

Guidelines for the MEDICAL management of eating disorders

CONE HEALTH PEDIATRICS
Updated February 2022

WHO SHOULD BE ADMITTED FOR MEDICAL STABILIZATION

These guidelines apply to all inpatients up to age 19 admitted for a new or previously diagnosed eating disorder diagnosis (see definition below) under the Pediatric Teaching Service.

When to admit to Inpatient Pediatric Unit

NOTE: Most eating disorder patients can be managed as outpatients. It is highly encouraged that referring outpatient physicians consult with adolescent specialist, to determine whether their patient is appropriate for inpatient care

Consider medical stabilization admission if any ONE of the following:

- 1) Refusal to eat and drink resulting in clinical dehydration and/or electrolyte imbalance
 - a. Hypokalemia <3.0 mmol/L
- 2) Need for cardiac monitoring
 - a. Heart rate <45 beats per minute during daytime or <40 bpm during nighttime
 - b. Orthostasis **with symptoms**: pulse up by ≥ 30 beats per min or systolic BP down by ≥ 20 mm Hg *note these values are different than standard definition of orthostasis
 - c. Syncope
 - d. Prolonged QTc ≥ 0.45
- 3) Acute medical complications of malnutrition, purging, or food refusal: e.g. esophageal tears/hematemesis, seizure, cardiac failure, pancreatitis
- 4) Temp < 35.5 C (96 F),
- 5) <70 %median BMI (also known as ideal body weight)¹ (because of increased risk of refeeding syndrome)
- 6) Rapid weight loss of $>15\%$ of body weight
- 7) BUN/Cr ratio over 35

Consider PICU admission when the following is present:

- 1) QTc \geq 0.5
- 2) Cardiac arrhythmia other than sinus bradycardia
- 3) Altered neurological status
- 4) Persistently low heart rate (<40 bpm) not responsive to warming or oral nutrition

A dedicated eating disorders unit admission is more appropriate when the following is present:

- 1) Ongoing weight loss despite intensive outpatient management
- 2) Not eating but drinking fluids and not dehydrated, with no medical criteria met

Admission to the medical unit is not a substitute for admission to an inpatient psychiatric unit when the latter is more appropriate.

For the purposes of this policy, **eating disorder** is characterized by at least ONE of the following:

- Significant low body weight compared with % median BMI (also referred to as ideal body weight/IBW¹)
- Unreasonable weight control methods (restriction of food intake or excessive use of laxatives, diet pills, exercise, etc.)
- Distorted body image
- intense fear of gaining weight or becoming fat, even though underweight
- NOTE that many patients who meet this definition of an eating disorder will not meet inpatient criteria (see “when to admit” above) and can be managed in a different venue

For the purposes of this policy, **refeeding syndrome** is defined as metabolic and physiologic consequences from feeding a chronically malnourished patient that include (but not limited to):

- decreases in potassium, magnesium, and phosphorus
- glucose and fluid intolerance
- cardiac, pulmonary, hematologic, and/or neuromuscular dysfunction
- Major risk factors for refeeding: BMI < 16 kg/m², unintentional weight loss >15% in past 3 months, minimal to no nutrient intake >10 days, baseline low levels of potassium, phosphate, magnesium
- Minor risk factors for refeeding: BMI < 18.5 kg/m², unintentional weight loss >10% in past 3 months, minimal to no nutrient intake >5 days, history of alcohol, insulin, chemotherapy, antacid, or diuretic misuse

INTENDED USERS

A multidisciplinary approach is a fundamental part of the treatment plan. Intended users include but are not limited to:

1. Pediatric Teaching Service Physician and Resident Physicians
2. Pediatric Psychology and/or Psychiatry
3. Registered Dietitian
4. Nursing
5. Recreation Therapy
6. Case Management/Discharge Planning
7. Social Work
8. Adolescent Medicine Team

GOALS

- 1) Institute consistent guidelines regarding criteria for admission to the medical unit.
- 2) Support an interdisciplinary team approach to managing medical needs of pediatric patients admitted with the primary diagnosis of an eating disorder.
- 3) Monitor for refeeding syndrome.
- 4) Minimize number of hospital days leading to medical stabilization and transfer or discharge to inpatient or outpatient care.
- 5) Create comprehensive outpatient plan for safe discharge to include dietitian, therapist and adolescent medicine team

INITIAL VITALS, LABS, MEDICATIONS

- 1) Vital signs/measurements
 - a. Orthostatics (on admission and once per day for at least 3 days – can be more frequent if abnormal. After 3 days, MD to decide whether to continue orthostatics)
 - i. Position the patient supine (as tolerated) for 5 minutes prior to the initial measurement, then record blood pressure and heart rate.
 - ii. Next, have the patient sit up on the edge of the bed with his/her legs dangling. Record the blood pressure and heart rate immediately.
 - iii. Ask the patient to stand. Record blood pressure and heart rate immediately.

- iv. Repeat blood pressure & heart rate check after patient standing for 3 minutes; record findings.
 - v. While checking the patient's blood pressure and pulse, note his/her symptoms with each change in position.
 - vi. Positive orthostatics = pulse up by ≥ 30 beats per min or systolic BP down by ≥ 20 mm Hg
 - b. Weight and height (on admit, Mondays, Thursdays and at discharge)
 - i. Performed after first void in a gown. (6a-8a)
 - ii. The staff should show a neutral response to any weight gain or loss and not discuss the actual weight in front of the patient.
 - iii. Do not reweigh on patient's request
 - c. Vital signs Q4
 - i. If HR < 40 , check EKG stat for QTc, strict bed rest until HR stabilizes
 - ii. If temp < 35.5 C (96 F), warm with blankets and recheck
 - d. CR monitor – Initiate if bradycardic, orthostatic, or abnormal QTc. Can be discontinued once vital signs have been normal for 24 hours. RN may use clinical judgment to set alarms on monitor (e.g., if patient's HR consistently < 50 then the alarm can be set lower to detect a change)
 - e. Strict I/Os
 - f. The % median BMI can be an indicator of the severity of weight loss (see appendix on how to calculate)
- 2) Admission labs
- a. CBC, ESR
 - b. CMP, Phos, Mag, calculate anion gap
 - c. Cholesterol, Triglyceride, GGT
 - d. Amylase, lipase
 - e. TSH, Free T4, T3
 - f. Vitamin D, Thiamine, Ferritin (If vegan/vegetarian add B9 and B12)
 - g. LH, FSH, Prolactin, Estradiol if amenorrhoeic
 - h. Urine Pregnancy Test
 - i. Urine Toxicity Screen
 - j. Urinalysis - for urine pH ($> 8-9$ suggests purging) and specific gravity (< 1.010 suggests water-loading)
- 3) Daily labs/studies:
- a. BID or daily (depending on severity of caloric restriction prior to admit) BMP, phosphorous, & magnesium. If stable, can space out as appropriate. Typical signs of refeeding include low phosphorus, low magnesium, low potassium, or high glucose.
 - b. Daily EKG x 3 days then may do as needed (depending on electrolytes)
- 4) Medications

- a. Multivitamin with zinc 1 tablet PO daily
 - b. Consider Neutra-Phos 1 packet (phosphorus 250 mg + potassium 7.1 mEq + sodium 7.1 mEq) PO BID either empirically or if phos or K is low
 - c. Consider medication to help with sleep (melatonin or hydroxyzine)
 - d. Miralax 1 capful daily on admission. If no BM in 24 hours, increase to 2 caps daily until BM. Decrease if diarrhea.
 - e. Hydroxyzine 10-25 mg TID (meal anxiety)
 - f. Consider olanzapine 2.5 mg at bedtime
- 5) A 24 hour sitter will be ordered – order as “suicide sitter for eating disorder.” A checklist will be provided to sitters to delineate their responsibilities that may differ slightly from other suicide cases.

PARTNERING WITH THE FAMILY

- 1) All patients and families to receive and sign a treatment contract
 - a. Contract will be discussed with family by Psychologist or Attending Physician (see separate document)
 - b. Family to have copy of contract upon signing
- 2) At least one multidisciplinary team and family meeting to occur within 48-72 hrs of admission. Social Worker will schedule meetings thereafter as needed.
- 3) Presentations (residents, medical students, and nurses on rounds)
 - a. Focus on medical condition and objective data such as vital signs, labs, and orthostatic information.
 - b. Avoid discussing the patients’ weight or calorie goals in front of patient (can be done outside room)
 - c. Avoid positive or negative reactions towards amount eaten – neutral is best. May state whether patient is following their medical plan.
- 4) Interdisciplinary team management
 - a. Psychology assessment should be completed as soon as possible, to include assessment of psychosocial factors that may interfere with inpatient treatment. If there is concern for co-morbid psychiatric conditions or the diagnosis is in question and psychology is not available, Adolescent Medicine Team will help assess further
 - b. Nutrition consult as soon as possible. A Registered Dietitian will see the patient M-F and is available for questions by pager Saturday afternoons to Sunday evenings. Use after hours pager information.
 - c. Recreational therapy consult
 - d. Social work consult

- e. Adolescent Medicine Consult- NP will round on patient daily Monday-Friday. Available by phone on weekends.
- f. Communication between all disciplines will occur through daily progress notes, sticky notes and during rounds in the patient’s room.

NUTRITION, ACTIVITY

1) Meals/Snacks

- a. Food is medicine for patients with eating disorders. Therefore food (and supplements) are not negotiable
- b. Caloric goals: Start with [1800 kcal/day](#). Increase by 200-250 kcal/day starting on hospital day 2. Target weight gain of 0.3-0.4 lb/day (100 – 200 grams/day) but it is common to lose weight the first week.
- c. Meals and snacks will be selected with the dietician and patient. At least 3 meals/24 hours will be ordered at a time. Patient will be given Ensure Enlive if a supplement is required for meal/snack replacement. Resident physician should place an order for 6 bottles of Ensure Enlive. RN to let secretary know to keep a par level of 6 bottles. Patient may be provided other supplements at the discretion of the RD.
- d. Vegetarian, lactose-free (if proven), and religious diets will be respected
- e. A Regular Diet should be ordered for the patient. *If the RD is not available*, the nurse will work with the patient to order meals using the following meal options from RD (the resident will order the diet in EPIC as Regular Diet and add in comments – “Eating disorder patient. ___ mL of fluid per day. RD to order meals.”)
- f. Nursing will document all fluid intake
- g. Please request a MANAGER CHECK with all trays.
- h. These meals range from 550-760 kcal meal. Day 1 provides an average of 1800 kcal/day, Day 2-3 2000-2200 kcal/day. Day 4 provides 760 calorie breakfast ideas. The patient should make meal choices. No swapping, exchanging, or substitutions allowed. If the patient is unable to make a choice, then the RN should choose option 1 or 2 at their discretion. Condiments may be offered with the exception of hot sauce and salt packets.

	Breakfast	Lunch	Dinner
Day 1	Option 1	Option 1	Option 1
	2 slices of whole wheat toast 1 peanut butter Scrambled Eggs Apple Whole milk (8 oz.) 1 margarine	Tuna salad sandwich on whole wheat Applesauce Vanilla yogurt Baked potato chips Garden side salad 1 packet ranch dressing	Hamburger on bun Garden side salad 1 packet creamy Italian dressing Fresh Fruit Cup Whole milk (8oz.)
	Option 2	Option 2	Option 2

	Oatmeal, raisins, brown sugar Fresh fruit cup Pork Sausage Whole milk (8 oz.)	Peanut butter and jelly on whole wheat Apple Whole Milk (8 oz.) Baked potato chips	Balsamic grilled chicken Corn Mashed potatoes w/ gravy Strawberry Yogurt Apple Juice (8 oz.) 2 margarine 1 BBQ sauce
Day 2	<p>Breakfast</p> <p>Option 1 2 Raisin bran Whole milk Apple Scrambled Eggs (w/ American cheese) 1 slice of bacon</p> <p>Option 2 French toast w/ syrup and margarine Strawberry Yogurt Apple Cranberry juice (8 oz.) Scrambled eggs</p>	<p>Lunch</p> <p>Option 1 Turkey and cheddar cheese sandwich on whole wheat Chicken Noodle Soup w/ crackers Garden side Salad 1 packet creamy Italian dressing Applesauce Cranberry Juice (8 oz.) Baked potato chips</p> <p>Option 2 Peanut butter & jelly on wheat bread Green Beans Fresh fruit cup Vanilla Yogurt Apple Juice (8 oz.) Baked potato chips</p>	<p>Dinner</p> <p>Option 1 Grilled chicken sandwich (w/ provolone cheese) Carrots Applesauce Whole Milk (8 oz.) Baked potato chips</p> <p>Option 2 Veggie Burger on bun w/ provolone cheese Applesauce Whole Milk (8 oz.) Cranberry juice (4 oz.) Garden side salad 1 packet ranch dressing</p>
Day 3	<p>Breakfast</p> <p>Option 1 Grits Scrambled Eggs Wheat toast Pork Sausage Whole Milk (8 oz.) Apple 2 margarines</p> <p>Option 2 2 French toast w/ 1 syrup 1 margarine Scrambled eggs Applesauce Vanilla yogurt Orange juice (4 oz.)</p>	<p>Lunch</p> <p>Option 1 Grilled cheese sandwich (w/ 2 slices American cheese on wheat bread) Green Beans Tomato soup Fresh fruit cup Baked potato chips Whole Milk (8 oz.)</p> <p>Option 2 Balsamic grilled chicken Mashed potatoes w/ gravy Dinner roll Garden side Salad 2 small packets of ranch dressing Orange Whole milk (8 oz.) 1 margarine</p>	<p>Dinner</p> <p>Option 1 Chef salad 3 small packets of ranch dressing 4 Crackers Fresh fruit cup Whole milk (8 oz.)</p> <p>Option 2 Hamburger (on bun w/ American cheese) Carrots Apple Strawberry yogurt Cranberry juice (4oz.)</p>
Day 4	<p>Breakfast</p> <p>Option 1 2 slices whole wheat toast 2 peanut butters Scrambled eggs w/ cheese Fresh fruit cup Vanilla yogurt 2 slices of bacon</p>		

	<p>Option 2</p> <p>Oatmeal (w/raisins and brown sugar)</p> <p>Scrambled eggs w/ cheese</p> <p>Pork sausage</p> <p>Strawberry yogurt</p> <p>Apple</p> <p>1 margarine</p>
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- i. If the patient is admitted after the cafeteria closes and they are hungry, RN can provide one of the following meals/snacks:
 - i. Raisin Bran Cereal (1 container), Whole Milk (8oz), Fruit Cup or Apple
 - ii. Saltines (8 crackers), Peanut Butter (2 packets), Applesauce
 - iii. Cheerios (1 container), Whole Milk (8 oz), Juice (8oz)
 - iv. Cheese (1 ounce), Saltines (8 crackers), Juice or Applesauce (8 oz)
- j. Trays will be delivered to nurses' station (not the patient room) at the selected time.
- k. The nurse or nurse tech should place all food in unlabeled containers
- l. The tray will be checked against the tray ticket for accuracy and corrections are to be made as needed. Condiments may be sent to the room (no salt packets or hot sauce are allowed) as long as they do not have a nutrition facts label. All labels should be removed from foods before going into the room.
- m. No food or condiments from home will be allowed.
- n. The patient will only eat in his/her room. Meals/snacks to be eaten sitting in the chair or side of the bed
- o. The patient will be observed throughout the meal by a sitter. Patients may watch TV, read a book, complete a puzzle, etc. while they eat as this may be a coping strategy for completing meals. It is the patient's responsibility to complete the meal in 30 minutes (snacks in 20 minutes) whether or not they chose a form of distraction.
- p. When the patient is first admitted, no family members or visitors are allowed during meals. However, recent studies have shown benefit of family mealtime as the patient progresses. This is allowable after the parents have met with the nutritionist and/or pediatric psychologist and have been "coached" on how to best approach shared mealtimes with their child.
- q. Meals last for 30 minutes, including any time needed for reheating of food items, and snacks last for 20 minutes.
- r. Staff must check trays for hidden food or food discarded in napkin or hidden in tray table
- s. Any uneaten or vomited foods will be removed and replaced with a supplement.

Meal Completed	Amount of Ensure Enlive to be provided
0-24%	14 oz
25%	10 oz
50%	7 oz
75-99%	4 oz

The patient has 20 minutes to drink the entire supplement. If this does not happen or vomiting occurs, a nasogastric tube will be placed and caloric replacement will occur via this route. The primary or covering resident physician will be contacted so that orders can be given for NG tube placement as well as numbing agents which can be offered to the patient. The appropriate amount of Ensure Enlive will be bolused through the NG tube at 400 mL/hr. The medical team will decide on a case-by-case basis whether to pull the tube after the supplement has been infused or keep it in

- t. Portions consumed and any replacement supplements that the patient received will be documented in the electronic medical record by the RN.
- u. No other food or liquid or condiments will be permitted in the patient's room at any time (family members', visitors', etc.). The sitter may have one unlabeled drink with a lid in the room.
- v. If the patient has significant mealtime anxiety interfering with eating, MD can consider short term use of hydroxyzine or a benzodiazepine (lorazepam, alprazolam, or clonazepam). SSRIs, SNRIs, or Olanzapine are options for longer term use.

2) Fluid intake

- a. The resident and RD should determine the target daily fluid intake case-by-case depending on age, level of hydration, and presence of symptomatic orthostasis. Typically this will be maintenance rate if not dehydrated. Please write the target amount in the diet order (see 1e above). Patient should not consume more than 2500 mL fluid/day.
- b. This can be given orally as water, whole milk, juice, or regular soda, if tolerated. No diet drinks are allowed.
- c. The RN will document all po intake
- d. No fluids 30 minutes prior to meals/snacks (to preserve appetite) and 30 minutes prior to daily weighing (to ensure weight is not inflated)
- e. IVF should not be routinely used unless patient is truly dehydrated or has symptomatic orthostasis. NG fluids are an option if needed.

3) Activity

- a. Rest periods:

- a. 60 minutes in bed after meals
- b. 30 minutes in bed after snacks
- c. No bathroom/shower use during this time (bedside commode is OK).
- b. Patients may use home electronic devices (i.e. cell phones, tablets, laptops) unless otherwise indicated by parent. Content not monitored unless requested by parent.
- c. If currently enrolled in school, parents should be responsible for collecting assignments from school for work missed. Patients are encouraged to keep up with work missed.
- d. Patient may wear shirt/shorts/pants with no pockets/no hoods (except when weighed)
- e. The amount of activity allowed the patient is at the discretion of the care team. Use the following principles to determine a safe level of activity. **MD order required for activity level.** (team will post this in patient room for family)

Level 1 HR <45 or symptomatic orthostasis or hypotension	Bedrest Bedside commode No shower Wheelchair to playroom
Level 2 Vitals stable x 24 hours	Up to chair Bathroom with door open 5 min seated shower monitored Walk to playroom
Level 3 Vitals stable x 48 hours	OOB as tolerated Bathroom with door open 10 min shower monitored Walk to playroom

- f. If patient unable to ambulate by 48h then order SCDs

DISCHARGE CRITERIA & PLANNING

- 1) Normal electrolytes
- 2) Normal vital signs (HR \geq 45 daytime & \geq 40 nighttime), normal BP for age, and no *symptomatic* orthostasis.
- 3) Normal rhythm and normal QTc (< 0.45) on EKG
- 4) No acute medical complications: e.g. no esophageal tears/hematemesis, no seizure, no cardiac failure, no pancreatitis
- 5) **Comprehensive discharge planning must be done and should start soon after admission**
 - a. **Dietician will create a written meal plan for home that will be reviewed with the caregivers**

- b. Social work will send applications to inpatient eating disorder units if appropriate (admission to one of these units may not occur until after discharge)**
- c. Resident team and adolescent medicine will ensure follow ups in place, which can include PCP, adolescent medicine, therapist, registered dietitian (RD), etc. If possible, have the patient go to clinic the day of discharge to get a weight done on the clinic scale that can be used as baseline**

This clinical pathway is based upon medical evidence and a consensus of pediatric practitioners at Cone Health Pediatrics. These clinical pathways are intended to be a guide for practitioners with a special emphasis on those working at community hospital sites. Management needs to be adapted for each specific patient based on the practitioner's professional judgment, unique patient circumstances, the needs of each patient and their family, and the availability of resources at the health care institution where the patient is located.

Accordingly, these clinical pathways are not intended to constitute medical advice or treatment, or to create a doctor-patient relationship between/among Cone Health physicians and the individual patients. These clinical pathways may not be in every respect accurate or complete, and may not apply to a particular patient or medical condition.

Evidence Base

- 1) American Academy of Pediatrics —Identification and Management of Eating Disorders in Children and Adolescents. PEDIATRICS 2021;147(1)
- 2) Committee on Adolescence, American Academy of Pediatrics. Policy Statement: Identifying and Treating Eating Disorders. PEDIATRICS 2003;111(1):204-211.
- 3) Eating Disorders in Adolescents: Position Paper of the Society For Adolescent Medicine. JOURNAL OF ADOLESCENT HEALTH 2003;33:496–503
- 4) Clinical Practice Guidelines for treating restrictive eating disorder patients during medical hospitalization. CURRENT OP IN PED 20: 390-397
- 5) National Institute for Health and Care Excellence (2017). Eating disorders: recognition and treatment. Available at: <https://www.nice.org.uk/guidance/ng69/resources/eating-disorders-recognition-and-treatment-pdf-1837582159813>

APPENDIX:

Steps to calculating % median BMI:

- Find patient's BMI using the following link (need patient's height & weight):
https://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmicalc.htm
- Using a CDC growth/BMI chart to find the BMI at the 50th percentile* for the patient's age:
 - BOYS: <http://www.cdc.gov/growthcharts/data/set2clinical/cj41c073.pdf>
 - GIRLS: <http://www.cdc.gov/growthcharts/data/set1clinical/cj41l024.pdf>
- Divide the patient's BMI (from #1) by the 50th %tile BMI for age (from #2). For example, if a patient has a BMI of 15 and the 50th %tile BMI for age is 20, then the %median BMI is 75% ($15 \div 20 \times 100$)

Anorexia Nervosa (AN) (Diagnostic Criteria from the DSM-IV-TR)

- Refusal to maintain body weight at or above a minimally normal weight for age and height (i.e., less than 85% Expected Body Weight – see Appendix A). This can be from weight loss or from failure to gain adequate weight during a period of growth.
- Intense fear of gaining weight or becoming fat, even though underweight.
- Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight
- The presence of amenorrhea in postmenarcheal females (i.e., the absence of three or more consecutive menstrual periods). A post-menarcheal female is also considered to have amenorrhea if her menstrual periods only occur following hormone administration, (i.e., estrogen and progesterone).
- Types

Restricting Type: During the episode of AN, the patient engages in severe caloric restriction (e.g., dieting, fasting, and excessive exercise). However the patient does not engage in binge-eating/purging behaviors (e.g., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Binge-Eating/Purging Type: During the current episode of AN, the patient engages in both severe caloric restriction and binge-eating/purging behaviors.

Bulimia Nervosa (BN) (Diagnostic Criteria from the DSM-IV-TR)

Rather than restriction, the patient engages in recurrent episodes of binge-eating. An episode of binge-eating is characterized by both of the following:

1. Eating, in a discrete period of time (e.g. within any 2 hour period), an amount of food that is definitely larger than most people would eat during a similar period of time or under similar circumstances.
2. A sense of lack of control over eating during the episode (e.g. a feeling that one cannot stop eating or control what or how much one is eating).
3. Recurrent, inappropriate compensatory behaviors in order to prevent weight gain (e.g., self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise).

4. The binge-eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for three months.

5. Self-evaluation is unduly influenced by body shape and weight.

6. The disturbance does not occur exclusively during episodes of AN.

• Types:

Purging Type: During the current episode of BN, the patient has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.

Non-Purging Type: During the current episode of BN, the patient has used other inappropriate compensatory behaviors, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.

• Note: These patients tend to be of normal weight or even overweight with intact menses.

Eating Disorder Not Otherwise Specified (Diagnostic Criteria from the DSM-IV-TR)

• All criteria for AN are met except that the patient has normal menses.

• All criteria for AN are met except that despite significant weight loss, the patient's weight remains in the normal range (i.e., greater than 85% Expected Body Weight).

• All criteria for BN are met except that binge-eating and inappropriate compensatory behaviors occur less frequently than twice per week or for less than three months.

• The patient is of normal body weight (i.e., greater than 85% Expected Body Weight) but regularly engages in inappropriate compensatory behavior after eating small or normal amounts of food (e.g., self-induced vomiting after eating two cookies).