“Isn’t She Too Old for Treatment?”:

Challenges in the Management of Anorexia Nervosa in an Elderly Patient in the General Hospital

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BACKGROUND

Eating disorders (ED) are complex conditions affecting individuals across their lifespan and are associated with significant medical and psychiatric comorbidity. ED in some patients fall under the sparsely-studied category of Severe and enduring eating disorder (SE-ED), and even less is known about these disorders in older-aged patients.

OBJECTIVES

1. Review a case of a complex eating disorder presentation in an older patient
2. Understand one general hospital’s approach to managing complex eating disorder presentations
3. Appreciate management approaches for patients with SE-ED

CASE

ID: 68 yo female; beta thalassemia trait, cold agglutinin hemolytic anemia, stress cardiomyopathy, L hip fracture

Initial Vital Signs:
T 37C HR 63 BP 70/P RR 12 SpO2 100% RA Wt 63.7lb

HPI:
- Patient found down in the community, passers-by called EMS
- Hypotensive on evaluation by EMS
- Brought to ED, admitted for severe malnutrition
- History of previous inpatient admissions for chronic malnutrition, but not eating disorder (ED) per se

Hospital Course:
- C-L Psychiatry initially consulted to assess decision making capacity as patient wanted to leave AMA; lacked capacity and remained in hospital
- Eating disorder protocol was initiated
- Met criteria for anorexia nervosa, restricting type, extreme. No evidence of co-occurring affective, anxiety, obsessive-compulsive, psychotic, neurocognitive, personality disorders
- Patient monitored for re-feeding syndrome and progressive weight gain; C-L met with patient at least weekly; C-L team led multidisciplinary meetings
- Monitored for re-feeding syndrome; 27-lb weight gain over several-week stay.

Disposition:
- Patient discharged to an inpatient, ED treatment program
- In decades long history of disordered eating, this was her first known admission to an ED specific program

Follow-up:
- Patient remained at the program for several weeks
- Eventually, she signed a three-day notice and was discharged to home
- Aftercare plan included follow-up with patient’s PCP

FIGURES

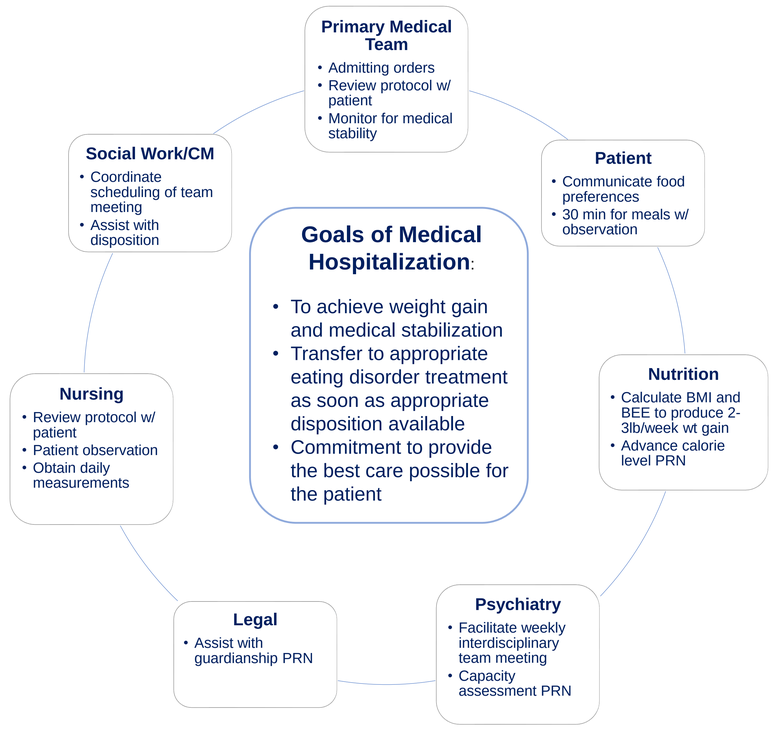

Figure 1. A multidisciplinary approach for management of medically unstable eating disorder patients in the general hospital. Adapted from the Beth Israel Deaconess Medical Center (BIDMC) multidisciplinary guideline. “Medically unstable” is defined as: electrolyte abnormality, arrythmia/prolonged QTc, pulse<40, temp<97F, BP<90/60, orthostatic changes in pulse or BP>20, weight<75% IBW, hypo/hyperglycemia in pt w/ DM, or other medical complication. BMI, body mass index. BEE, basal energy expenditure.

Total no. consults 2022-2023	3128
No. consults containing an eating disorder (ED)	**92**
No. ED consults containing anorexia nervosa (AN) diagnoses (AN unspecified, AN restrictive type, AN binge-purge type)	**42**
No. of patients diagnosed with AN who were 60 years or older	**2**
Median age in years of patients seen in consultation with diagnosis of AN	**30**
Mode age in years of patients seen in consultation with diagnosis of AN	**20**

Table 1. Consultation data from Beth Israel Deaconess Medical Center (BIDMC) 2022-2023. Of the 3128 consults placed in 2022-2023, 1.3% involved a diagnosis of anorexia nervosa (AN).

DISCUSSION

- This patient’s presentation is consistent with a severe and enduring eating disorder (SE-ED)
- About 20% of cases can progress to severe and enduring status
- Patients with SE-ED often experience cycles of weight restoration and weight loss
- Prevalence of late-life ED range 1.8% - 3.8%
- Most common ED across aging is binge eating disorder
- Late-life ED categorized as early onset (recurring) or late onset (first occurrence in late-life)
- **Management**
  - Inpatient treatment programs: CBT based; more effective at short-term reduction of sxs than long-term
  - Outpatient and day programs: longer term sx reduction, may be more effective at increasing motivation for recovery
  - Brain stimulation (rTMS and DBS): improvements in depression sx
  - Several medications have been studied:
    - *Dronabinol*, small improvements in weight gain, no significant improvements in eating disorder sx overall
    - *Olanzapine,* shown to lead to significant increases in weight
    - *Ketamine,* contributed to improvement in compulsive behaviors for some, weight gain was variable
    - One case study showed decreased binge-purge behaviors after starting *duloxetine*
- Ethical and legal considerations in the treatment of SE-ED are manifold; commitment, guardianship pursual, harm reduction, palliative approach, and medical futility.

CONCLUSIONS

- Although rarely encountered in older patients, SE-ED may become more common as our population ages
- A multidisciplinary approach is key in achieving medical stability for these patients
- Treatment approaches are varied with differing degrees of efficacy; evidence is scant overall

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Neither Dr. Donaghey nor Dr. Leo have any financial relationships or conflicts of interest to disclose.