Pearls and Pitfalls in the Diagnosis and Treatment of Eating Disorders

1. **Misinterpreting weight** – The majority of individuals with eating disorders (EDs) are normal weight or higher. Low weight is seen only in individuals with Anorexia Nervosa (AN) which is the least common ED. AN has a lifetime prevalence of 0.5-1% whereas Bulimia Nervosa (BN) and Binge Eating Disorder (BED) are seen in 2-3% and 5-10% of the general population respectively.

2. **Misinterpreting labs, vitals and ECG** – Labs, vital signs and ECG can all be "normal" even in a seriously ill individual with an ED. In fact, in the absence of purging behavior, normal findings are the rule rather than the exception in ED patients due to the body's incredible capacity to adjust to chronic malnutrition in order to maintain homeostasis and vital organ function. Intracellular depletion can be profound even in the presence of normal extracellular, or serum, components such as potassium, magnesium, phosphorus.

3. **Misinterpreting abnormal labs** – When laboratory abnormalities do occur in ED patients they are usually related to purging behaviors. Hypokalemia is most common. Even mildly low potassium (3-3.4mEq/L) can indicate significant total body depletion and require more supplementation than is usually needed to correct. In addition, if the patient does not cease purging they will continue to lose electrolytes despite supplementation. Consider hospitalization in anyone with ongoing purging behaviors and electrolyte abnormalities.

4. **Misinterpreting bradycardia** – Bradycardia is a physiologic response to starvation and, despite popular belief, is **not** normal even in conditioned athletes. This is especially true when bradycardia is severe (<50bpm). Misinterpreting bradycardia as being an indicator of fitness minimizes the seriousness of this finding and reinforces the individual's belief that they are not ill.

5. **Treating secondary amenorrhea** – Do not treat with OCPs in someone with an ED. First line treatment is restoration of nutrition. Amenorrhea in these patients is most often due to disruption of the hypothalamic-pituitary axis which is not corrected with OCP treatment. Regular menses induced by OCPs be misinterpreted by both patients and caregivers as indicating that "all is well" when in fact these individuals are still at significant risk of bone mineral density loss, infertility and other complications of ED.

6. **Overlooking EDs in groups traditionally thought not to be at risk** – EDs occur in all races/ethnicities with rates equal to that of Caucasians. They are also seen in all genders and in people of all ages.

7. **Encouraging weight loss or prescribing diets** – Traditional restrictive "diets" are absolutely **contraindicated** in individuals with EDs regardless of their weight. Dieting is quite often an inciting factor in the development of an ED and often triggers worsening of ED symptoms in someone already struggling.

sdh 10/18