7: Summary sheet for paediatricians

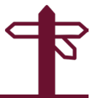
Who is this for?

Paediatricians in emergency departments and paediatric wards assessing and managing children or young people with severe eating disorders.

a. Risk assessment

Patients with eating disorders can appear well even though severely malnourished. The patient may falsify their weight and over-exercise. Consult the risk assessment tool (Chapter 2) and use measures that seem relevant to the patient you are assessing. Consult parents/carers to obtain more information about symptoms and behaviours. Common risks relate to daily intake, rapid weight loss, low weight, electrolyte imbalance and self-harm. In the emergency department, consult a psychiatrist or eating disorders clinician, especially before discharging a patient.

See Chapter 2 and Appendix 3



b. Location of care

The patient may be referred because of malnutrition or low potassium. However, for a severely ill patient with an eating disorder, a brief admission to a paediatric ward is usually appropriate followed by community treatment by a specialist eating disorders service. The support of an eating disorders specialist in person or online should be obtained urgently.

See Chapter 3

c. Safe refeeding

For most underweight patients with eating disorders, feeding can start between 1,400 and 2,000 kcal per day, rising by at least 200 kcal per day until weight gain is achieved. Advice on managing nasogastric feeding is provided. For most, this begins in hospital, accompanied by a plan to transition to oral food, usually with parental support, as soon as possible. The possibility of refeeding syndrome (e.g. falling phosphate) should be borne in mind and for some patients with coexisting medical illness lower rates of refeeding may be appropriate, in which case underfeeding syndrome with weight loss must be avoided.

See Chapters 4 and 5

d. Behavioural manifestations of eating disorders

Challenging weight losing behaviours such as exercising, hiding food or falsifying weight is difficult in a busy paediatric setting. Recruit a nurse with experience in eating disorders.

Write a management plan for sharing among ward staff. Consult an eating disorder specialist.

See Chapter 6

e. Families and carers

Parents should be seen as an integral part of the management team. Difficulties can arise when there is high anxiety, dissatisfaction with treatment and multiple clinical opinions. To pre-empt problems, invite parents to meetings to be included in decisions, and answer questions. Agree to second opinions arranged by the hospital in the normal way.

See Chapter 7

f. Compulsory admission and treatment

Preventing a patient leaving hospital and imposing treatment are closely controlled activities. Certain types of nurse (see Chapter 8) may prevent a patient leaving hospital for up to 6 hours while a medical opinion is obtained. The doctor in charge can prevent a patient leaving the ward for up to 72 hours while mental health legislation is considered. Before this situation occurs, check what you are allowed to do and if it seems likely, contact a psychiatrist as soon as possible. In the emergency department, a way to prevent a patient from leaving is by using the Mental Capacity Act, but this would be extremely rare. For children, parental consent can potentially be used to enforce treatment, but this is rarely done nowadays and the Mental Health Act or equivalent is preferred.

See Chapter 8

g. Diabetes mellitus type 1

Diabetes complicates the management of any eating disorder. The patient might avoid insulin to promote weight loss and this can lead to failure of diabetic control. In the long term, increased severity of diabetic complications can occur. Reintroduction of insulin can cause electrolyte shifts (especially potassium) and insulin should only be administered under supervision. The diabetes team should guide management, working closely with psychiatrists.

See Chapter 9 and Annexe 3