Binging: means eating an excess of food while feeling a loss of control.
Purging:: gets rid of ingested calories by using diuretics, laxatives, enemas, and vomiting. Non-purging uses means such as fasting or excessive exercise to counter periods of high caloric intake.

These are important concepts to understand when diagnosing eating disorders. The three main types are anorexia nervosa, bulimia nervosa, and binge eating disorder (there are a few less-common types that we won't get into on this podcast).

These three diagnoses have overlapping characteristics but here is a simple framework to help delineate them:

- anorexia involves restriction of caloric intake relative to requirements, leading to a lower than expected body weight (a net negative).
- Bulimia is defined by binging followed by compensatory (non-purging) behaviors to get rid of calories (net neutral or net positive).
  Up to 50% of anorexia patients develop bulimia.
- And binge eating disorder involves episodes of binge eating without purging or non-purging (net positive).

There are specific time frames and subtypes that also help to define each disorder.

All three disorders are serious psychiatric conditions characterized by a pathologic relationship with food that adversely affects psychosocial functioning.

These do occur on a spectrum and although today we won't go into the disordered eating side of things, let's acknowledge that in popular culture diets and restrictive eating are normalized and often celebrated. Beauty standards police bodies and it's our job as primary care practitioners to reject those values and focus on things that we know lead to better outcomes: things like a healthy relationship with food, sustainable physical activity, mental health support, stress reduction, and quality sleep.

Objective 1: During clinical encounters with children, adolescents, and young adults, include an assessment of the risk of eating disorders, irrespective of the patient's gender, as this may be the only opportunity.

While eating disorders often present in adolescence, they can occur in pre-pubertal children as well. They affect people in all body shapes and sizes. Though the majority of cases are female, it is essential to screen all patients regardless of gender.

According to Tintinalli's, men may account for between 10% and 25% of cases of anorexia and bulimia, and binge eating is more prevalent in men than other types of eating disorders.

For the most part, young people do not frequent their family doctor's office on a regular basis, so get the screen in when you can.

Here are 9 red flags which should raise the alarm for an eating disorder:

1. Non-specific gastrointestinal complaints
2. Weight crossing percentiles (even if they have an elevated weight or BMI)
3. Menstrual irregularities (the presence of a normal menstrual cycle does NOT rule out an eating disorder)
4. Difficulty concentrating or lack of energy
5. Changes in diet not consistent with family or culture
6. Becoming irritable, especially around mealtimes
7. Avoiding social situations that involve food
8. Body checking, which can show up as checking in mirrors, photo editing, tracing bones, or wrapping wrists
9. Frequent trips to the bathroom after meals

As with most things in medicine, there's a screening questionnaire if your spidey senses are tingling after noticing some red flags. Three options, in fact:

1. The SCOFF questionnaire https://www.bmj.com/content/319/7223/1467 is useful in a brief encounter to screen for anorexia and bulimia, and is easily remembered by its

acronym: Sick, Control, One stone, Fat, Food. This questionnaire was created in the UK, where one stone is a weight measurement equivalent to 14 pounds. And here are the questions:

   a. Do you make yourself **Sick** because you feel uncomfortably full?
   b. Do you worry that you have lost **Control** over how much you eat?
   c. Have you recently lost more than **One stone** (14 lb) in a 3-month period?
   d. Do you believe yourself to be **Fat** when others say you are too thin?
   e. Would you say that **Food** dominates your life?

   Each "yes" equals 1 point, and a score of 2 indicates a probable eating disorder with a sensitivity of 85% and a specificity of 90%.
2. Eating Attitudes Test. This one is more extensive, and the link is in the show notes.
3. There is also the Questionnaire on Eating and Weight Patterns, which specifically looks for binge eating disorder.

Eating disorders are NOT a diagnosis of exclusion. It is important to have a low threshold to suspect the diagnosis.

Objective 2: When caring for a patient with ongoing psychological distress or unexplained physical symptoms, ask about body image and self-harm behaviours, including disordered eating.

This one is pretty self-explanatory. Most patients do not volunteer this information without prompting, so you need to ask for it. Use the above-mentioned SCOFF questionnaire as a tool to have in your back pocket for situations like this.

And conversely, if an eating disorder is suspected, Tintinalli's recommends screening for depression, anxiety and suicidality, as these may coexist or the patient may demonstrate the symptoms due to starvation.

Objective 3: In a patient for whom concerns about eating behaviours have been identified, take an appropriate history.

The CAMH suggests structuring this in a few nice categories: weight history, body image, eating behaviours, and purging behaviour https://www.camh.ca/en/professionals/treating-conditions-and-disorders/eating-disorders/eating-disorders---diagnosis

Weight history

Take a comprehensive lifetime weight history that includes:

- current weight and height—
  Ask: “How do you feel about this weight? At what weight do you feel fat?”
- highest and lowest adult weights.

Ask questions about the following issues to help clarify treatment goals and obstacles:

- ideal weight—Ask: “How would your life be different at that weight?”
- menstrual threshold weight—target weight for treatment must be above this weight.
- frequency and routine of weighing self—this information will help you understand how the eating disorder governs the patient’s life.

Body image

Ask the patient:

- “How do you see yourself currently? Where exactly do you feel fat?” ·· “How much does your weight and shape determine how you feel about yourself as a person?”
- “Do you fear gaining even small amounts of weight?”

Eating behaviours

Ask the patient about:

- dieting history
- caloric and food group restrictions

- episodes of binge eating with a sense of loss of control, and consumption of foods the patient typically would avoid.

Purging behaviours

Ask the patient about:

- self-induced vomiting
- use of laxatives, diuretics, diet pills
- intensive exercise to lose weight
- cigarette smoking to suppress appetite.

Important to screen for underlying mental health, alcohol, and substance use problems. Also investigate the use of prescribed and over-the-counter medications, tobacco, caffeine, laxatives, and supplements.

Inquire about physical activity habits - some activities including gymnastics, ballet and other dance, wrestling, swimming and cross-country running may raise the risk of eating disorders.

And please keep in mind that holding a nonjudgmental approach to encourage trust and truthful disclosure is extremely important, as denial of symptoms and behaviours is a hallmark of eating disorders.

Objective 4: In a patient with disordered eating behaviour(s):
a) Assess for physiological and metabolic complications
b) Determine if there is a need for hospitalization or immediate intervention

Testing for organic diseases caused by eating disorders is a key concept. Medical complications are responsible for half of all deaths in patients with restrictive eating disorders.
Start with an ECG and extended electrolytes which includes magnesium, calcium, and phosphorus.

Phosphorus is particularly important because hypophosphatemia is one of the main mechanisms of refeeding syndrome, where fluid and electrolyte shifts can lead to hyperkalemia, congestive heart failure, rhabdomyolysis, seizures, hemolysis, and respiratory distress.

Also order:

- a CBC to assess for anemia;
- check ferritin,
- creatinine,
- glucose,
- a pregnancy test (if applicable),
- liver enzymes,
- serum albumin, and
- TSH.

Tintinelli's also recommends checking a urinalysis, along with lipase and amylase. UpToDate wants you to check a vitamin D level, testosterone in biological males, and an INR.

You won't go wrong with the basics and add others based on your clinical judgement based on the presenting complaint.

Imaging is only necessary to rule out other causes of presenting symptoms or to exclude medical complications. For example, echocardiography can be useful in patients with cardiac complaints such as syncope, edema, or unexplained hypotension.

Determine if there is need for hospitalization

Admission to hospital is warranted for anyone with significant and persistent vital sign abnormalities like bradycardia, hypotension, or hypothermia.

Medical instability in patients with anorexia nervosa

Medical instability is characterized by one or more of the following:
▪ Pulse <40 beats/minute
▪ Blood pressure <80/60 mmHg
▪ Orthostatic increase in pulse (>20 beats/minute) or decrease in systolic blood pressure (>20 mmHg)
▪ Cardiac dysrhythmia (eg, QTc >0.499 msec), or any rhythm other than normal sinus rhythm or sinus bradycardia
▪ Cardiovascular, hepatic, or renal compromise requiring medical stabilization
▪ Marked dehydration
▪ Serious medical complication of malnutrition (eg, electrolyte imbalance, hypoglycemia, or syncope)
▪ Body mass index <14 kg/m^2 or <70% ideal body weight

Other reasons to admit are electrolyte disturbances, hypoglycemia, a QTc greater than 450 ms, syncope, seizures, or other serious medical complications. Some resources use ideal body weight or BMI cutoffs starting at BMI of 18.5 for mild anorexia.

For example, for anorexia nervosa, the DSM-5 uses a severity index, based on the patient's BMI:

- Mild – BMI 17 to 18.49 kg/m^2

●Moderate – BMI 16 to 16.99 kg/m^2

●Severe – BMI 15 to 15.99 kg/m^2

●Extreme – BMI <15 kg/m^2

Our friends at the Portico network offer the following general guidelines for hospitalization in eating disorders: https://www.camh.ca/en/professionals/treating-conditions-and-disorders/eating-disorders

Consider the need for hospitalization:

- In anorexia nervosa, when weight loss becomes precipitous and out of control or reaches frank emaciation, hospitalization is usually required to minimize the multiple physical complications and to provide intensive and supervised re-feeding.
- In bulimia nervosa, hospitalization is rarely required unless there is severe metabolic instability, electrolyte disturbance with cardiac risk from hypokalemia, or suicidality.

- In binge eating disorder, there is no current role for hospitalization.

This might feel overwhelming at first but just know that if your patient is refusing food, continuing to lose weight, or not responding to outpatient therapies they should be referred immediately to inpatient treatment programs because eating disorders have the highest mortality of mental health conditions, approximately 5 per 1000 cases.

Objective 5: When assessing a patient presenting with a problem that has defied diagnosis, include “complication of an eating disorder” in the differential diagnosis.

Always be pursuing that wiiiiide differential people. Let’s walk through some examples of presenting complaints that might hide an eating disorder:

- arrhythmias or syncope without cardiac disease;
- electrolyte imbalance without drug use or renal impairment;
- amenorrhea without pregnancy;
- hair loss and cold intolerance with a normal TSH;
- muscle atrophy without neurological disease or malignancy.

This is a reminder that the physical manifestations of malnutrition can be profound, so eating disorders should be on your differential for when things don’t add up.

Did you hear that? That was the sound of a clinical pearl dropping.
Here’s another that you heard under objective numero uno: recall that one of the most common presenting symptoms of an eating disorder in primary care is non-specific GI complaints like abdominal pain, nausea, vomiting, or constipation.

Objective 6: When an eating disorder has been diagnosed:
a) Discuss the impact and potential consequences, regardless of the patient's acceptance of the diagnosis
b) Engage the parents/caregivers/partners in treatment when appropriate and with consent
c) Collaborate with the patient and, when appropriate, family to develop a treatment plan, including an inter- and intra-professional referral when necessary
d) Use simple cognitive behavioural intervention first (i.e., do not automatically assume tertiary care is needed)
e) Periodically reassess behaviours and their impact on mood, anxiety, cognitive function, and relationships

a) Discuss the impact and potential consequences, regardless of the patient's acceptance of the diagnosis

Going back to diagnosis, starting this discussion can be difficult. It may feel like a breaking bad news situation, as this patient probably does not want to be told they have an eating disorder. They believe they are solving a problem with their behavior, even if it causes them distress, so prepare for mixed reactions.

Reducing stigma is imperative. Do this by discussing prevalence and explaining where your concern comes from. Exploring the health impacts and consequences is one way to take the focus off a patient's size or appearance.

The list of complications is long as malnutrition affects all organ systems. Common problems you can mention include arrested growth, amenorrhea, chronic constipation or diarrhea, decreased kidney function, muscle wasting, anemia, fatigue, dry skin, hair loss, and tooth decay after purging. If osteoporosis develops it is irreversible.

The serious complications include arrhythmia, seizures, respiratory failure, and death.

The average age at diagnosis for eating disorders is 18 and this adds another layer of complexity as you may be treating children, adolescents, or young adults, along with their families. Don't forget that for mature minors, consent must be obtained to break confidentiality. Starting conversations with the "conditional confidentiality" talk is recommended. This is where you explain reasons for disclosure which are incidents of abuse, or serious threat to safety of the patient or others.

b) Engage the parents/caregivers/partners in treatment when appropriate and with consent

A national panel of stakeholders came together recently and in 2020 published the Canadian Practice Guidelines for Children and Adolescents with Eating Disorders. They recommend Family Based Treatment as first line intervention for this population, which means parents or family members are in charge of the refeeding process. See the show notes for a great CPS statement on this. Cognitive behavioral therapy has also been shown to help.

Some self-help resources to include for both the patient and their concerned family include the hotline discussed earlier, and some reading materials for patients will be listed here in the shownotes as well:

- Sheena's Place . Community-based support centre in Toronto for people with eating disorders and their families.
- Overcoming Bulimia Nervosa and Binge Eating: A Self-Help Guide Using Cognitive-Behavioral Techniques (2nd ed.), by Peter Cooper, Basic Books, 2009.
- Overcoming Binge Eating (2nd ed.), by Christopher G. Fairburn, Guilford Press, 2013.
- Help for Eating Disorders: A Parent's Guide to Symptoms, Causes and Treatments, by Debra K. Katzman and Leora Pinhas, Robert Rose, 2005.
- Help Your Teenager Beat an Eating Disorder (2nd ed.), by James Lock and Daniel Le Grange, Guilford Press, 2015.
- The Overcoming Bulimia Workbook, by Randy E. McCabe et al., New Harbinger, 2003.

c) Collaborate with the patient and, when appropriate, family to develop a treatment plan, including an inter- and intra- professional referral when necessary

It's important to recognize that most eating disorders can be managed in primary care. That being said, as generalists we should be reaching out to our colleagues with expertise in these conditions to help guide our treatment. Eating disorders are first and foremost a psychiatric illness with considerable physical complications. How can our colleagues help us?

Well, dieticians can direct nutritional rehabilitation including healing people's relationships with food. They can also help with meal plans and weight goals.
Psychologists or other mental health professionals focus on cognitions and behaviors, and explore underlying issues that may have triggered the eating disorder once appropriate medical treatment has been undertaken.
Others such as pediatricians, internists, and nurses can all have special interest or extra training in eating disorders.

Passing the team lead torch to someone more experienced is an option. Knowing your local resources is extremely helpful to ensure your patient gets the care they need. Treatment centres also exist to help out complex patients.

So when do you refer to psychiatry? According to the Canadian resource “Psychiatry in Primary Care” from the Center for Addiction and Mental Health, you should refer if there is diagnostic uncertainty, or you are worried about multiple concurrent mental health conditions.

There is also an amazing toll-free eating disorders hotline https://nedic.ca/about/ by NEDIC the national eating disorder information centre, which we will link to in the shownotes and is something you can refer your patient to regardless of where in the country you are.

d) Use simple cognitive behavioural intervention first (i.e., do not automatically assume tertiary care is needed)

Pharmacotherapy is not recommended as first line for anorexia nervosa, but bulimia and binge eating disorders have been shown to benefit from SSRIs in conjunction with behavioral and nutritional therapy, even in the absence of other psychiatric conditions.

http://www.bcchildrens.ca/mental-health-services-site/Documents/Clinical%20Practice%20Guidelines%20for%20the%20BC%20Eating%20Disorders%20Continuum%20of%20Services.pdf

Some treatment recommendations from BC Children’s Clinical Guidelines, linked in the shownotes for the main eating disorders are:

ANOREXIA NERVOSA

Psychotherapy is considered a first-line treatment in cases of anorexia nervosa (AN), as pharmacotherapy has been found to be generally ineffective for reducing symptoms of AN. However, medications are often used to treat comorbid psychiatric conditions.

Evidence

- Across four placebo-controlled trials, no significant evidence was found for the superiority of antidepressant medication over placebo for improving weight gain, eating disorder (ED) psychopathology, or associated functioning (Claudino et al., 2006)
- Olanzapine, a second-generation antipsychotic (SGA), is the only medication for which there is evidence of efficacy supported by randomized controlled trials (RCTs)
  a. The evidence suggests that olanzapine may increase the rate of weight gain when compared to placebo (Attia et al., 2008; Bissada et al., 2008), but not the overall amount of weight gained (Bissada et al., 2008; Brambilla et al., 2007)

Clinical Recommendations – Anorexia Nervosa

- Individual psychotherapy remains the treatment of choice for AN, as this disorder is mostly resistant to treatment with medication
- Comorbid conditions (i.e., depression, obsessive-compulsive disorder) may still be treated with medication, but the effects of starvation on neurotransmitter functioning may reduce the efficacy of such medications
- While some evidence exists for the efficacy of olanzapine in promoting weight gain, the use of SGAs in treating AN are generally considered experimental and typically reserved for severe cases characterized by chronic resistance to weight gain
- Patient adherence to SGAs may be challenging considering that weight gain is an established side effect
  – SGA medications, if used, should be titrated slowly
- It is important to be acutely aware of adverse events and side effects in the AN population since many patients can be medically unstable

BULIMIA NERVOSA

Of the antidepressant medications which have been found to be effective in the treatment of bulimia nervosa (BN), fluoxetine is considered the "gold standard".

Evidence

- Antidepressant medications have demonstrated effectiveness in the treatment of BN (Jackson, Cates, & Lorenz, 2010)
  a. Fluoxetine, a selective serotonin reuptake inhibitor (SSRI), has been established as the "gold standard" medication in the treatment of BN and is the only pharmacological treatment for BN that has been approved by the Food and Drug Administration (FDA) (Broft, Berner, & Walsh 2010)
  b. Tricyclic antidepressants and monoamine oxidase inhibitors (MAOIs) have a more problematic side effect profile which makes them less useful than SSRIs (Broft, Berner, & Walsh 2010)
  c. While buproprion, an antidepressant, has demonstrated a dramatic reduction in binge eating and purging for individuals with BN (Horne et al., 1988), it also has an unacceptably high rate of seizures. The FDA has issued a black box warning regarding the use of buproprion in patients with EDs, particularly those who are binge-eating and purging, and thus it is rarely used in the treatment of EDs.
- Topiramate, an anticonvulsant medication, has been found to be efficacious in the treatment of BN (Hedges et al., 2003; Hoopes et al., 2003; Nickel et al., 2005). However, it also has a more problematic side effect profile, including the side effect of weight loss, which may not be desirable in this group of patients.

Clinical Recommendations – Bulimia Nervosa

- CBT has been shown to be at least as effective as pharmacotherapy for the treatment of BN, and thus it may be appropriate to initiate a pharmacological approach in cases of patient preference, lack of full response to CBT, or unavailability of CBT
- If medications are being used, fluoxetine should be the medication of choice, which has demonstrated greater efficacy at a higher dose (60 mg/day)
  – Fluoxetine has demonstrated greater efficacy in the treatment of BN at higher doses (60 mg/day), and patients can begin treatment at this dosage or titrate to it quickly
- Due to their relatively benign side effect profile, other SSRIs or serotonin-norepinephrine reuptake inhibitors (SNRIs) should be used if fluoxetine is ineffective, but other antidepressant classes may also be considered
- If antidepressants prove insufficient, topiramate may be used.

EATING DISORDER NOT OTHERWISE SPECIFIED (EDNOS)

Although pharmacotherapy has been found to be better than placebo at reducing binge-eating symptoms associated with eating disorder not otherwise specified (EDNOS), it does not appear to add to the effectiveness of CBT, and medication alone has been found to be less effective than CBT alone. Thus, CBT is still considered the treatment of choice for reducing binge-eating symptoms associated with EDNOS.

Evidence

- Significant evidence to suggest that antidepressants, particularly SSRIs, can reduce the frequency of binge eating in the short term, but they do not appear to be associated with long-term significant weight loss.
  a. When combined with CBT or other psychosocial interventions, antidepressants not appear to have added beneficial effects.
- Across three RCTs, sibutramine, an appetite suppressant, has consistently been associated with a greater decrease in binge-eating frequency and weight compared to placebo (Appolinario et al., 2003; Milano et al., 2005; Wilfley et al., 2008).
- Topiramate (McElroy, Arnold, et al., 2003; McElroy, Hudson, et al., 2007) and zonisamide (McElroy, Kotwal, et al., 2006), both anticonvulsant medications, have been found to be more effective than placebo in reducing frequency of binge-eating episodes and aiding weight loss, but are poorly-tolerated by patients.
- Atomoxetine, a norepinephrine reuptake inhibitor, was found to be superior to placebo in reducing frequency of binge-eating and weight, but ineffective in reducing depressive symptoms (McElroy, Guerdjikova, et al., 2007).

Clinical Recommendations – EDNOS

- CBT should be considered treatment of choice to reducing a range of binge-eating symptoms
- If treatment is primarily concerned with weight loss, appetite suppressants should be considered, as they have been shown to consistently reduce weight, and is most effective when combined with psychosocial treatments
- However, there is little evidence to suggest that medication alone should be considered the treatment of choice for binge-eating, given that CBT alone has been found to be more effective than medication alone in decreasing binge-eating symptoms
- Medications may be considered due to reasons of treatment availability, cost, preference, or alternative treatment goals, like weight loss or treatment of comorbid psychiatric disorders

CHILDREN AND ADOLESCENTS

Pharmacotherapy research for eating disorders has been conducted primarily in adult populations. As such, there is a general lack of evidence demonstrating the efficacy of pharmacotherapy for children and adolescents with eating disorders.

Evidence

- Currently, no RCTs exist examining pharmacotherapy for eating disorders amongst children and adolescents (Golden & Attia, 2011)
- Further study is required to determine whether medications shown to be efficacious in adult BN are also efficacious and safe when used in younger populations

Clinical Recommendations – Children and Adolescents

- Behavioural or family-based treatments are considered the first line of treatment for AN, BN, and EDNOS, given the lack of evidence for the efficacy of medication for children and adolescents with eating disorders
- Medication treatments should be used only in cases in which other approaches are ineffective and/or in which significant co-morbid conditions are present
- If medications are to be used as an adjunct to other treatments, those which have demonstrated efficacy in adults, and particularly those which have been safely administered in children with other psychiatric disorders, may be attempted
- Close monitoring of side effects is essential to pharmacotherapy for younger populations, due to the lack of established side effect profiles

e) Periodically reassess behaviours and their impact on mood, anxiety, cognitive function, and relationships

As always, use the gem of family medicine to assess the efficacy of your interventions: the therapeutic follow up visit.

Appendix: Diagnostic Criteria

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Anorexia Nervosa

The DSM-IV-TR diagnostic criteria for AN are (p.589):

Anorexia Nervosa – DSM-IV-TR Diagnostic Criteria (abbreviated)

A. Refusal to maintain body weight at or above a minimally normal weight for age and height

B. Intense fear of gaining weight or becoming fat, even though underweight

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self evaluation, or denial of the seriousness of current low body weight

D. In post-menarcheal females, amenorrhea, defined as the absence of at least three consecutive menstrual cycles. NOTE: this is not a useful criterion in females who are younger, taking hormones, or pregnant.

Bulimia Nervosa – DSM-IV-TR Diagnostic Criteria

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
   i. Eating in a discrete period of time (e.g., within any 2-hour period) an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.
   ii. A sense of lack of control over eating during the episode (e.g., feeling that one cannot stop eating or control what or how much one is eating)

B. Recurrent inappropriate compensatory behaviour in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting or excessive exercise.

C. The binge eating and inappropriate compensatory behaviours both occur, on average, at least twice a week for 3 months

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of AN.

Links

https://www.camh.ca/en/professionals/treating-conditions-and-disorders/eating-disorders

https://www.eat-26.com/

https://keltyeatingdisorders.ca/wp-content/uploads/2017/05/Eating-Disorders-Toolkit-for-PCP-2018.pdf

https://www.massgeneral.org/assets/MGH/pdf/psychiatry/eating-disorders-medical-guide-aed-report.pdf

https://www.cps.ca/documents/position/anorexia-nervosa-family-based-treatment

https://www.cps.ca/documents/position/goal-weights

https://pedsinreview.aappublications.org/content/37/8/323

Patient resources (Courtesy of Dr. Clare Whitehead)

- Kelty mental health ED toolkit: https://www.youtube.com/watch?v=SnyIF750w5U&list=PL21D7E85D804263B2
- Change creates change parent blog: https://changecreateschange.com/resources/?mc_cid=b24fa46a44&mc_eid=16479905d4
- National eating disorder information centre: https://nedic.ca/
- https://canped.ca/
- http://www.maudsleyparents.org/
- https://www.feast-ed.org/

Guidelines and References

Bornick, Gemma C. L. "Eating Disorders." Tintinalli's Emergency Medicine: A Comprehensive Study Guide, 9e Eds. Judith E. Tintinalli, et al. McGraw Hill, 2020, https://accessmedicine.mhmedical.com/content.aspx?bookid=2353&sectionid=190079482.

Couturier, J., Isserlin, L., Norris, M., Spettigue, W., et al. (2020) 'Canadian practice guidelines for the treatment of children and adolescents with eating disorders', Journal of Eating Disorders, 8(1), p. 4. https://doi.org/10.1186/s40337-020-0277-8.

Reus, Victor I. "Feeding and Eating Disorders." Harrison's Principles of Internal Medicine, 20e Eds. J. Larry Jameson, et al. McGraw Hill, 2018, https://accessmedicine.mhmedical.com/content.aspx?bookid=2129&sectionid=251889587.

UpToDate: Eating Disorders: Overview of prevention and treatment; Anorexia nervosa in adults and adolescents: Medical complications and their management; Confidentiality in adolescent health care

Van der Leer, G., Geller, J., Goodrich S., Chan, K., et al. (2012) 'BC Eating Disorders Clinical Practice Guidelines'.

Whitehead, C. Northwest Territories Medical Grand Rounds: Pediatric Eating Disorders. Sept 16 2021.