Statements and Disclosures

• I hereby certify that, to the best of my knowledge, no aspect of my current personal or professional circumstance places me in the position of having a conflict of interest with this presentation.
• Accanto Health is the parent company of The Emily Program, Veritas Collaborative, and Gather Behavioral Health.
Ohio AAP DEI Toolkit Acknowledgement

• I have considered the Ohio AAP Diversity, Equity, and Inclusion standards in preparing this presentation.
Objectives

1. Recognize presenting concerns and screening tools that can be used to assess children and young adolescents with a suspected eating disorder.
2. Describe the medical evaluation of children and young adolescents with a known or suspected eating disorder.
3. Understand how the most serious medical complications of eating disorders should be managed in children and young adolescents.
Eating disorders are common in children and young adolescents, with an estimated prevalence rate of 6 to 8%.

Rising numbers of admissions for acute medical stabilization in children and adolescents documented during the COVID-19 pandemic.

Prevalence in young males, ethnic and racial minorities is increasing.

In younger patients, males may represent one fourth of eating disorders patients.
The changing landscape

• We are seeing patients present with eating disorders at younger ages
Decreased Average Age of Onset

- Age of onset
  - Median age of onset used to be 14 years old
  - New evidence that average age of onset is 12 years old
- Favaro, 2009
  - Significant decrease in age of onset by year of birth
  - Age of onset of anorexia nervosa and bulimia nervosa is decreasing in younger generations
- Swanson, 2011
  - Median age of onset of AN is 12.3 years old (IQR 11.2 to 13.0)
  - Median age of onset of BN is 12.4 years old (IQR 11.1 to 13.5)
Why has it changed?

• Social factors
  – Bullying about body size and appearance is the most common form of bullying in middle school
  – 81% of 10-year-olds are afraid of being fat

• Impact of factors related to COVID-19
  – Social isolation
  – Screen time
  – Body dissatisfaction/return to school

• Increased recognition/changes to DSM-5
Changes to the DSM-5

- Updated criteria in the DSM-5
  - Changes in diagnostic criteria for AN-R (i.e., removed requirement for amenorrhea)
- Inclusion of new diagnoses
  - Atypical Anorexia Nervosa
    - Increasing numbers presenting for care
    - Comprise up to one third of inpatient admissions for medical stabilization (Garber, 2018)
  - Avoidant Restrictive Food Intake Disorder (ARFID)
    - 15% of new eating disorder cases
    - Mean age of diagnosis is 11 years old
    - 20-30% of ARFID patients are male
A New Challenge

- Seeing younger patients with eating disorders brings new challenges
  - Detection
  - Treatment
  - Medical Management
- Seeing younger patients with eating disorders brings new risk
  - Growth and Puberty
  - Bone development
  - Brain health and social development
Eating Disorders in Children and Young Adolescents

• Restrictive eating disorders have medical complications that are the direct result of starvation
• Starvation can present with different medical presentations in children and young adolescents than those seen in older adolescents and adults
• In children and young adolescents, unique medical complications related to restriction prevail in restrictive EDs
  – Anorexia Nervosa
  – Avoidant/Restrictive Food Intake Disorder (ARFID)
  – Atypical Anorexia Nervosa
### Presenting Medical Symptoms of Eating Disorders

<table>
<thead>
<tr>
<th>Anorexia Nervosa</th>
<th>Bulimia Nervosa</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Weight loss</td>
<td>• Irregular menses</td>
</tr>
<tr>
<td>• Amenorrhea</td>
<td>• Palpitations</td>
</tr>
<tr>
<td>• Dizziness/syncope</td>
<td>• Acid reflux</td>
</tr>
<tr>
<td>• Chest pain/palpitations</td>
<td>• Fatigue/weakness</td>
</tr>
<tr>
<td>• Seizures</td>
<td>• Constipation or diarrhea</td>
</tr>
<tr>
<td>• Fatigue/weakness</td>
<td>• Upper and/or lower extremity edema</td>
</tr>
<tr>
<td>• Abdominal pain/constipation</td>
<td>• Frequent sore throat</td>
</tr>
<tr>
<td>• Spontaneous or low impact fractures</td>
<td>• Sensitive teeth</td>
</tr>
<tr>
<td>• Hair loss</td>
<td>• Swollen cheeks</td>
</tr>
<tr>
<td>• Dry skin</td>
<td></td>
</tr>
<tr>
<td>• Cold intolerance</td>
<td></td>
</tr>
</tbody>
</table>

For children, what is missing?
Presenting Concerns in Children

• In children and young adolescents, the patient or parent may note:
  – Patient is excessively concerned about their weight
  – Patient is engaging in inappropriate dieting
  – Patient has a pattern of weight loss
  – Patient has failed to achieve appropriate increases in weight or height and should be growing
  – Patient has delayed or interrupted puberty, which may include amenorrhea
Interviewing Children and Young Adolescents

• When talking to children and young adolescents with known or suspected eating disorders
  • Include parents or other members of their community of support
  • Do a developmentally appropriate interview
  • Remember that many eating disorder behaviors may not have occurred to a younger patient
Age-appropriate interviews
Screening for Eating Disorders

• **SCOFF Questionnaire**
  – 1. Do you make yourself sick because you feel uncomfortably full?
  – 2. Do you worry you have lost control over how much you eat?
  – 3. Have you recently lost one stone (about 14 pounds) in a 3-month period?
  – 4. Do you believe yourself to be fat when others say you are too thin?
  – 5. Would you say that food dominates your life?

• **Eating Disorder Screen for Primary Care (ESP)**
  – Are you satisfied with your eating patterns?
  – Do you ever eat in secret?
  – Does your weight affect the way you feel about yourself?
  – Have any members of your family suffered with an eating disorder?
  – Do you currently suffer with, or have you ever suffered in the past with an eating disorder?
Screening in Children and Young Adolescents

• Bright Futures, American Academy of Pediatrics
  – How do you feel about your present weight?
  – How much would you like to weigh?
The Role of the Medical Evaluation

• Rule out other disorders
• Evaluate the patient’s medical, nutritional, and psychosocial status
• Determine severity of the condition
• Make plan of care
Differential Diagnosis for Eating Disorders

- Gastrointestinal disorders such as inflammatory bowel disease, celiac disease, or eosinophilic esophagitis
- Endocrine disorders such as hyperthyroidism, diabetes mellitus, or adrenal insufficiency
- Chronic infections such as HIV infection or tuberculosis
- Food allergies
- Psychiatric disorders especially depression, OCD, or anxiety
- Substance abuse
“Rule In” Eating Disorders

• Commonly held tenant that in adults, an exhaustive “rule out” is of other medical conditions is not recommended, the eating disorder should be quickly “ruled in”
  – May delay initiation of care
  – May see increased severity of medical concerns secondary to delays
  – May increase risk of iatrogenic injury

• Lengthy “rule out” evaluations in children are also not recommended
  – May make patients and families more reluctant to accept an eating disorders diagnosis
  – May see a less obvious link between behaviors and concerns initially in children
  – May not see weight loss until later in illness
Comprehensive History in Children and Young Adolescents

• Targeted History
  – Weight and height history: Last check up? Cessation of growth?
  – Exercise history: Extra exercise? Secret exercise?
  – Eating habits and recent changes? (i.e., vegan but family is not)
  – Binge eating and/or purging? (i.e., Hidden wrappers, stolen money – young patients don’t have cars or credit cards)

• Past Medical History
  – Family history: Eating disorders, Depression, Anxiety
  – Puberty and Growth: Onset of puberty, growth, menarche, or h/o shaving

• Social History
  – Family function and resources – divorce, work, transportation
  – History of abuse – especially bullying
  – Psychiatric symptoms - especially suicidality
Medical Evaluation in Children and Young Adolescents

- Collect weight and height
- Collect vital signs (Body temperature, orthostatic BPs and HRs)
- Calculate BMI for age/gender (Percent median BMI, BMI Z-score)
- Calculate severity of weight suppression (Percentage and rate of weight loss)
- Obtain growth curves (Changes in weight/height percentiles)
- Calculate mid-parental height
- Perform physical exam (Common physical findings of eating disorders)
- Collect labs
Percent Median BMI (%mBMI)

• Calculating %mBMI
  • Determine Centers for Disease Control and Prevention (CDC) 50th percentile BMI-for-age
  • Participant’s weight status is expressed as a percentage of this 50th percentile value

• “Examination of an adolescent’s weight in relation to the 50th BMI percentile… is perhaps the most frequently used method to determine the weight criterion for an eating disorder diagnosis.”, LeGrange et al, 2012

• However, must often calculate manually
BMI Z-scores

- May be available in many EHRs
- Can plot on World Health Organization (WHO) graphs
  - [https://www.who.int/tools/growth-reference-data-for-5to19-years/indicators/bmi-for-age](https://www.who.int/tools/growth-reference-data-for-5to19-years/indicators/bmi-for-age)
- Can calculate with online calculators such as Children’s Hospital of Philadelphia (CHOP) Research Institute: [https://zscore.research.chop.edu/](https://zscore.research.chop.edu/)
Mid-Parental Height (MPH)

- Calculate mid-parental height in all children and young adolescents with a known or suspected eating disorder
- MUST consider growth in terms of genetic potential

For biologic females:
\[
\frac{(\text{Father’s height (in)} + \text{Mother’s height (in)} - 5)}{2}
\]

For biologic males:
\[
\frac{(\text{Father’s height (in)} + \text{Mother’s height (in)} + 5)}{2}
\]

Predicted range: +/- 3 inches
Don’t forget

• Children should be growing
Growth Considerations in Eating Disorders

- In older adolescents and adults
  - **Growth is finished**
  - The body does not have the option to halt or slow growth when faced with energy insufficiency
  - Will see other medical complications as starvation impacts organ systems
- In children and young adolescents
  - **Growth is not complete**
  - The body can slow or halt growth and/or puberty to conserve energy
  - May see less compromise of other organ systems
Look at Growth Curves in Children and Young Adolescents

• Children grow at predictable rates and track along growth curve percentiles (Weintraub, 2010)
  – Shifts across 2 or more percentile lines on the growth curve after age 3 or 4 are uncommon
  – In malnourished children, a drop is first seen on the weight curve followed by a drop on the height curve

• **Primary treatment goal is to restore normal growth**
  – When variance in detected from expected growth we can use growth curves
    • To frame initial discussions with patients and parents
    • To set goal weights
    • To outline treatment expectations
• What is wrong with this growth curve?
Don’t forget

• Adolescents should be in puberty
Impact of Puberty on Growth

**Girls**
- **Take off** – 9 years old
- **Peak height velocity** - Age 11 years old
  3.7 inches/year
  Tanner stage 2-3
- **Growth spurt**
  17% of final height
  Up to 13 inches of final height

**Boys**
- **Take off** – 11 years old
- **Peak height velocity** - Age 13 years old
  4.3 inches/year
  Tanner stage 3-4
- **Growth spurt**
  18% of final height
  Up to 14 inches of final height

- Weintraub, *Pediatrics in Review*, 2010
CDC Growth Curves
What were risks to this patient?
Importance of Growth Charts

• Marion, 2020
  – 48% of patients had a deviation in the growth curve before first symptoms were reported by parents
  – Growth curve changes occurred 9.7 months before the first symptoms were reported
  – IQR: 3 to 18 months
Threshold for Intervention

- Threshold for intervention is **lower** in children and adolescents (SAHM, 2003)
  - Potentially irreversible effects on physical and emotional growth and development
  - High mortality
  - Evidence suggesting improved outcomes with early treatment
- Initial intervention should be determined by medical and psychological severity
  - Assessment of children and young adolescents must include a comprehensive medical evaluation
  - Medical evaluation should include physical exam, laboratory studies, and EKG and an evaluation of **growth**
Presenting Physical Exam Findings of Eating Disorders

<table>
<thead>
<tr>
<th>Restriction</th>
<th>Purging</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Hypothermia</td>
<td>• Callouses on back of hand (Russell’s sign)</td>
</tr>
<tr>
<td>• Hypotension</td>
<td>• Salivary gland hypertrophy</td>
</tr>
<tr>
<td>• Bradycardia</td>
<td>• Erosion of dental enamel</td>
</tr>
<tr>
<td>• Dry skin</td>
<td>• Caries</td>
</tr>
<tr>
<td>• Brittle nails</td>
<td>• Mouth ulcers</td>
</tr>
<tr>
<td>• Lanugo</td>
<td>• Edema</td>
</tr>
<tr>
<td>• Acrocyanosis</td>
<td>• Abdominal bloating</td>
</tr>
<tr>
<td>• Lower extremity edema</td>
<td>• Cardiac arrhythmias</td>
</tr>
<tr>
<td>• Cardiac murmur (MVP)</td>
<td>• For children, what is missing?</td>
</tr>
<tr>
<td>• Orthostatic blood pressure and pulse changes</td>
<td></td>
</tr>
</tbody>
</table>

For children, what is missing?
Modified Laboratory Evaluation

For all patients:
• Complete blood count (CBC)
• Comprehensive metabolic panel (CMP)
• Phosphorous, calcium, and magnesium
• Urinalysis
• Thyroid function tests (TSH, free T4)

Plus: For all patients consider electrocardiogram (ECG)

Plus: For some patients consider hormone evaluation (LH, FSH, estradiol or testosterone levels)

Plus: For some patients consider bone densitometry (DXA)

May need: For patients with significant or suspected self-induced emesis consider pancreatic enzymes (amylase, lipase)

Pearl: Normal labs do not mean the patient is not sick, especially in younger patients
Medical Stabilization in Children and Young Adolescents

- The medical evaluation process may reveal significant abnormal findings
  - Severely abnormal findings may require a medical admission
  - Medical admission may be necessary for acute medical stabilization
- Medical criteria for acute hospitalization exist for children and adolescents
  - American Academy of Pediatrics (AAP)
  - Society of Adolescent Health and Medicine (SAHM)
Medical Criteria for Hospitalization – SAHM 2022

One or more of the following:
1. < 75% Median body mass index for age and sex
2. Dehydration
3. Electrolyte disturbance (hypokalemia, hyponatremia, hypophosphatemia)
4. ECG abnormalities
5. Physiologic instability (HR < 50 daytime, < 45 night, BP < 90/45, temp <96F, orthostatic increase in pulse > 40 or decrease in SBP > 20, DBP>10)
6. Arrested growth and development
7. Failure of outpatient treatment
8. Acute food refusal
9. Uncontrollable bingeing and purging
10. Acute medical complications of malnutrition (i.e., seizure, syncope, cardiac failure)
11. Comorbid psychiatric or medical condition that prohibits or limits appropriate outpatient treatment (i.e., IDDM, SI, OCD)
Improving Outcomes for Children and Adolescents

• Three key elements that can help attain positive outcomes:
  • Early detection
  • Early intervention
  • Restoration of body weight
    – Weight restoration facilitates the recovery process
    – Medical admission may be necessary initially

Goals of Medical Admission

• Initiate correction of malnourished state
• Promote healthy eating and weight gain
• Evaluate psychiatric comorbidities
• Manage medical complications
• Develop plan of care for after hospital discharge
Medical Complications of Starvation

• Children and adolescent can have similar medical complications in restrictive eating disorders as adults
• Children and adolescents can also have unique medical complications due to overlap with critical windows for growth and development
  – Bone health
  – Linear growth and puberty
  – Brain development
Complications of Starvation: Cardiovascular

- Severely malnourished patients lose heart mass
- Bradycardia
  - Associated with greater total weight loss and recency of weight loss
  - Not associated with admission weight (Whitelaw, 2018)
- Hypotension
- Congestive heart failure
- May also have
  - Low heart rate variability
  - Pericardial effusion
  - Mitral valve prolapse
Complications of Starvation: Endocrine

- Euthyroid sick syndrome
- Slowing or cessation of linear growth
- Slowing or cessation of pubertal development
- Impaired bone health
  - Growth and bone complications are potentially irreversible
Slowing or Cessation of Linear Growth

  - Systemic review and meta-analysis
  - 27 studies reviewed
- Growth and pubertal delay commonly reported
- Evidence for catch up growth found
  - However, *catch up growth not seen in all patients and may be suboptimal*
- Younger age and longer duration of illness associated with increased risk for growth delay
- Weight restoration must be encouraged to avoid adverse effects and allow an opportunity for catch up growth
Poor nutrition may cause down regulation of the HPG axis
- Females - Decreased serum estrogen levels
- Males - Decreased serum testosterone levels
All adolescents need an evaluation of pubertal status
- By history (menses, shaving)
- By exam (Sexual Maturity Rating)
- By laboratory studies (estradiol, testosterone, LH, FSH)
Puberty should resume with weight restoration
- However, pace may be brisk
- Adolescents may run out of time
Impaired Bone Health

• Children and adolescents with restrictive eating disorders are at risk for impaired bone health
  – No significant differences by gender or diagnosis
  – Bone deficits seen in male and female adolescents with AN
  – Impaired bone health seen in underweight adolescents with ARFID
  – Disordered bone health reported in adolescents with AAN

• Low bone density in adolescents is different from that seen in adults
  – In adults, decreased formation and increased resorption
  – In adolescents, missed opportunity for bone deposition
    • 40-60% of peak bone mass normally accrued during adolescence
    • Onset of restrictive eating disorders may coincide with peak years for building bone mass
Bone Loss is Not Reversible

- Bone loss is **not reversible**
- Persisting negative effects on bone health despite recovery of body weight
  - Reduced cortical and trabecular bone
  - Reduced bone at femoral neck and arms
  - Subset of patients with multiple fractures
A “Wake Up Call”

“If adolescents are receptive to the news of a low bone mass, discussions about this health outcome could serve as a ‘wake up call’ on their road to recovery. The findings of Mumford et. al. provide compelling data on the long-term skeletal implications of AN that could be cited in these conversations with patients and families. These data are another reminder of the importance of the adolescent years for bone health and beyond (i.e., peak bone mass attainment and outcomes). They are another reminder of why we want our teenagers with eating disorders to get on the road to recovery just as soon as possible”.

• *Journal of Adolescent Health*, Editorial by Catherine Gordon and Amy DiVasata, 2019
Treatment for Low Bone Density

- Treatments such as bisphosphonates, DHEA are **not** recommended for adolescents and may be deleterious
- Oral combined estrogen-progestin has not been found to increase bone mineral density
- Some promise for transdermal estrogen (Misra, 2011)
- Treatment for children and adolescents includes weight restoration, resumption of menses, calcium intake and vitamin D supplementation if indicated (SAHM, 2015)
- Proxys for skeletal maturity such as bone age have been used in past, but methods such as MRI to determine physeal closure may be needed in the future (Peebles, 2019)
Complications of Starvation: Neurologic

• Cognitive deficits
• Wernicke encephalopathy
  • Thiamine deficiency
• Cortical atrophy
  • Decreased volume of gray matter
  • Decreased integrity of white matter
  • Enlarged ventricles and increased CSF
Cortical Loss May Be Greater in Adolescents


• Meta-analysis of 29 studies

• In acute AN – gray matter and white matter were decreased compared to healthy controls
  • Acute adolescent patients with AN had significantly larger grey matter reduction than adults
  • Grey matter volume loss was correlated with cognitive deficits

• In adults, grey matter and white matter were improved after 1.5 to 8 years

• In adolescents, long term studies are scarce to demonstrate improvement
Impact on Brain Development

• Grey matter reductions may be seen in adolescents with AN
  – May result in neuronal apoptosis
  – May modify the process of dendritic pruning
  – May result in a more “ergonomic” brain

• White matter differences are also seen in AN
  – Represent changes in myelination
  – May reverse with short-term weight restoration

• Dendritic pruning and increased myelination are important
  – Development of abstract thinking
  – Development of executive function
Impact of Eating Disorders on Development

• Adolescence is a critical period for brain development
  • Dendritic pruning occurs – cognition and impulse control
  • Emotion and reward centers are evolving
  • Reproductive and stress hormones impact development of cognition and reward pathways

• When brain development is interrupted, the brain may continue to rely on pathways from adolescence
  • Individuals remain stuck in the adolescent brain
Other Complications of Starvation

- Gastrointestinal
  - Gastroparesis
  - Constipation
  - Abnormal liver function
  - Superior mesenteric artery syndrome
- Hematologic
  - Leukopenia
  - Anemia
  - Thrombocytopenia
- Metabolic
  - Hypothermia
  - Hypercholesterolemia
  - Hypoglycemia
  - Electrolyte imbalances
  - Refeeding syndrome
Refeeding Syndrome

Chronic malnutrition
- Prolonged fast

- Hypophosphataemia
- Hypokalaemia
- Hypomagnesaemia
- Thiamine deficiency
- Sodium and water retention

↑ Glucose uptake
- Uptake of Phosphorus, Magnesium and Potassium
- Thiamine use

- Convulsions, delirium, ataxia, Wernicke's Encephalopathy
- Hypotension, Arrhythmias, Heart Failure
- Renal failure, Paralytic ileus, Anaemia, hyperglycaemia
- Peripheral oedema, paraesthesia, Fasciculation, Rhabdomyolysis

Insulin secretion

- Depletion of electrolytes, proteins, fats, minerals, vitamins

- Refeeding
Risk of Refeeding Complications – NICE Criteria

Patient has one or more of the following:

- **BMI** less than 16 kg/m²
- Unintentional **weight loss** greater than 15% within the last 3-6 months
- **Little or no nutritional intake** for more than 10 days
- Low levels of potassium, phosphate or magnesium prior to refeeding

OR Patient has two or more of the following:

- **BMI** less than 18.5 kg/m²
- Unintentional **weight loss** greater than 10% within the last 3-6 months
- **Little or no nutritional intake** for more than 5 days
- A history of alcohol abuse or drug use including insulin, diuretics, chemotherapy, or antacids
Refeeding Syndrome in Children and Young Adolescents

- Pediatric eating disorder patients are at high risk of developing refeeding complications
- BMI, weight loss and absolute oral intake are less useful at predicting risk in children and young adolescents
- ASPEN Consensus statement, March 2020
  - For pediatric patients look at:
    - BMI Z-score
    - Percentage weight loss as defined by less weight gain than expected
    - Less energy intake or protein intake relative to estimated need
    - Prefeeding lab values
Table 5. ASPEN Consensus Criteria for Identifying Pediatric Patients at Risk for Refeeding Syndrome

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Mild Risk: 3 Risk Criteria Needed</th>
<th>Moderate Risk: 2 Risk Criteria Needed</th>
<th>Significant Risk: 1 Risk Criterion Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight-for-length z-score (1–24 months) or BMI-for-age z-score (2–20 years)</td>
<td>-1 to -1.9 z-score that is a change from baseline</td>
<td>-2 to -2.9 z-score that is a change from baseline</td>
<td>-3 z-score or greater that is a change from baseline</td>
</tr>
<tr>
<td>Weight loss</td>
<td>&lt;75% of norm for expected weight gain</td>
<td>&lt;50% of norm for expected weight gain</td>
<td>&lt;25% of norm for expected weight gain</td>
</tr>
<tr>
<td>Energy intake</td>
<td>3–5 consecutive days of protein or energy intake &lt;75% of estimated need</td>
<td>5–7 consecutive days of protein or energy intake &lt;75% of estimated need</td>
<td>&gt;7 consecutive days of protein or energy intake &lt;75% of estimated need</td>
</tr>
<tr>
<td>Abnormal prefeeding serum potassium, phosphorus, or magnesium concentrations</td>
<td>Mildly abnormal or decreased to 25% below lower limit of normal</td>
<td>Moderately/significantly abnormal or down to 25%–50% below lower limit of normal</td>
<td></td>
</tr>
<tr>
<td>Higher-risk comorbidities (see Table 4)</td>
<td>Mild disease</td>
<td>Moderate disease</td>
<td>Severe disease</td>
</tr>
</tbody>
</table>
Children and adolescents are at **significant risk** of refeeding syndrome with:
- BMI Z-score of -3 or greater that is a change from baseline
- Weight loss defined as less than 25% of the norm of expected weight gain
- 7 or more consecutive days with protein or energy intake less than 75% of estimate needs

No electrolyte changes needed to determine significant risk in children and young adolescents

Patients at significant risk of refeeding syndrome will need to initiate refeeding in a medical setting with close monitoring of vital signs and labs, and with electrolyte replacement as needed
Guidelines for Transferring Care

- Inpatient hospitalization is for acute medical stabilization
- Start restoration of weight
- Normalize eating patterns
- Correct physical and psychological complications of malnutrition
- Once a patient is medically stable
  - Transfer patient to a team that can provide the appropriate level of psychiatric care
  - Continue refeeding as started under expert inpatient dietetic guidance
  - Ensure that the family is supported and guided
  - Build upon gains of the inpatient team
Approaching Eating Concerns in Children

- Children today are bombarded with nutrition and weight messages daily
- AAP 2016 Clinical Report “Preventing Obesity and Eating Disorders in Adolescents” (Golden, et. al.)
  - Discourage dieting
  - Encourage more frequent family meals
  - Promote positive body image – do not encourage body dissatisfaction
  - Encourage families not to talk about weight – talk about eating and being active to stay healthy
  - Inquire about a history of mistreatment or bullying in overweight and obese teenagers
Thank you

• To read more:
  – “Unique considerations for the medical care of restrictive eating disorders in children and young adolescents”, Journal of Eating Disorders, Tanner, 2023

• Questions?