

Maladaptive Eating

Prevention, Management and Treatment

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Objectives

- Discuss prevention strategies for maladaptive eating.
- Use case discussions to review the evaluation of a patient with disordered eating including the differential diagnosis for weight loss.
- Discuss the multidisciplinary team approach to treatment of eating disorders.
- Review management of disordered eating including determination of appropriate level of care.

Prevention Pearls

- Watch our language
- Family meals
- Risk factors
- Early intervention
- Menstrual cycle as a vital sign
- Parent involvement

Preventing Obesity and Eating Disorders in Adolescents
Neville H. Golden, Marcie Schneider, Christine Wood, COMMITTEE ON NUTRITION, COMMITTEE ON ADOLESCENCE and SECTION ON OBESITY
Pediatrics August 2016, e20161649; DOI: <https://doi.org/10.1542/peds.2016-1649>

Case 1: TA

TA is an 11 year old boy who comes to your office for weight loss. His parents state he has been withholding food and liquid intake recently. He has lost 15 lbs. in the past 3 months. He denies any vomiting after eating. He recently started seeing a therapist (1 month ago) for some obsessive compulsive behaviors. His grandfather passed away 6 months ago, and he moved schools to start 6th grade 3 months ago.

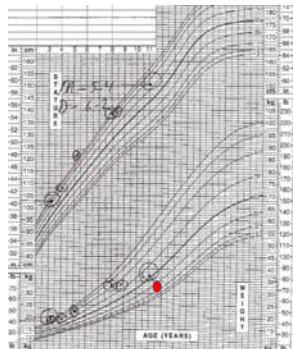
Where to start?

- Think about the DDX of weight loss
- Physical Exam
- Psychological concerns: What comorbid disorders may be ongoing?
- Height, weight, and BMI percentiles (and graphs)
- Percent of expected BMI (or % median BMI)

% Median BMI

Value	Imperial	%ile	Z-score	50%ile
Weight (kg)	32.5kg	20%	-0.83	37.7 kg
Stature (cm)	153.5cm	86%	1.07	146 cm
BMI-for-age	13.8	1%	-2.47	17.4

- PEBMI: 79.3%
- PEBW: 86.2%



Differential Diagnosis of Eating Disorders

GI disorders	Inflammatory Bowel Disease Celiac disease
Oncologic processes	Including CNS lesions
Infectious diseases	Chronic infections such as HIV, tuberculosis, etc.
Endocrine disorders	Hyper/hypothyroidism Diabetes mellitus Hypopituitarism Addison disease
Other Psychiatric disorders	OCD and Anxiety disorders Substance use disorder
Consequences of weight loss	SMA syndrome

Adapted from Rosen and Committee on Adolescence. *Pediatrics* December 2010, 126 (6) 1240-1253; DOI: <https://doi.org/10.1542/peds.2010-2821>

Where to start: Initial Labs and Studies

- CBC
- CMP
- Mag
- Phos
- Urinalysis
- Thyroid function testing (TSH and free T4)
- ECG (with any CV complaint, purging, significant weight loss, or electrolyte abnormalities)

Where to start: Don't forget!

- Substance use screening
- Suicidal thoughts
- Psychology/counseling referral
- Is psychiatry (or psychiatric medication) needed?

More about Case 1...

• Labs:

POC Urine Specific Gravity.	1.025
Reference Range: 1.003-1.030	
POC Urine pH.	6.0 [4.5-8.0]
POC Urine Protein.	NEGATIVE [NEG]
POC Urine Glucose.	NEGATIVE [NEG]
POC Urine Ketone.	TRACE [NEG]
POC Urine Leukocytes.	NEGATIVE [NEG]
POC Urine Nitrite.	NEGATIVE [NEG]
POC Urine Occult Blood.	NEGATIVE [NEG]
POC Urine Bilirubin.	NEGATIVE [NEG]
POC Urobilinogen.	1.0 [+2.0]

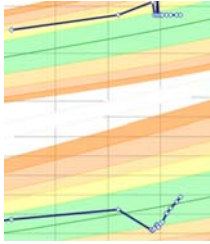
• ECG: Sinus bradycardia

Sodium Level Blood	137 # [138-145 mmol/L]
Potassium Level Blood	4.3 [3.4-4.7 mmol/L]
Chloride Level Blood	103 [96-107 mmol/L]
Carbon Dioxide Level Blood	22 [17-26 mmol/L]
Anion Gap.	12 [9-18 mmol/L]
Glucose Level Blood Lab Performed	95 [60-100 mg/dL]
Blood Urea Nitrogen	22 # [7-21 mg/dL]
Creatinine Level Blood	0.84 # [0.31-0.61 mg/dL]
Calcium Level Blood	9.3 [9.2-10.5 mg/dL]
Total Protein Level Blood	6.8 [5.5-6.1 g/dL]
Albumin Level Blood	4.7 [4.1-4.8 g/dL]
Alanine Transaminase Level	12.8 [9.0-25.0 U/L]
Aspartate Aminotransferase Level	22 [18-36 U/L]
Alkaline Phosphatase Level	99.2 # [0/L]
Magnesium Level Blood	2.12 [1.60-2.60 mg/dL]
Phosphorus Level Blood	3.3 # [4.1-5.9 mg/dL]
Complete Blood Count with Automated Differential	
White Blood Cell Count Blood	3.96 # [4.31-11.00 10 ³ /uL]
RBC.	5.13 # [3.96-5.03 10 ⁶ /uL]
Hemoglobin.	14.7 # [10.7-13.4 g/dL]
Hematocrit Blood	43.1 # [32.2-39.8 %]
MCV.	84.0 [74.4-96.1 fL]
MCH.	28.7 [24.8-29.2 pg]
MCHC.	34.1 [32.2-34.9 g/dL]
RDWCV.	13.7 [12.3-14.1 %]
RDWSD.	42.2 # [35.1-41.7 fL]
MPV.	9.8 [9.2-11.4 fL]
Platelet Count.	202 [140-440 10 ³ /uL]

Treatment is Multidisciplinary

- Mental Health Professional
 - Family-based therapy and CBT has best outcomes.
- Medical Provider (Physician, Nurse, etc.):
 - Once EDO is established, address medical comorbidities of maladaptive behaviors (restriction and purging)
 - Review and manage medications (e.g. SSRI).
 - Assure level of care is appropriate.
 - Support family through process.
- Registered dietician
 - Assess current behaviors and nutritional knowledge
 - Includes behavioral counseling and education: Food is medicine!

Case 1: How is he doing?



- Goal weight gain per week = 0.5 to 2 lbs
- Fluid goal
- Slowly added back exercise
- Important to keep assessing for height increase!
- Why is he doing so well?

Family based therapy

TABLE 4 Principles of Family-Based Treatment of EDs and Role of the Pediatrician

- Principles of treatment
- Parents are not to blame
 - Parents are vital to therapeutic success
 - Parents are responsible for weight restoration
 - Separate the child from the illness
 - Nonauthoritarian approach
- Three phases of treatment
- Phase 1: parents restore patient's weight
 - Phase 2: control transferred back to the child or adolescent
 - Phase 3: focuses on adolescent developmental issues and termination of treatment
- Examples of the role the pediatrician can play
- Act as a consultant to the parents and therapist
 - Explain the medical seriousness of the ED
 - Monitor and manage the medical status of the adolescent
 - Empower the parents in decision-making
 - Communicate with the patient, family, and therapist

Preventing Obesity and Eating Disorders in Adolescents Neville H. Golden, Marcie Schneider, Christine Wood. COMMITTEE ON NUTRITION, COMMITTEE ON ADOLESCENCE and SECTION ON OBESITY. Pediatrics August 2016, e20161649; DOI: <https://doi.org/10.1542/peds.2016-1649>

Case 2: SB

15 year old young lady comes in for a yearly physical. She reports no complaints and has had no weight loss. You give her a SCOFF questionnaire:

- Do you make yourself sick because you become uncomfortably full? **Yes**
- Do you worry that you have lost control over how much you eat? **No**
- Have you recently lost more than 15lbs in 3 months? **No**
- Do you believe yourself to be fat when others say you are too thin? **Yes**
- Would you say food dominates your life? **Yes**

One point should be given for every "yes" answer.
A score of ≥ 2 indicates a likelihood of AN or BN.

Case 2: SB

- Admits to bingeing and purging (by vomiting) for 3 years. Also cuts herself with a pencil sharpener. Her intention is to relieve stress and anxiety. She thinks that the bingeing and purging also help with her anxiety.
- SB is adopted since birth. Biological mother has h/o drug use. Currently SB has a strained relationship with her adoptive mother.
- Parents have noted her going to bathroom more after meals for long periods of time.
- She exercises 1-2 hours daily.

Initial Labs

AMYLASE	69			U/L	19-76
COMP METABOLIC PANEL					
SODIUM	140			mmol/L	133-145
POTASSIUM		3.4	L	mmol/L	3.5-5.0
CHLORIDE				mmol/L	96-106
CO2	27			mmol/L	19-27
UREA NITROGEN	0			mg/dL	0-10
CREATININE	0.9			mg/dL	0.5-0.9
GLUCOSE	71			mg/dL	70-105
CALCIUM		10.3	H	mg/dL	8.4-10.2
AST	27			U/L	<33
BENZILATES MAY BE FALSELY INCREASED DUE TO SLIGHT HEMOLYSIS.					
TOTAL BILIRUBIN	0.1			mg/dL	0-1.2
ALBUMIN	4.0			g/dL	3.2-4.5
ALT	13			U/L	5-20
ANION GAP		21	H		7-17
CALC OSMOLALITY	276			mosm/kg	
BUN/CREAT	7				2-36
COMMENT	NONE				
FREE T4		1.57	H	ng/dL	0.83-1.44
PREALBUMIN	28			mg/dL	22-45
TSH	1.81			uIU/mL	0.36-5.60
VITAMIN D,25 HYDROXY					
VIT D,25 HYDROXY	31.6			ng/mL	
INTERPRETATION					

CBC/DIFF					
WBC COUNT	4.88			10 ³ /uL	4.20-10.60
HEMOGLOBIN	5.70	H		10 ⁶ /uL	4.00-5.20
HEMATOCRIT	16.1	H		g/dL	12.0-16.0
MCV	87.2			fL	80.0-100.0
MCH	28.2			pg	26.0-34.0
MCHC	32.4			g/dL	31.0-37.0
RDW	14.6			%	11.4-14.9
PLATELET COUNT	231			10 ³ /uL	170-430
MPV	11.3			fL	7.5-12.0
NEUTROPHILS	5.20			10 ³ /uL	1.60-7.20
LYMPHOCYTES	2.14			10 ³ /uL	1.50-4.50
MONOCYTES		0.33	L	10 ³ /uL	0.35-1.00
EOSINOPHILS		0.08	L	10 ³ /uL	0.20-0.70
BASOPHILS	0.06			10 ³ /uL	0.00-0.20
NEUTROPHIL	46.3			%	
LYMPHOCYTE	43.9			%	
MONOCYTE	6.8			%	
EOSINOPHIL	1.6			%	
BASOPHIL	1.2			%	
IMMATURE GRANULOCYTES	0.2			%	0.0-0.3

At Children's of Alabama...

- Repeat labs were obtained with no further metabolic alkalosis.
- Findings:
 - Hypoglycemia (glucose 59)
 - Creatinine 0.91
 - Potassium, Mag, Phos, thyroid studies normal
- PHQ-9 was 22. SSRI was begun.
- Two weeks later, had SI and was admitted to inpatient psychiatry (in another city).

SB's progress

- Continued to have binge/purge behaviors that alternated with restriction of intake associated with depression and anxiety.
- Had outpatient counseling every other week in home town.
- Because of worsening behaviors (restriction and purging) and mood, we referred patient to inpatient / residential eating disorder treatment in Atlanta.
- After 60 days, she was discharged to a partial hospitalization program near Nashville, TN.

Case 3: AC

- 16 year old who has been vomiting 2-3 times per day since her well child check when she saw her weight of 168 lbs (overweight for BMI). She has a history of anxiety and has been taking paroxetine for 1 year.
- She is cared for by her grandmother because of parental substance use disorders. She has two younger siblings.
- Patient states most of her vomiting is "involuntary" because of stomach pain.
- Her grandmother states she complains about how her abdomen and thighs look.
- ROS: Constipation (no BM x 2 weeks); monthly menstrual cycles

Case 3: AC's Exam

- Today's weight = 128 lbs (40 lb weight loss in 4 months)

<u>Value</u>	<u>Imperial</u>	<u>%ile</u>	<u>Z-score</u>	<u>50%ile</u>
• Weight (kg)	58.3 128.5 lb	66%	0.42	54.1
• Stature (cm)	163 64.2 in	52%	0.06	163
• BMI-for-age	21.9	66%	0.41	20.5

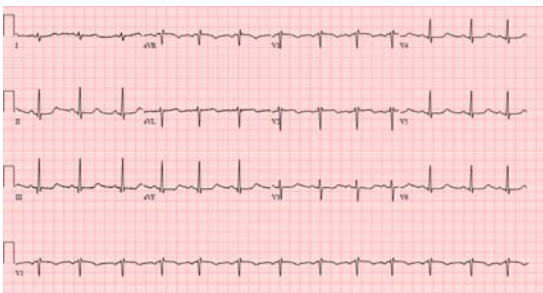
PEBMI: 106.8%

PEBW: 107.8%

Initial labs

- Hyponatremia
- Hypokalemia
- Hypochloremic metabolic alkalosis

ECG



Indications for Inpatient Hospitalization

Table 4
Indications supporting hospitalization in an adolescent with an eating disorder

One or more of the following justify hospitalization

- <75% Median body mass index for age and sex
- Dehydration
- Electrolyte disturbance (hypokalemia, hyponatremia, hypophosphatemia)
- EKG abnormalities (e.g., prolonged QTc or severe bradycardia)
- Physiological instability
 - Severe bradycardia (heart rate <50 beats/min daytime; <45 beats/min at night)
 - Hypertension (>90/45 mm Hg)
 - Hypothermia (body temperature <96°F, 35.6°C)
 - Orthostatic increase in pulse (>20 beats/min) or decrease in blood pressure (<20 mm Hg systolic or >10 mm Hg diastolic)
- Arrested growth and development
- Failure of outpatient treatment
- Acute food refusal
- Uncontrollable bingeing and purging
- Acute medical complications of malnutrition (e.g., syncope, seizures, cardiac failure, pancreatitis, and so forth)
- Concomitant psychiatric or medical conditions that prohibits or limits appropriate outpatient treatment (e.g., severe depression, suicidal ideation, obsessive compulsive disorder, type 1 diabetes mellitus)

EKG = Electrocardiogram; QTc = Corrected QT interval.

Journal of Adolescent Health 56 (2015) 121e125.

Labs

Sodium Level Blood	↓ 137	↓ 137	↓ 137	139	140	139	13
Potassium Level Blood	↓ 2.9	↓ 2.5	↓ 2.6	↓ 3.0	↓ 2.7	↓ 3.0	3
Chloride Level Blood	↓ 83	↓ 88	↓ 88	102	107	↓ 108	10
Carbon Dioxide Level Blood	↓ 33	↓ 33	↓ 32	↓ 29	↓ 27	↓ 24	2
Anion Gap	↓ 21	16	17	↓ 8	↓ 6	↓ 7	↓ 2
Glucose Level Blood Lab Performed	78	79	76	103	93	94	8
Blood Urea Nitrogen	13	15	11	8	12	10	1
Creatinine Level Blood	0.79	0.64	0.70	0.52	0.45	↓ 0.48	0.5
Albumin Level Blood	↓ 5.1	4.7	4.8	↓ 3.8	↓ 3.1	↓ 3.3	↓ 3
Alanine Transaminase Level	14.2						
Aspartate Aminotransferase Level	↓ 27						
Alkaline Phosphatase Level	97.2						
Bilirubin Level Total	0.72						
Gamma Glutamyl Transferase Level							
igA Level Blood							
lipase Level							
Magnesium Level Blood	2.34	2.29	2.45	2.03	1.62	1.72	2.0
Phosphorus Level Blood	4.7	4.6	4.2	↓ 3.3	↓ 3.1	↓ 3.7	3

Refeeding syndrome

- More likely in patients with longstanding severe malnutrition
- Complication related to phosphate shifting from extracellular to intracellular in setting of low total-body phosphate
- Typically only in first 1-2 weeks of nutritional rehabilitation
- Other findings:
 - Hypokalemia
 - Glucose intolerance
 - Gastrointestinal dysfunction
 - Cardiac arrhythmias
 - Dependent edema

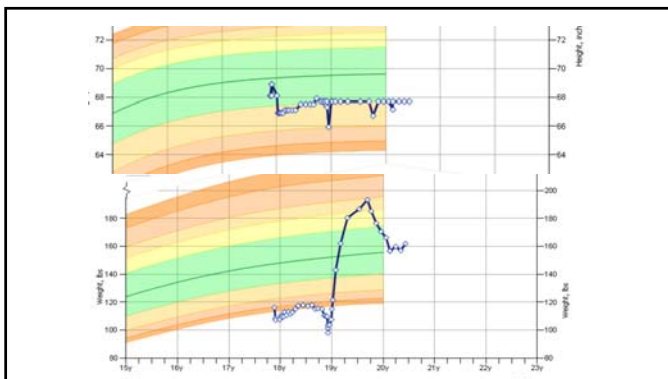
Case 4: JS

21 year old male (currently) who first presented at age 17 with 35 lb weight loss in 5 months. Medical evaluation found bradycardia and hypotension. He had no intake for 2 days prior to hospitalization.

- He had thoughts about trying to obtain a certain physique and exercising excessively while restricting his food in order to try to obtain this physique.
- RD plan: Initiated diet at 1200 kcal/day, increased to 2000 kcal/day by discharge (over 1 week).

Case 4: JS

- Continues to be followed as outpatient in eating disorder clinic (3 years)
- Psychiatric diagnoses (after 2 week inpatient admission):
 - Anorexia nervosa, restricting type
 - Major depressive disorder (with h/o SI)
 - Delusional disorder
- Medications included antipsychotics which led to weight gain over time



Case 5: EC

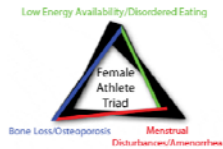
15 year old young lady with 2 year history of eating small portions with weight loss over past year in context of daily cardio exercise (running 5-6 miles per day) presents with concern for lack of menstrual cycles. She has no pain in legs or history of fractures.

- Menarche at 13 years of age. Had 2 cycles at that time, then one more cycle (5 days) 9 months ago, and none since.
- On cross country team, currently off season.
- Currently has 80% expected BMI and 73% expected body weight for age and gender.

Case 5: EC

- Treatment plan after visit 1:
 - Gave nutrition plan.
 - Exercise plan: No cardiac exercise at all. OK to do some yoga/stretching daily.
 - Cardiology referral given abnormal ECG.
 - Ordered labs and DEXA scan for amenorrhea.
 - Vitamin D and Calcium supplementation recommended.

Amenorrhea



- Increased risk of low bone mineral density and osteoporosis
- Associated with cognitive deficits seen in AN
- Goal of medical treatment for AN: Resumption of spontaneous menses!

Treatment for Amenorrhea / Low BMD

Weight Restoration

???

- Calcium and Vitamin D supplementation
- Supplemental Estrogen
 - Oral Contraceptive Pills
 - Transdermal estrogen
- DHEA + OCP
- rhIGF-1 + OCP
- Bisphosphonates not recommended in adolescents



Important Notes

- Decreased bone accrual has been seen in atypical AN (normal weight) and bulimia nervosa, not just anorexia nervosa.
- Weight restoration may not fully restore bone health, so even a HISTORY of amenorrhea or low weight may need bone evaluation.

Case 6: SS

12 year old young man with history of OCD (on SSRI) presents with restrictive eating and weight loss (26 lbs/3 months) motivated by desire to be thin and fear of weight gain.

- He is already connected with a mental health provider.

Weight %: 20%

Height %: 56%

BMI %: 8%

BMI z-score: -1.38

Percent estimated BMI: 86%

Percent estimated weight: 85%

Case 6: SS

• Initial labs

Sodium Level Blood	142	141			
Potassium Level Blood	4.2	3.7			
Chloride Level Blood	106	103			
Carbon Dioxide Level Blood	29	25			
Albumin Day	11	10			
Urea Level Blood Lab Performed	89	79			
Blood Urea Nitrogen	20	22			
Creatinine Level Blood	0.87	0.72			
Calcium Level Blood	10.1	10.2			
Total Protein Level Blood	7.3	7.6			
Albumin Level Blood	5.2	5.1			
Alanine Transaminase Level	12.0	11.5			
Aspartate Aminotransferase Level	16	14			
Alkaline Phosphatase Level	230.4	213.6			
Bilirubin Level Total	0.81	0.81			
Magnesium Level Blood	2.37				
Phosphorus Level Blood	3.2				
Vitamin D 25-OH	17.2				
Thyroid Stimulating Hormone Level	0.72				
Thyroxine Level	5.2				
Lactate Level		17			
C-Reactive Protein Level					

Case 6: SS

- The day after ER visit for vomiting (dx: viral gastroenteritis), had an eating disorder visit with us. Nausea was improved and had not vomited in over 12 hours.
- Six days later, patient had continued to vomit, unable to keep solids down. Emesis became black.
- To ER again: Vital signs showed tachycardia.
- Abdominal xray
- Labs

Case 6: SS Lab Trend

Sodium Level Blood	142	141				141
Potassium Level Blood	4.2	3.7				3.2
Chloride Level Blood	106	103				94
Carbon Dioxide Level Blood	29	25				26
Albumin Day	11	10				10
Urea Level Blood Lab Performed	89	79				102
Blood Urea Nitrogen	20	22				21
Creatinine Level Blood	0.87	0.72				0.72
Calcium Level Blood	10.1	10.2				11.1
Total Protein Level Blood	7.3	7.6				6.2
Albumin Level Blood	5.2	5.1				5.2
Alanine Transaminase Level	12.0	11.5				11.2
Aspartate Aminotransferase Level	16	14				12
Alkaline Phosphatase Level	230.4	213.6				274.4
Bilirubin Level Total	0.81	0.81				0.80
Magnesium Level Blood	2.37					2.16
Phosphorus Level Blood	3.2					3.7
Vitamin D 25-OH	17.2					
Thyroid Stimulating Hormone Level	0.72					
Thyroxine Level	5.2					
Lactate Level		17				19
C-Reactive Protein Level						



Next step?



Case 7: JC

13 yo female with history of mild intellectual delay, unilateral hearing loss, anxiety, self harm (cutting), headaches presents after her PCP referred her for "being too skinny". She denies any fear of weight gain or purging behaviors.

- Social history: She lives with her maternal grandmother. Her biological mother used drugs and alcohol during pregnancy.
- Initial appointment: 148 cm (4%), 33.75 kg (1%), BMI 15.4 (4%)
- Per grandmother and uncle, pt is a "picky eater" and a "homebody"
- Refuses to eat fruits or vegetables

Case 7: JC

- Challenges to treatment
 - Intellectual delay
 - Picky eating
 - Unclear diagnosis (ARFID or anorexia? Neither?)
 - Genetic predisposition?
 - Transportation to clinic
- Benefits from Medicaid's Alabama Care Plan (Alabama Coordinated Health Network)

Where is she now?

- Most recent appointment: 12/30/2019
148 cm (2%), 35.65 kg (<1%), 16.3 (6%) → Increase in weight by 2 kg in 1 year
- GM states that she has increased her proportion of the foods that she will eat
- Continues to not eat any fruit or vegetable
- Remains without PE during to palpitations when running.
- Goal weight of 85 pounds by Christmas, and said that she has been eating more lately than she did previously.

Case 8: JG

- 17 yo with history of major depressive disorder and history of suicide attempt by overdose presents with weight gain. She is concerned that she meets criteria for binge eating disorder.
- Today, she feels depressed and has some passive SI.

- BMI-for-age is 48.7 (99%), z score 2.53. 50% median BMI is 21.2.
- Extremely obese: BMI of 48.7 is 162% of the 95%ile BMI (30.1)

Case 8: JG

- She had severe body dissatisfaction, perfectionism, scored highly for bulimia nervosa. PHQ-9 25 and GAD-7 17 (both very elevated).
- Labs:
 - CMP, Mag, Phos normal
 - Cholesterol panel – LDL 205, HDL 40, Tg 131
 - Thyroid studies normal
 - Hgb A1C = 5.5%
- Diagnosis?
- Treatment options?

Eating Disorders –
Supplementary Slides

Psychotropic Medications in Disordered Eating

- Anorexia Nervosa: No psychotropic medications have an FDA approved indication for treatment
 - Olanzapine has shown improvement in weight and dysfunctional thinking in AN. (SE's: metabolic syndrome, weight gain)
- Bulimia nervosa:
 - Fluoxetine :only antidepressant approved by the FDA
 - Efficacy of other SSRIs demonstrated e.g. including sertraline
 - Mechanism - decrease binge eating and improve mood
- Binge Eating Disorder: Topiramate and Lisdexamfetamine have shown improvement in studies.



DSM V Criteria

DSM V Criteria: What You Need To Know



Anorexia Nervosa

- Persistent restriction of energy intake leading to significantly low body weight (in context of what is minimally expected for age, sex, developmental trajectory, and physical health)
- Either an intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain (even though significantly low weight)
- Disturbance in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight:
 - **Subtypes:**
 - Restricting type
 - Binge-eating/purging type



Bulimia

- Recurrent inappropriate compensatory behaviour in order to prevent weight gain, such as self-induced vomiting, misuse of laxatives, diuretics, or other medications, fasting, or excessive exercise.
- The binge eating and inappropriate compensatory behaviours both occur, on average, at least once a week for three months.
- Self-evaluation is unduly influenced by body shape and weight.



Avoidant/Restrictive Food Intake Disorder DSM V Criteria

- A. Eating or feeding disturbance (including but not limited to apparent lack of interest in eating or food; **avoidance based on the sensory characteristics of food; or concern about aversive consequences of eating** as manifested by **persistent failure to meet appropriate nutritional and/or energy needs** associated with one or more of the following:
1. Significant weight loss (or failure to gain weight or faltering growth in children);
 2. Significant nutritional deficiency;
 3. Dependence on enteral feeding;
 4. Marked interference with psychosocial functioning.
- B. There is no evidence that lack of available food or an associated culturally sanctioned practice is sufficient to account alone for the disorder.
- C. The eating disturbance does not occur exclusively during the course of Anorexia Nervosa or Bulimia Nervosa, and there is **no evidence of a disturbance in the way of which one's body weight or shape** is experienced.
- D. The eating disturbance is not better accounted for by a concurrent medical condition or another mental disorder. When occurring in the context of another condition or disorder, the severity of the eating disturbance exceeds that routinely associated with the condition or disorder and warrants additional clinical attention.



Feeding and Eating Conditions Not Elsewhere Classified DSM V

1. Atypical, mixed, or below-threshold presentations:

- **Atypical Anorexia Nervosa**
 - All of the criteria for Anorexia Nervosa are met, except that, despite significant weight loss, the individual's weight is within or above the normal range.
- **Sub threshold Bulimia Nervosa (low frequency or limited duration)**
 - All of the criteria for Bulimia Nervosa are met, except that the binge eating and inappropriate compensatory behaviors occur, on average, less than once a week and/or for less than for fewer than 3 months.
- **Sub threshold Binge Eating Disorder (low frequency or limited duration)**
 - All of the criteria for Binge Eating Disorder are met, except that the binge eating occurs, on 'average', less than once a week and/or for fewer than for 3 months.



Feeding and Eating Conditions
Not Elsewhere Classified
DSM V

2. Other specific syndromes not listed in DSM-5:

- **Purging Disorder**
 - Recurrent purging behavior to influence weight or shape, such as self-induced vomiting, misuse of laxatives, diuretics, or other medications, in the absence of binge eating.

- **Night Eating Syndrome**
 - Recurrent episodes of night eating, as manifested by eating after awakening from sleep or excessive food consumption after the evening meal. There is awareness and recall of the eating. The night eating is not better accounted for by external influences such as changes in the individual's sleep/wake cycle or by local social norms. The night eating is associated with significant distress and/or impairment in functioning. The disordered pattern of eating is not better accounted for by Binge Eating Disorder, another psychiatric disorder, substance abuse or dependence, a general medical disorder, or an effect of medication.