"Managing Eating Disorder Presentations in the Emergency Department".

RPAH Emergency Department Assessment and Admission Guidelines

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Presentations to the Emergency Department

- Following the opening of the tertiary inpatient eating disorders unit in 2015, RPAH ED saw an increase in eating disorders presentations from all over NSW.
- Identified need for refined processes for eating disorder patients in ED.
- Most presentations are the result of medical complications associated with starvation or purging.
- Some present with mental health risk such as suicidal ideation (also require medical assessment).
- Effective management of a person with an eating disorder requires close collaboration between general and mental health care streams.

Physical Assessment

- A thorough physical examination must be completed including the following:
  - Body Mass Index (weight [kg]/height [m^2])
  - Postural blood pressure and heart rate
  - ECG (including measurement of QTc interval, corrected for rate)
  - Bloods including full blood count, electrolytes, glucose, renal function, liver function, thyroid function (T3, T4, TSH), calcium, magnesium, phosphate, amylase, ESR.
  - Urinalysis

NOTE: RPAH is a specialist tertiary end-point treatment facility and as such, criteria for admission both to the specialist service (PBU) and the medical wards vary because we attract high numbers at severe levels of presentation. LHDs will utilise a lower threshold.

Criteria for Endocrinology Consult

- BP <80/40mmHg or BP 90/60mmHg plus postural drop (15mmHg).
- BMI <14/m2 in women or 16kg/m2 in men plus acute medical issue (e.g. infection).
- Significant electrolyte disturbance (i.e. serum potassium <2.5mmol/L, hypophosphatemia).
- Haematological abnormalities such as significant anemia (Hb < 70) or bone marrow suppression (neutrophils <1).
- LFT dysfunction (3 upper limit of normal).
- Hypothermia (temperature < 35.5*C).
- Renal failure
- Symptomatic hypoglycemia (<2.7mmol/L).
- Tachycardia (>110 standing or lying).
- Bradycardia (<45)

Management following assessment…

- The Endocrine team/registrar will determine if an admission for medical instability is required.
  - If none of the previous criteria present the patient may be discharged with adequate eating disorders follow up.
- If the patient is admitted for medical intervention, Consultation Liaison (CL) psychiatry MUST be called so they can assess the patient and provide mental health management recommendations.
- If admitted, the patient will come into RPAH under the Endocrine team, with dietetics and CL input.

Mental Health Assessment

- If the patient is not to be admitted for medical reasons but there are indications for a mental health assessment, CL or the Mental Health Liaison Nurse will be contacted to assess and determine if a Mental Health Admission is required.
  - **The patient must remain in the Emergency department until the Mental Health Assessment is complete.**
- If the patient is to be admitted for MH intervention, they will be transferred into an acute psychiatric ward at PMBC (or their local district MH unit) w dietetic support as required.
- If the patient is refusing treatment, contact CL psychiatry for advice and/ or assessment as the Mental Health Act or Guardianship Act may need to be considered.

Discharge

- Patients discharged from the ED to follow-up with usual eating disorder services +/- local mental health service.
  - With the information for RPAH Peter Beumont EDS.
- If patient has no current eating disorders services involved, or there are other concerns about follow-up, they will be referred to Peter Beumont EDS intake for 'urgent slot' OPA.
- Children and Adolescents and people residing outside SLHD will have referral followed up by the SLHD Eating Disorders Network Coordinator via PBU EDS intake.

Case - Melissa

- 35 year old woman with long Hx A.N.
- Brought into RPAH ED from outside SLHD fearful about safety and for 'second opinion' following recommendation for palliative care.
- Weight 21.7kg, **BMI 7.9**
- LFT abnormalities, anaemia (Hb 67), hypotension (80/40), ECG normal (discussion amongst staff regarding chronic nature of these)
- Patient and family requesting admission and treatment.
- Patient seen by Endocrine registrar.
- Admitted under Endocrine team for re-feeding.

When to admit?

- Admission and assessment criteria will vary in each LHD depending on
  - Local Eating Disorder Services
  - Mental Health Services
  - Inpatient/Outpatient options
  - The state-wide guidelines encourage earlier admission within LHDs to reduce medical morbidity, length of stay, cost of admission, and burden to families and carers, and to encourage recovery earlier in the treatment illness.
  - NB. At the moment Emergency Departments in many cases and places are the 'the perceived' or actual only entry point for a person with an eating disorder requiring medical care, which has implications for the patient and emergency departments and their criteria.

Assessment and Admission Guidelines for Eating Disorder Presentations in the Emergency Department
http://cedd.org.au/wordpress/wp-content/uploads/2015/04/1.pdf

Emergency Department Pathway Flowcharts
http://cedd.org.au/wordpress/wp-content/uploads/2015/04/ED_PathwayFlowcharts.pdf

ED's in the Emergency Department

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- Assessment
  - Physical
  - Psychological
- Treatment options
- Case study
- Emergency Guideline

Assessment

- Medical
  - Physical findings (weight, height, HR, BP, Temp, E.C.G)
  - Urinalysis (pH, SG, ketones)
  - Bloods (LFT's, FBC, Mg, Ca, hormones, TSH, T3, T4)
  - Rapidity of weight loss (max and min)
  - Dietary history
  - Menstruation Hx
  - Weight controlling behaviours (exercise, laxatives etc…)

Assessment

- Psychological
  - Self harm/suicide risk assessment
  - Distorted body image
  - Ideal weight according to pt.
  - Concentration
  - Sleeping
  - Family Hx of mental health issues
  - Co-morbid presentation (depression, anxiety, OCD)

Treatment

- Ideally manage in outpatient setting
- Reasons for admission
  - Medical safety
    - HR < 50
    - Temp < 35.5
    - B.P. < 80/40
    - Electrolyte imbalance
  - Psychological safety
    - Risk to self &/or others
- Aim of medical admission
  - Stabilisation
  - Introduction of 'normal' eating pattern
  - Demonstrated weight gain with parents
- Aim of psychological admission
  - Guarantee of safety
  - Clear management plan

Initial Management

- If unstable
  - Monitored bed
  - Heating
  - NGT (continuous overnight feeds 100ml/hr either 1 kcal /ml or ½ strength)
  - Oral phosphate and multivitamin
  - Usual medications(SSRI, olanzapine etc.)
  - Frequency obs (2-4 hrly temp and BP, continuous pulse)
  - Sedation from extreme agitation, usually start with olanzapine 2.5 to 5 mg wafer.

Initial Management

- If stable
  - Clear management plan
    - Ensure pt eats prior to discharge
    - Medical follow up arranged
      - Paediatrician
      - GP
    - Meal plan/advise on same
    - Clear expectations (when to represent etc…)
      - When does an admission need to occur (planned admission)
    - Psychological support (if available)
      - CAMHS
      - Eating Disorder Service if available
      - Private psychologist
      - Headspace

Case Study

- 12 yo girl
- Sent in by GP
- Lethargic
- Dehydrated
- Parents report decreased intake

Presenting Problem: Decreased intake

Initial Observations

- Weight: 31.4kg (clothed including shoes)
- Height : not attended
- HR: 56
- BP: 86/49
- Temp: 36.1

History

- Diagnosed with Anorexia Nervosa by GP 5/12 ago
- Decreased intake for past 2 weeks
  - Banana and up and go daily
- Weight loss 30 kg in past 5/12
- Increasingly withdrawn
- Significant bullying around weight last year
- High achiever
- Low mood
  - No self harm or suicidal ideations

Further observations

- ECG: HR 47
- Temp 35.5
- Bloods: NAD (phosphate >1)
- U/A: Sg 1030, pH 9, ketones +++

Treatment

Discuss need for admission with family and patient

Treatment Plan

- Medication
  - Phosphate 500mg stat
  - Olanzapine prn (given prior to NG due to agitation)
  - Multivitamin daily
- NG inserted
- Commenced on continuous feeds
  - 100ml/hr of 1cal/ml feed
- Bed rest
- Continuous cardiac monitoring
- Nil by mouth besides feeds and medication
- Heating with warm blankets

Inpatient Plan

- Continuous feeds for first 18hrs
- Introduced food
  1. 1500 cal + 1000mls overnight
  2. 2100 cal + 400 mls overnight
  3. 2400 cal plan
- Mobilisation graded
  1. Bed rest first 18hrs
  2. Mobilise around ward
  3. Leave outside of ward
  4. Physio
- Weight gain
  - Aiming for 800gm – 1kg week
- Managing to eat with parents without requiring supplements
- Leave outside of hospital
  - Weight gain or stabilisation is essential on leave
- Clear discharge follow-up
  - Medical
  - Family treatment if possible

Key Points

- If a patient is medically unstable hospitalisation is not negotiable
- Admission criteria will vary in each LHD for patients who are medically stable
  - Risk
  - Current eating status (are they eating?)
  - Family functioning
  - Outpatient options