Protocolized Interdisciplinary Behavioral Management of Medically Decompensated Eating Disorder Patients on a C-L Service Can Reduce Length of Stay

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Background

Medically decompensated eating disorder patients are often challenging to manage on a consultation-liaison psychiatry service due to the lack of a specialized milieu and limited training of medical staff. Meeting the medical clearance criteria necessary for psychiatric admission can become unnecessarily prolonged and lead to delays in initiating formal treatment. While specialized eating disorder units have implemented structured behavioral care plans geared toward rapid weight restoration[1], this is not yet considered the standard of care in medical/surgical settings. We describe the case of a difficult eating disordered patient who was highly resistant to refeeding, but did ultimately respond to a rigorous interdisciplinary behavioral protocol. The patient achieved medical clearance for transfer to an inpatient psychiatric unit within a shorter time frame than is typical for such patients on our service, did not require tube feeding, and did not experience refeeding syndrome.

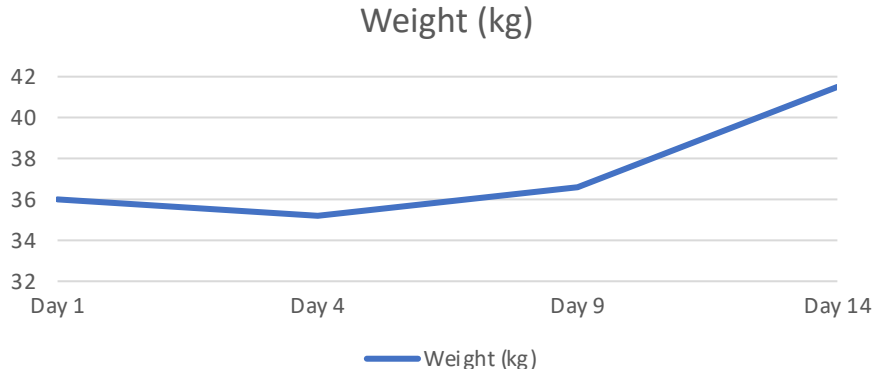
Objectives

- To refeed and medically stabilize eating disorder patients in a safe but timely fashion, thus expediting transfer from the general hospital setting to inpatient psychiatry for further treatment
- To reduce length of stay for eating disorder patients in the general hospital setting
- To standardize treatment and facilitate improved interdisciplinary communication between all team members and services involved in the care of eating disorder patients in the general hospital setting

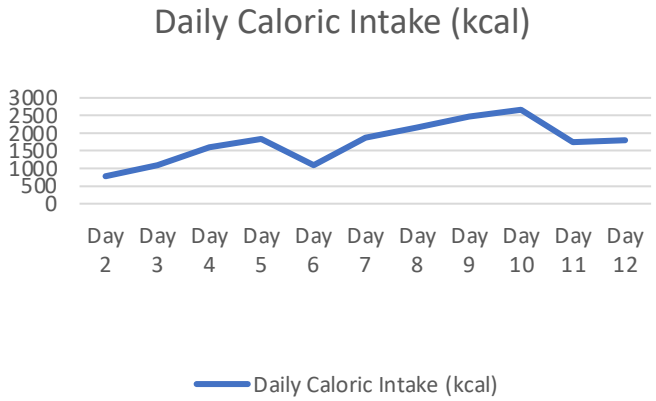
Case

- R.Q. is a 27-year-old woman whose family brought her to the hospital for severe weight loss due to anorexia nervosa. Her BMI on admission was 12.4 and her labs were notable for transaminitis. Upon consultation, we instituted a behavioral care plan (based on those used on inpatient psychiatric eating disorder units) with initial restrictions in place including 1:1 observation, limitation of exercise, and strict meal times. The protocol involved a "reward" system with successive privilege levels in which restrictions would be incrementally loosened based on the patient's meal consumption. Conversely, failure to meet caloric parameters would result in initiation of nasogastric tube feeding.
- We explained and distributed this plan to the patient and family, primary team, nursing, and nutrition services. The patient was ultimately able to meet medical clearance criteria for psychiatric admission with no need for tube feeding. Refeeding syndrome did not occur. Her medical length of stay was 14 days (compared to an average of 20.7 days for other similar patients on our C-L service).

Results



Results (cont.'d)



On Day 6, the patient received a reminder that failure to meet daily caloric requirements would result in initiation of tube feeding.

Conclusion

We propose that C-L services consider more broadly implementing interdisciplinary, regimented behavioral care plans akin to those used on psychiatric eating disorder units. This may help ensure that such patients receive the psychiatric standard of care while simultaneously reducing length of stay and time to medical clearance.

1 Redgrave GW, Coughlin JW, Schreyer CC, et al. (2015). Refeeding and Weight Restoration Outcomes in Anorexia Nervosa: Challenging Current Guidelines. *Int J Eat Disord*, 48(7), 866-873.