

# Dietetic support for young people with eating disorders

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# What we will cover

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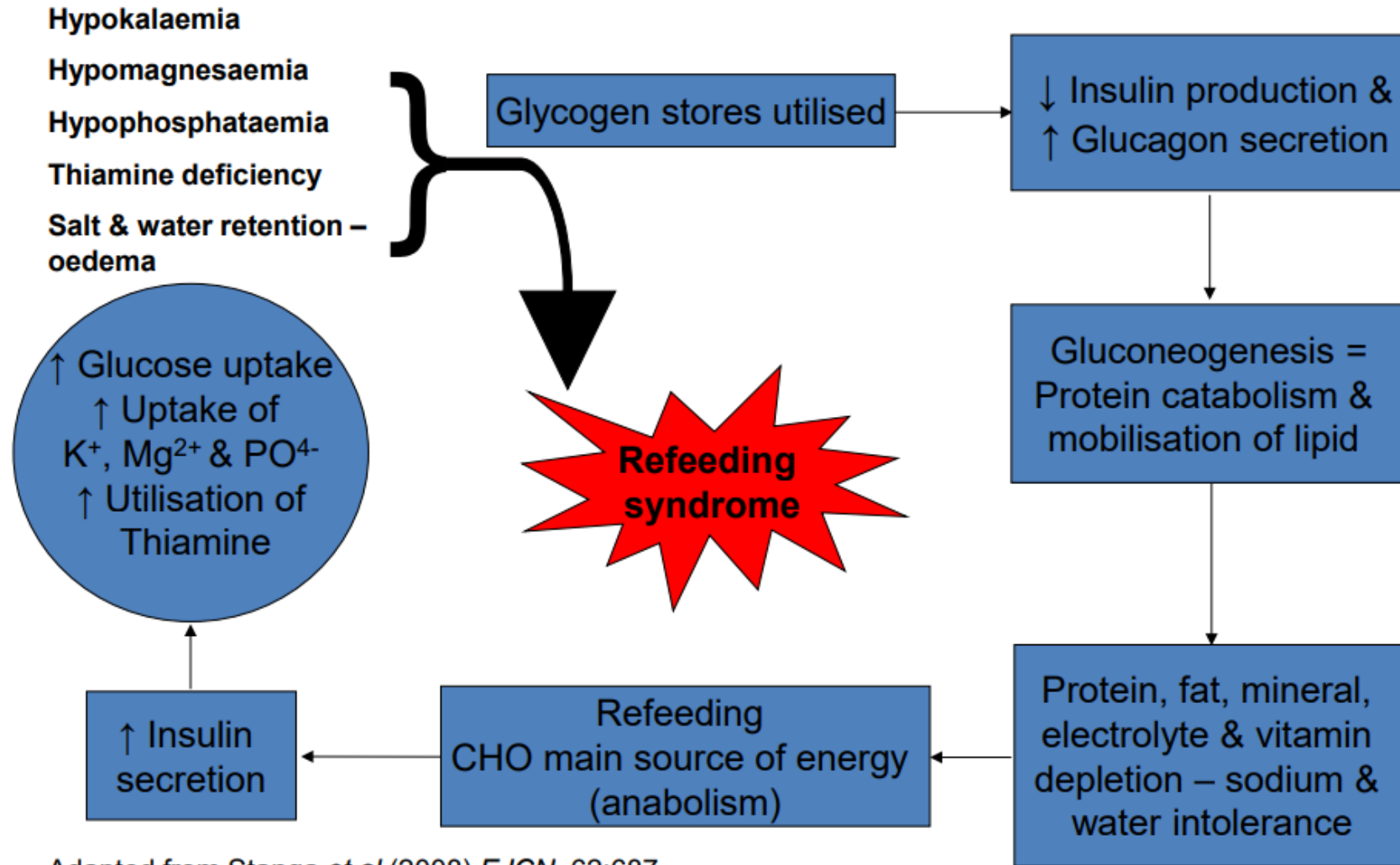
- Refeeding and underfeeding
- NGT feeding
- NGT feeding under restraint

# Refeeding syndrome

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**The change in the body's metabolism from the starved state (catabolic) to the fed state can cause:**

- Sudden release of insulin
- Shift in electrolytes
  - Low blood levels of Phosphate, Magnesium, Potassium and Calcium
- Muscle weakness
- Neurological changes: Confusion / Seizures / Fits
- Cardiac abnormalities: abnormal heart rate, rhythm and ultimately cardiac arrest
- Deranged fluid balance e.g. puffy ankles
- Associated with significant morbidity and mortality
- Can be seen regardless of the route of nutrition: oral diet, NGT or TPN



Adapted from Stanga *et al* (2008) *EJCN*, 62:687

# Refeeding in hospital

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Refeeding syndrome is RARE

The majority of patients will be managed safely in the community.

If RED risks identified from MEED – discuss with Paediatrics (admission not always needed though)

Good working relationships with local Paediatrics is key – if not in place already, try to establish:

- Identify a nominated Paediatrician – can lead to less admissions!
- Local admission pathway
- Emergency admission meal plans
- Skilling up paediatric nurses re meal support (not just RMNs) – empower parents to do meal support
- CYP-ED team in-reach

# Refeeding

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**Restoring regular eating and weight gain is the most effective treatment for the cardiac abnormalities seen in underweight patients.**

**HIGH RISK PATIENTS WHO MAY NEED MEDICAL STABILISATION:**

## Full risk assessment – MEED

- Rapid weight loss >1kg/week
  - Acute onset = no physical adaptation
- Severe malnutrition <70%*m*BMI
- Abnormal electrolytes
- Low white blood cell count - <3.5 x 10<sup>9</sup>/l
  - But if raised CRP (infection) this is not reliable

# Refeeding – monitoring

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## **Refeeding bloods:**

- U&E's, LFTs, Ca, Mg, PO<sub>4</sub>
- Day 1, 3, and 7 unless indication to do more frequently

## **Physical health observations:**

- BP, pulse, temperature
- Weight (monitor for fluid retention)
- ECG – repeat if abnormal

## **Nutritional supplementation**

- Correct any abnormal biochemistry
- Prophylactic supplementation - evidence unclear
  - Can consider Thiamine 200mg daily for first 14 days

If refeeding syndrome is suspected, do not continue with calorie increase until stabilised – DO NOT REDUCE INTAKE

# Refeeding v's underfeeding

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## Avoid underfeeding' syndrome

- when weight loss while inpatient due to inadequate caloric input to support rapid weight gain and medical stabilization
- Underfeeding leads to further medical instability
- It often occurs because the clinician is afraid of complications associated with the refeeding syndrome.
- Failure to adequately feed the patient can be fatal.





# Refeeding meal plans

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Research suggests that for those at HIGH risk and require a Paediatric admission:

- It is ok to start at 1,400kcal/day, increasing by 200kcal/day if biochemistry stable (U&E's, LFT's, Ca, Mg, PO<sub>4</sub>).
  - Can be 'portioned plans' ½, ¾ to full portions etc...
  - Anticipatory anxiety will always be high
- Global trend is towards higher starting calories
- Ensure that 'underfeeding' does not happen

Majority of patients will not require a Paediatric admission and therefore it is safe to start on 1,500kcal/day or 2,000kcal/day meal plan

- Ensure it is never less than current intake

# Refeeding meal plans

## Top tips

- 2 copies one for patient (no calories) one for nursing team
- Do NOT talk about calories to the patient
- Do NOT comment on the food 'that looks nice' 'you must have been hungry'
- 'Food is medicine'
- Accurate food record charts are really important
- Minimal negotiation – 3 pre-illness dislikes (not whole food groups)
- Distraction techniques helpful
- Bathroom before meal/snack
- Clear guidelines on time to eat
  - 30mins main /10mins snack

Day 1	Meal ideas and Nutritional Supplements
<b>Breakfast</b> 200kcal	1 cup cereal (40g) + 1 cup milk (200mls) or Slice of toast with spread and topping or 135mls Nutritional Supplement ( 1.5kcal/ml)
<b>Mid Morning</b> 200kcal	Biscuits x 2 or cereal bar and glass of milk (200mls) or Large pot of full fat yogurt or 135mls Nutritional Supplement ( 1.5kcal/ml)
<b>Lunch</b> 200kcal	½ sandwich with filling (with spread) Or ½ jacket potato and filling or ½ tin of soup with 1 x bread (with spread) or 135mls Nutritional Supplement ( 1.5kcal/ml)
<b>Mid afternoon</b> 200kcal	Biscuits x 2 or cereal bar and a glass milk (200mls) or Larger pot of full fat yogurt or 135mls Nutritional Supplement ( 1.5kcal/ml)
<b>Evening meal</b> 200kcal	½ carbohydrate measure, ½ protein measure and small amount of vegetables or 135mls Nutritional Supplement (1.5kcal/ml)
<b>Supper</b> 200kcal	1 cup cereal (40g) or 1 cup milk (200mls) or slice of toast with spread and topping or 135mls Nutritional Supplement ( 1.5kcal/ml)
<b>Total</b>	1200 Kcal

# NGT feeding

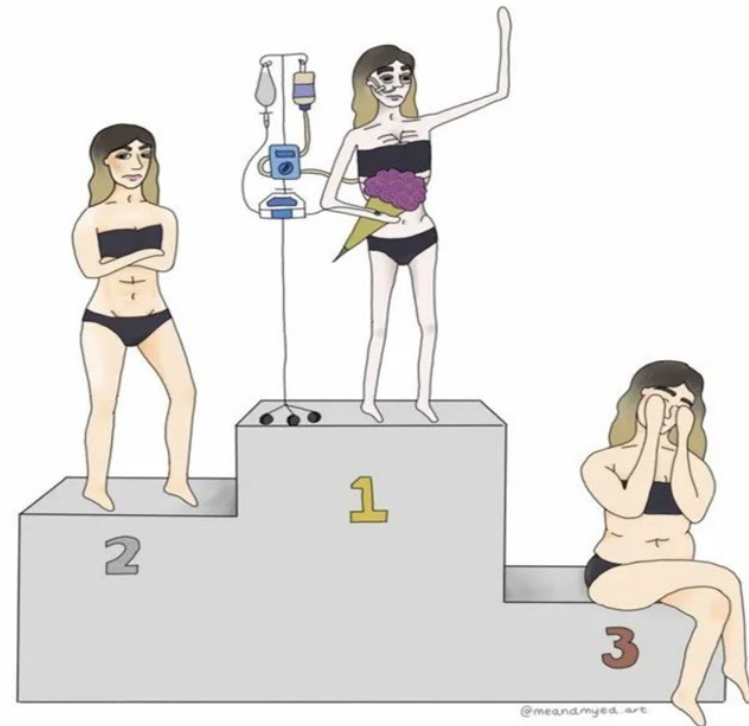
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Be cautious in starting, needs long discussion with the patient – especially those with ASD and emotional dysregulation

Can help promote weight gain/physical health restoration and reverse starved state to transition to oral diet

Understand MHA 'least restrictive practice' considerations

Hindley, K., Fenton, C. & McIntosh, J. A systematic review of enteral feeding by nasogastric tube in young people with eating disorders. *J Eat Disord* 9, 90 (2021). <https://doi.org/10.1186/s40337-021-00445-1>



# NGT feeding under physical restraint

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Don't back people into a corner

BUT can save someone's life – identify your exit strategy

Guidance available:

- Dietetic practice
- Fuller, S. J., et al. "The development of consensus-based guidelines for dietetic practice in nasogastric tube feeding under restraint for patients with anorexia nervosa using a modified Delphi process." *Journal of Human Nutrition and Dietetics* 33.3 (2020): 287-294.
- Legal & ethical
- Fuller, S., Chapman, S., Cave, E., Druce-Perkins, J., Daniels, P., & Tan, J. (2022). Nasogastric tube feeding under physical restraint on paediatric wards: Ethical, legal and practical considerations regarding this lifesaving intervention. *BJPsych Bulletin*, 1-6. doi:10.1192/bjb.2022.11
- Nursing practice
- Out soon!



# NGT feeding under restraint

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- Requires detention under the MHA
- Only staff who are trained in restraint practices can facilitate this
- Therefore the principle of least restrictive practice applies and standard paediatric NGT feeding protocols need to be adapted
- Top tips:
  - 2 bolus feeds a day
  - Push syringe bolus
  - Start at 500ml per bolus and is safe to go up to 1,000ml/bolus
  - Higher Fr NGT will aid the passing of enteral feed
  - Use 'compact' sip feeds, and products as calogen or 5cal to minimise volume of feed
  - Can thin this mix slightly with water
  - 1,000ml can safely be delivered in ~10mins
  - Always have an exit strategy