

Anorexia Nervosa/Eating Disorders - Summary Clinical Guideline

Reference no.: CG-T/2012/153

Anorexia nervosa has one of the highest mortalities of any psychiatric condition. Patients may be admitted to Royal Derby Hospital as a result of other problems, e.g. trauma, pneumonia, or as a result of severe malnutrition

On admission to RDH

- 1) Refer all patients to Ward Dietitian. This includes patients with known Eating Disorder admitted via ED / MAU and patients admitted with other problems, e.g. trauma, pneumonia
- 2) Refer to nutrition team consultant (gastroenterology consultant)
- 3) Undertake risk assessment: how ill is the patient?

Appropriate Ward

- Where patients are admitted for feeding/medical treatment of malnutrition this should be to ward 305
- Where patients are admitted for other reasons, e.g. trauma, pneumonia, initial care may be provided on specialist ward. Consideration should be given to subsequently moving patient to ward 305 at the discretion of the nutrition consultant when the condition has stabilised.

Risk Assessment

Weight and Body mass index: weight/height^2 (kg/m^2)

- Anorexia <17.5 , medium risk 13–15, high risk <13

Physical examination

- low pulse, blood pressure and core temperature
- muscle power reduced
- Sit up–Squat–Stand (SUSS) test

2. Sit-up: patient lies down flat on the floor and sits up without, if possible, using their hands.

3. Squat–Stand: patient squats down and rises without, if possible, using their hands. Scoring (for Sit-up and Squat–Stand tests separately)

0: Unable, 1: Able only using hands to help 2: Able with noticeable difficulty 3: Able with no difficulty

Baseline Investigations

- FBC
- Urea and electrolytes/ LFTs
- Phosphate, calcium, magnesium, albumin, CRP
- Glucose (by BM stix and/or laboratory method)
- Zinc, copper, selenium
- Iron profile, vitamin B12 and folate
- Vitamin A/D/E and carotene
- Thyroid function
- ECG

Daily Investigations

- U+Es, phosphate, calcium, magnesium – daily for 1 week,
- Glucose by BM stix before main meals

Correcting electrolyte abnormalities

Do NOT stop feeding patient when electrolyte abnormalities occur

Hypokalaemia

Oral (Potassium 2.5-3.5 mmol/L) Sando-K 2 tablets tds

Intravenous (Potassium <2.5 mmol/L or not responding to oral)

Potassium chloride 20–40 mmol in sodium chloride 0.9% 500–1000 ml, as required. Typically 60-100 mmol/24 hours

Hypophosphataemia

Oral (Phosphate 0.50 – 0.32 mmol/L) Phosphate-Sandoz 2 tablets tds

Intravenous (Phosphate <0.32 mmol/L, or falling rapidly, or not improving with oral) Phosphates

Polyfusor 500ml (50mmol) over 12 hours

If renal impairment will need lower doses (e.g. 10 mmol bolus over 12 hours)

Hypomagnesaemia

Oral (Magnesium 0.70 – 0.50 mmol/L) Maalox® suspension 10ml qds

Intravenous (magnesium <0.5 mmol/L or not improving with oral)

20 mmol MgSO₄ in 500 ml 5% dextrose over saline over 24 hours If Mg<0.40 mmol/l. ECG monitoring must be available

Hypocalcaemia

Calcichew®, 1–3 tablets daily, or equivalent

Calcium gluconate injection (10%) 10 ml (if Ca<1.8 mmol/l)

Nursing assessment and care formulation

- Bed rest
- Fluids: closely monitor fluid intake as patients may drink large amounts of fluid causing fluid overload and electrolyte disturbances
- Supervised showers and washes: owing to patients compromised physical state to monitor for abnormal behaviours
- Supervised toilet visits: owing to patients compromised physical state and to monitor for abnormal behaviours
- Meals: patients encouraged to take appropriate diet as advised by the dietician and to supplement oral nutrition using nasogastric feeding if necessary
- Leave: no ward leave permitted
- Physical observations: patient are vulnerable to hypothermia and hypoglycaemia; as well as carrying out physical observations ensure room is kept warm
- Staff should ensure that if there are more than one patient with anorexia on the ward, they should not be placed in the same bay
- Avoid placing patients in side rooms, unless 1:1 supervision is available

Discharge or transfer to SEDU

- No patient with an Eating Disorder should be discharged from RDH without discussion with Nutrition Team Consultant
- Should not be discharged simply because one risk factor (e.g. low potassium) has improved, but others (e.g. low BMI) remain