff with information about when to admit a child or adolescent with an eating disorder who presents to the hospital setting either through Emergency Departments or other pathways.

It is recognised that children and adolescents who present with an eating disorder are at high risk of medical instability, cognitive impairment, psychiatric conditions, suicidal ideation, and/or deliberate self-harm. These outcomes require timely and appropriate intervention to prevent further deterioration and enable recovery.

Scope of the Guidelines

These guidelines cover children and adolescents who present to the emergency department with a diagnosis or query diagnosis of an eating disorder. They are designed to be used in conjunction with local protocols and clinical expertise. For comprehensive inpatient management guidance, clinicians should refer to the *Eating Disorders Toolkit: A Practice-Based Guide to the Inpatient Management of Children and Adolescents with Eating Disorders* found on the Centre for Eating and Dieting Disorders Website (<http://cedd.org.au/>)

Background

Children and adolescents with an eating disorder are at great risk of medical and psychiatric complications, in particular those presenting with Anorexia Nervosa. It is therefore essential to have efficient and timely medical and psychiatric assessment and treatment commenced.

The cause of medical complications can be due to both the amount of weight loss, the rapidity of the weight loss and the compensatory behaviours (vomiting, laxative abuse, diuretic abuse, diet tablets and compulsive exercise) that may be being used. Children and adolescents with an eating disorder have high levels of psychiatric comorbidity. Acute psychiatric presentations include major depression, deliberate self-harm, suicidal ideation, anxiety disorders and obsessive compulsive disorder.

Emergency Medical Assessment

Triage

- All children and young people presenting to the Emergency Department will be triaged using the Australian Triage Scale (ATS). Triage category will reflect urgency of care.
- Baseline medical observations (pulse, blood pressure and temperature)

Monitoring

- Medical instability for the purpose of this document is defined as:
 - Heart Rate < 50 beats/min
 - Temperature < 35.5 C
 - Blood Pressure < 80/40 mm/Hg or postural drop >30 mm/Hg
- All unstable patients should have continuous monitoring of their heart rate and regular monitoring of their blood pressure and temperature. This can be done by placing the patient in a monitored bed or the use of a portable cardiac monitor.
- If a patient is deemed medically unstable treatment is to commence as soon as possible (refer to medical treatment).
- Patients who are medically stable should have 4 hourly monitoring of heart rate, blood pressure and temperature.

If a person presents dehydrated (urine SG \geq 1020) then this needs to be taken into consideration with their observations i.e. a person's heart rate will be higher when dehydrated.

Eating Disorder Assessment

History

- History of presenting illness
- Minimum weight (Current weight)
- Maximum weight
- Duration of weight loss
- Means of weight loss:
 - dietary restriction,
 - purging,
 - excessive exercise,
 - vomiting,
 - laxatives
- Fear of weight gain
- Body image distortion
- Date of menarche
- Primary or secondary amenorrhoea
- Family composition
- Co-morbid conditions
 - Medical
 - Psychiatric (see mental health assessment below)

Physical Examination and Investigations

- Height and weight (without shoes and in light clothing)
- Measurement of vital signs (pulse, postural BP and temperature)
- Cardiovascular examination including peripheral circulation
- GIT examination
- Evidence of self-harm
- Urinalysis
- ECG
- Recommended blood analysis: EUC, FBC, LFT, CMP TSH, T3, T4, LH, FSH, oestradiol, amylase, ferritin, CK, and BSL

Eating Disorder Inpatient Admission

Admission

If any of the signs listed below are present the patient should be admitted to hospital.

- Medical instability:
 - HR < 50 bpm,
 - Temp < 35.5 C,
 - BP < 80/40 mm/Hg or postural drop >30 mm/Hg,
 - electrolyte imbalance,
 - cardiac arrhythmia
- Significant risk of self-harm or suicide

Consider Admission

Psychiatric or medical admission should be considered if any of the following criteria are met.

- Dehydration and refusal to eat or drink
- BMI \leq 14
- Rapid weight loss (>6kg in 6 weeks)
- Increased aggression resulting in either the patient and/or family being at risk of harm
- Prolonged outpatient care with minimal or no progression

Consent

- In children under the age of 14 years treatment including naso-gastric refeeding can occur with parental consent
- In children between the ages of 14 and 16 years treatment ideally requires adolescent and parental consent.
- In children aged 16 years and older treatment requires the consent of the adolescent.
- In children aged over 14 years who are medically unstable and consent is refused, alternate consent should be sought with consideration given to the use of the Mental Health Act or the Guardianship Act.
- Consent should be documented in patients notes

Medical Treatment

- It is essential to commence treatment as soon as possible once it is determined that a patient is medically unstable.
- It is recommended that a long-term silastic naso-gastric tube (size 8) is inserted and feeding commenced as below (to be documented in patients notes):
 - If phosphate < 1.0 mmol/l, feeds to be 0.5 kcal/ml at 100ml/hour
 - If dehydrated (urine SG ≥ 1020), feeds to be 0.5 kcal/ml at 100ml/hour
 - If BMI < 14 the feeds to be 0.5 kcal/ml at 100ml/hour
 - Otherwise commence feeds at 1 kcal/ml at 100mls/hour
 - Appropriate feeds include nutritionally complete liquid enteral formula 1kcal/ml
- Aggressively replete all electrolyte deficiencies. Oral repletion is preferable but IV supplementation may be necessary. It is not necessary to correct fluid and electrolyte imbalance before initiating feeding. With careful monitoring, this can be safely achieved simultaneously.
- Prior to the commencement of feeds 500mg Phosphate to be given either orally or via NGT
- Continue Phosphate at 500mg BD
- Give thiamine orally at a dose of 100mg a day and a multivitamin with phosphate
- Continuous cardiac monitoring
- Bed rest
- No regular meals during nasogastric feeding
- Commence overhead heating with Bair Hugger or heating lamps if
 - HR <50 b/min
 - Temperature ≤ 35.5 C
- Alter calling criteria only in consultation with a consultant
 - Yellow zone = HR < 40 b/min
 - Red zone = HR <35 b/min
- A minimum of once daily monitoring of EUC, CMP and LFTs for at least a week to address the risk of refeeding syndrome

Mental Health Assessment Post-Acute Medical Treatment

Mental health assessment should occur in all medically stable patients prior to discharge.

Psychiatric assessment should also occur in medically unstable patients once acute medical treatment, including naso-gastric refeeding, has commenced.

Assessment should include:

- History of presenting illness including
 - Onset and duration of illness
 - Maximum and minimum weights
 - Duration and speed of weight loss
 - Methods of weight-loss (dietary restriction, exercise, purging)
 - Fear of weight gain
 - Abnormal body image
 - Denial of illness severity
 - Previous eating disorder admissions
- Presence of comorbid psychiatric illnesses
 - Mood Disorders (Major Depressive Disorder, Bipolar Disorder)
 - Anxiety Disorders (Generalised Anxiety Disorder, Social Anxiety Disorder, PTSD, Panic Disorder, Separation Anxiety Disorder)
 - Obsessive Compulsive Disorder
 - Psychotic Disorders
 - Drug and Alcohol use
- Safety assessment
 - Suicidal ideation
 - Deliberate self-harm
 - Past suicidal behaviour and deliberate self-harm
 - Risk to others
 - Sexual history
- Family and Social History
 - Family composition
 - Family stressors
 - Family history of eating disorders or psychiatric disorders
- Past Medical and Psychiatric History
- Current Medications

Psychiatric Treatment

Treatment should be decided following assessment in conjunction with the on call mental health team.

- In the case of significant patient distress consideration should be given to the use of regular or PRN antipsychotic medication (Olanzapine 2.5 – 5.0mg, Quetiapine 25 – 100mg, Risperidone 0.5 – 2.0mg)

Discharge to community

If the young person does not require an inpatient admission it is essential to ensure adequate follow up is organised before they leave the department.

Key considerations:

- Medical follow up with
 - Paediatrician
 - GP
- Psychological support from
 - CAMHS
 - Eating Disorder Service if available
 - Private psychologist
 - Headspace

Tertiary Support

If you require support or advice regarding a young person who presents with an eating disorder you can contact:

- Jo Titterton, Clinical Nurse Consultant, Eating Disorder Network Coordinator: Sydney Children's Hospital Network (SCHN).
joanne.titterton@health.nsw.gov.au or 9845 2446