Commencing a Paediatrician-Led Adolescent Eating Disorder Service

Katie Sales, Tamsin Newlove-Delgado, Karen Street.
Royal Devon and Exeter Hospital; University of Exeter; Devon Partnership Trust

10.1136/bmjpo-2022-RCPCH.27

Objectives
To describe a Paediatrician-led Eating Disorder Service (P-EDS) model. We present an evaluation of the service, characterising the caseload and service outcomes to inform the conversation around incorporating specialist Paediatrician input into routine care.

Methods
Retrospective Observational Service Evaluation of a P-EDS located at a District General Hospital in the South West of England. Data collected from all adolescents (10–17 years) referred by Child and Adolescent Mental Health Services or their GP due to concerns around their physical risk secondary to an eating disorder. The study quantifies the number of patients referred and cared for in the P-EDS, the diagnoses, number of appointments, length of time spent in the service, % median Body Mass Index (BMI) at assessment and discharge as well as need for local and tier 4 admission.

Results
244 patients were referred to the P-EDS between April 2016–2020. Of these, 81% were accepted beyond initial assessment. Half of referrals were classified as Eating Disorder Not Otherwise Specified (EDNOS) and just over a quarter as Anorexia Nervosa (AN), the remaining cohort consisted of Bulimia Nervosa, Other Mental Health (MH) Disorders and Avoidant-Restrictive Food Intake Disorder (ARFID). The number of patients diagnosed with ARFID and ED secondary to other MH disorder climbed yearly.

The median length of time spend in the service was 3.5 months (IQR 1.2–8.6), and patients had a median of 4 appointments each (IQR 2–9). However, this varied considerably by diagnosis with AN patients spending substantially longer in the service than EDNOS and ARFID patients (median 9m/10appts vs 2.5m/4appts and 3.4m/4appts respectively). For patients with a diagnosis of AN, the average increase in % median BMI between assessment and discharge was 10.1%.

The vast majority of patients (205 patients (84%)) required less than 1 year of P-EDS input, and 95% (233 patients) were discharged prior to two years. The likelihood of needing tier 4 referral increased the longer a patient remained in the service.

Conclusions
The number of referrals demonstrates the significant demand for specialist medical (Paediatrician) involvement in the care of adolescents with eating disorders. This is likely a reflection of the overlap that EDs present between mental and physical health and the lack of time and training that GPs receive.

Patients who present at a higher % median BMI require less clinician input supporting the argument that early intervention improves outcomes. Adolescents with Anorexia gained a significant amount of weight whilst under the P-EDS thus decreasing their physical risk and reducing pressure on stretched tier 4 services.

The number of patients diagnosed with ARFID and an ED secondary to another MH disorder rose yearly, this may be secondary to the introduction of ICD-11 with its superior diagnostic specificity. This should enable better recognition of the triggers leading to disordered eating, and thus to improved treatments and outcomes.

As far as the authors are aware this is the first comprehensive service evaluation of a P-EDS published. Further studies on Day-case models, nurse led initiatives and tertiary level inpatient care will enable the development of best practice based on objective evaluation.