The challenges of managing pregnant women with anorexia nervosa during prolonged obstetrical hospitalizations: a case report

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Background

- The prevalence of anorexia nervosa (AN) increases in women of childbearing age and relapse may be triggered during pregnancy.
- Women with AN are at an increased risk of complications for mother and child including pre-eclampsia, preterm birth, growth restriction, postpartum depression, and perinatal mortality.
- Early identification of AN in pregnancy may be difficult as many women do not disclose this history to their obstetrician which may make inpatient stabilization outside of a specialized unit difficult (Kimmel 2016; Arnold 2019).

Case

HPI: 37 yo G3P2 at 28w4d with AN (BMI ~ 15) who presented by emergent medevac from western Africa after prenatal ultrasound revealed complete placenta previa, accreta, and intrauterine growth restriction (9%) and for concerns for worsening AN. She had received limited care while abroad, in part due to delay in detecting the pregnancy due to baseline amenorrhea.

Past Psych History

- Dx: Anorexia (restrictive & purging type), MDD, unspecified anxiety
  - H/o depression & anorexia exacerbated during pregnancy
- No prior psychiatric hospitalizations or suicide attempts
- Prior history of superficial cutting, distant
- Previously received CBT for anorexia & medication management briefly
- Currently on fluoxetine 20mg, no prior known medication trials

Pertinent Social History

- B/R near Washington, DC to intact union
- Masters degree in teaching
- Married, 3 children
- Lives with husband/family in Western Africa, working as missionaries.

Pre-arrival

- **Presents to hospital abroad for vaginal bleeding**
- US: Concern for placental abruption/low-lying placenta
- Given dexamethasone x 1
- Decision to Medivac to USA

Day 1

- **Admitted to IFH OB @ 29w6d**
- Vaginal bleeding stopped
- Labs: **COVID-19+**, Mild anemia (H/H 9.9/28.8), BMP WNL
- VSS
- US: +Complete placenta previa with acreta, IUGR
- **BMI 15 (patient report)**
- Droplet precautions
- PICC line placed
- Nutrition consulted
- Planned admission until 34 wks

Day 3

- **Psych consult placed for AN management & attempted but patient declined today** (wants to talk to family over phone)
- No phone number listed for husband for collateral
- Recs:
  - Vitamin B12 & D and folate levels, TSH
  - Monitor for refeeding syndrome
  - Calorie counts

Day 4

- **Psych consult completed**
- **+Restricting**, only wants cheesecake
- Feels she is "coping well" with the hospitalization
- Affect bright, I/J Poor, Frail
- **B12 <150**, TSH, Vit D WNL
- Recs:
  - EKG, IV high dose thiamine, B12 repletion, MVM
  - Strict calorie counts & blind weights
  - Continue home fluoxetine
  - 1:1 before/after meals

Day 8

- Blind weights ~83 lbs, **True BMI ~14**
- **Poor staff supervision** of food intake & calorie counts d/t droplet precautions
- Psych able to reach husband, concerned, flying back to the US
- **Patient refuses TPN**
- Intermittent vaginal bleeding re-starts, H/H stable
- Frustration shared from team & staff
- Inc. direct educational re: tips for working with pt with anorexia

Day 10

- MFM rec's **delay of delivery to 35+ wks**
- Patient unhappy, wants to see husband & kids sooner
- Patient agrees to TPN but **request "holiday" from calorie counts** first
- Interdisciplinary meeting held, team expresses fear of working with patient with severe anorexia
- Behavioral plan disseminated to OB staff

Day 11

- **Rushed to OR for severe vaginal bleeding**
- STAT cesarean & hysterectomy
- Received 4 U PRBCs + 4 FFP with ESBL 1.8 L
- Post-op **transferred to TICU**, intubated

Day 12

- **Extubated & still refusing TPN**, says she "**want(s) to eat**"
- Baby in NICU
- **BMI < 14**, no electrolyte or EKG abnormalities, improving anemia
- Re-education to TICU staff on behavioral management
- 2nd Interdisciplinary meeting, discuss transfer to eating disorders inpatient psych offsite

Day 14

- Transferred **back to OB service**
- **Refusing inpatient & outpatient eating disorders programs**
- **Refusing TPN**
- Wants to pursue **individual psychotherapy / psychiatry outpatient**
- Wants to leave, medically clear, family supportive of decision

Day 15

- Discharged to home with extensive counseling on risks to patient/family and referrals to eating disorders specialists

Discussion

- American College of Obstetrics and Gynecology recommends a team approach that is multidisciplinary including providers from Ob/Gyn, psychiatry and neonatology (ACOG 2018).
- Usual care for AN is often siloed within structured specialty psychiatric clinics and, if severe, specialized medical inpatient settings.
- With this case, there were opportunities to liaison with OB Teams/IM Medical floors, and CL Psychiatry, with psychoeducation, medical management along with nursing strategies all needing to be shared to highlight the different perspectives towards management of severe AN.
- There are limited guidelines on management of pregnant women with AN during prolonged medical hospitalizations (Wolfe 2016; Dinas 2008).

Conclusions

Further guidelines on the management of pregnant patients with AN during prolonged obstetrical stays is needed outside of a specialized eating disordered unit. While early identification of AN in pregnancy would be ideal, this is often not screened during routine perinatal visits and may be missed until complications already arise.

References

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