Perinatal Eating Disorders

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Perinatal Eating Disorders

Prevalence:
The perinatal period carries increased risk for development of new eating disordered behaviors or recurrence of illness previously in remission. Rates in pregnancy: 0.6-11.5% Rates postpartum: Up to 12.8%

Risk factors:
· Personal or family history of eating disorders
· Psychiatric comorbidities
· Trauma history
· LGBTQ

Screening: Personal history of eating disorder (ED) is biggest risk factor for ED symptoms in pregnancy. Early screening recommended. Include standardized ED screener at intake, such as Eating Disorder Screen for Primary Care:
1. Are you satisfied with your eating patterns?
2. Do you ever eat in secret?
3. Does your weight affect the way you feel about yourself?
4. Have any members of your family suffered with an eating disorder?
5. Do you currently suffer with or have you ever suffered in the past with an eating disorder?

"No" to q1 = abnormal
"Yes" to q2-5 = abnormal
2 abnormal answers = positive screen. Further follow up recommended

Differential:
Anorexia nervosa (AN)
Bulimia nervosa (BN)
Binge eating disorder (BED)
Avoidant Restrictive Food Intake Disorder (ARFID)
Other Specified Feeding & Eating Disorder—includes atypical anorexia
Appetite changes secondary to depression
Hyperemesis gravidarum

Assess Symptoms: Frequency, duration, intensity
Restriction—Skipping meals/snacks? Portion sizes? Are others concerned about intake? Limiting types of food? Eating the same thing every day?
Bingeing—Frequency, amount, eating in secret?
Purging—Vomiting, laxatives, diuretics, diet pills, exercise?

Interventions: Depend on severity of illness, medical stability, psychiatric comorbidities, ability to modify behavior independently. Multidisciplinary collaboration is important.
· Referrals to registered dietitian with ED expertise, therapy, psychiatry
If medical complications of ED or interference with functioning, consider referral to a higher level of care
· Blinded weights with a focus on baby's growth rather than weight gain
· Meal plan with frequent meals throughout the day—even for individuals whose primary ED behavior is identified as bingeing and/or purging, restriction is often a part of this cycle
· Treat psychiatric comorbidities—depression, anxiety, OCD

Medical complications: Thorough screen for medical complications
AN/Atypical AN/ARFID: Organ dysfunction related to malnourishment
BN: Complications of purging, electrolyte abnormalities

Pregnancy Complications:
AN: hyperemesis, antepartum hemorrhage, preterm birth, microcephaly, SGA
BN: hyperemesis**,** preterm birth, microcephaly
BED: tobacco use, maternal hypertension, need for c-section, higher gestational weight for age
All: ↑ risk of postpartum depression & anxiety

Birth control and infertility:
· Patients with EDs are at increased risk of unplanned pregnancy. Patients with amenorrhea/ oligomenorrhea patients may still be ovulating.
· There are increased rates of EDs in individuals seeking infertility treatment. Consider screening.

Perinatal Eating Disorder Resources

Patient resources:

National Eating Disorder Association:

https://www.nationaleatingdisorders.org/pregnancy-and-eating-disorders

Further reading:

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