What to Expect When You Are....
at this presentation:

I. Intro

II. Risk Factors

III. Eating Disorders and Body Image in the Pre & Perinatal Period

IV. Eating Disorders and Body Image in the Postnatal Period

V. Eating Disorders and Breastfeeding

VI. Case Study

VII. Wrap-Up
### Eating Disorders

<table>
<thead>
<tr>
<th><strong>Anorexia Nervosa</strong></th>
<th><strong>Bulimia Nervosa</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Anorexia Nervosa is a serious, potentially life-threatening eating disorder characterized by self-starvation and excessive weight loss. Individuals with anorexia nervosa are unable to maintain a body weight that is normal or expected for their age &amp; height.</td>
<td>Bulimia Nervosa is a serious, life-threatening eating disorder characterized by a cycle of bingeing and compensatory behaviors such as self-induced vomiting designed to undo or compensate for the effects of binge eating.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Binge Eating Disorder (BED)</strong></th>
<th><strong>Other Specified Feeding or Eating Disorder (Formerly EDNOS)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Binge Eating Disorder (BED) is characterized by recurrent binge eating without the use of inappropriate compensatory weight control behaviors.</td>
<td>The majority of those with eating disorders do not fall within the criteria for Anorexia Nervosa, Bulimia Nervosa or Binge Eating Disorder are classified as OSFED. There are numerous variants of disordered eating that nevertheless are eating disorders and require treatment.</td>
</tr>
</tbody>
</table>
Medical Complications of Eating Disorders

Brain Complications:
Impaired Cognitive Function (Ability to Process and Concentrate)

Eye Issues:
Broken Blood Vessels and Retinal Detachment

Esophageal/Throat Complications:
Diminished Gag Reflex, Difficulty Swallowing, Esophageal Tears, Barrett’s Esophagus, Esophageal Cancer, Reflux

Dental issues:
Cavities, Enamel Loss, Bleeding Gums, Tooth Decay/Rotting, Bleeding Gums, Tooth Loss

Cardiac Complications:
Loss of/Weakened Heart Muscle, Bradycardia/Tachycardia, Heart Failure, Edema, Heart Palpitations and Chest Pain, Sudden Cardiac Failure (Electrolyte Imbalances), Heart Disease

Glandular Issues:
Swollen Parotid Glands

Kidney/Pancreatic Complications:
Chronic Dehydration, Low Potassium, Pancreatitis

Type-2 Diabetes

Gallbladder Disease

GI Complications:
Stomach Aches, Constipation, Loss of Bowel Function, GI Bleeding, Gastric Rupture

Sexual Development Issues:
Delayed Puberty, Hormonal Imbalances

Menstrual/Fertility Issues:
Menstrual Loss, and/or Irregularities, Infertility, Miscarriage, Premature Birth, Low Birth-Weight Infants

Hand Issues:
Calluses and/or scars on knuckles (Russell’s Sign)
Eating Disorders disproportionately affect women of childbearing age

≤60% women undergoing infertility treatment have eating disorders

≤17% of all pregnant women may have eating disorders
Fast Fact:

- Amenorrhea ≠ Anovulation

“Unless a woman has gone through menopause, there is always the chance that she could get pregnant” (NICHD)

A woman releases an egg 12-16 days prior to her expected period, thus is its possible to get pregnant without having a period. Women who are not menstruating due to low body weight risk the chance of ovulating at any point.
Identifying Eating Disorders in Prenatal Women

- History/Family history of an eating disorder
- Amenorrhea/Complaints of Infertility
- Pre-Pregnancy BMI <19 or >35
- Obsessive concern with diet and/or pregnancy weight gain
- Concerns about the impact of pregnancy on exercise regime
- Copious postpartum weight loss plan
- Fear of OB appts (internal exams, monthly weight checks)
Questions to Ask

<table>
<thead>
<tr>
<th>Table 9.4</th>
<th>Screening for an Eating Disorder During Pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Body weight</strong></td>
<td></td>
</tr>
<tr>
<td>1. What is your current weight? Current height?</td>
<td></td>
</tr>
<tr>
<td>2. What is your usual weight?</td>
<td></td>
</tr>
<tr>
<td>3. What was your highest weight as an adult?</td>
<td></td>
</tr>
<tr>
<td>4. What was your lowest weight as an adult?</td>
<td></td>
</tr>
<tr>
<td>9. Do you think that your body shape will change during this pregnancy?</td>
<td></td>
</tr>
<tr>
<td>10. What do you think about any body shape changes?</td>
<td></td>
</tr>
<tr>
<td><strong>Weight control tactics</strong></td>
<td></td>
</tr>
<tr>
<td>Have you previously (or are you currently):</td>
<td></td>
</tr>
<tr>
<td>1. Gone on (On) a diet to lose weight?</td>
<td></td>
</tr>
<tr>
<td>2. Fasted (Fasting) for more than or equal to eight hours (other than during sleep)?</td>
<td></td>
</tr>
<tr>
<td>3. Made yourself vomit (Vomiting frequently)?</td>
<td></td>
</tr>
<tr>
<td>6. Eaten (Eating) very large amounts of food in a short period of time? If yes, how often?</td>
<td></td>
</tr>
<tr>
<td><strong>Dietary intake</strong></td>
<td></td>
</tr>
<tr>
<td>1. How frequently do you eat foods and drink beverages?</td>
<td></td>
</tr>
<tr>
<td>2. Do you ever skip meals?</td>
<td></td>
</tr>
<tr>
<td>3. Do you have any food allergies?</td>
<td></td>
</tr>
<tr>
<td>4. Do you have any food cravings?</td>
<td></td>
</tr>
<tr>
<td>5. Do you have any food aversions?</td>
<td></td>
</tr>
<tr>
<td>6. Have you had morning sickness?</td>
<td></td>
</tr>
<tr>
<td>7. Do you drink fluids in place of solid foods or meals?</td>
<td></td>
</tr>
<tr>
<td><strong>General health</strong></td>
<td></td>
</tr>
<tr>
<td>1. Were your menstrual cycles regular prior to this pregnancy?</td>
<td></td>
</tr>
<tr>
<td>2. Have you experienced constipation or diarrhea?</td>
<td></td>
</tr>
<tr>
<td>3. Have you experienced heartburn?</td>
<td></td>
</tr>
<tr>
<td>4. Do you feel “stressed” or anxious?</td>
<td></td>
</tr>
<tr>
<td>10. How does this pregnancy compare to your previous pregnancy (pregnancies)?</td>
<td></td>
</tr>
</tbody>
</table>

Psychosocial Pressures of Pregnancy

Has Jr. listened to Mozart yet this week?

Am I radiating pregnancy today?
Battle of Birth Plans

Birth Plan Debate:

**Epidural:**
wimp with drugged baby...or smart?

**“Natural”**
high pain tolerance, strong, healthy ...or crazy?

"I did all that labor without an epidural, just so I could tell everyone what a joyous experience it was..." said no one ever.

Just when I think I cannot handle anymore, I remember that I had a kid via natural childbirth, thus I am a certifiable unstoppable badass!
Baby Name Shame
ED Red Flags During Pregnancy

- Hyperemesis Gravidium
- Excessive and/or Failure to gain weight during 2 consecutive visits especially within the 2\textsuperscript{nd} trimester.
- Intense concern with body size/shape
- Missed OB appts
The American College of Obstetricians and Gynecologists and the Institute of Medicine recommend the following weight gain during pregnancy:

<table>
<thead>
<tr>
<th>BMI</th>
<th>Total Weight Gain</th>
<th>Weight Gain per Week (2\textsuperscript{nd} &amp; 3\textsuperscript{rd} Trimester)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;18</td>
<td>28-40 lbs</td>
<td>1-1.3 lbs/week</td>
</tr>
<tr>
<td>18.5-24.9</td>
<td>25-33 lbs</td>
<td>0.8-1 lbs/week</td>
</tr>
<tr>
<td>25-29.9</td>
<td>15-25 lbs</td>
<td>0.5-0.7 lbs/week</td>
</tr>
<tr>
<td>&gt;30</td>
<td>11-20 lbs</td>
<td>0.4-0.6 lbs/week</td>
</tr>
</tbody>
</table>
When is it okay to ask a woman if she is pregnant?
Comments *No* pregnant woman wants to hear

- “That is going to be one big baby!”
- “You popped right away” or “You look like you’re about to pop.”
- “How much weight have you gained?”
- “You really are eating for two.”
- “Are you gaining enough weight?”
- “You’re all belly” or “You’re so tiny.”
- “You don’t need to gain any more weight”
## Table 9.2

Nutrients of Special Concern in Women with Anorexia Nervosa (AN) or Bulimia Nervosa (BN) During Pregnancy

<table>
<thead>
<tr>
<th>Nutrient</th>
<th>Concern in AN or BN</th>
<th>Dietary Reference Intake(^d) during Pregnancy</th>
<th>Role during Pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Energy</td>
<td>Energy severely restricted in AN (200–700 kcal per day) or excessive (1,500–9,000 kcal per binge episode, followed by compensatory behavior) with limited energy availability</td>
<td>+340 kcal per day in second trimester and +452 kcal per day in third trimester</td>
<td>Energy to supply production and growth of maternal and fetal tissues of pregnancy</td>
</tr>
<tr>
<td>Carbohydrate</td>
<td>Severely restricted in AN or binging but purging in BN</td>
<td>Minimum of 175 g per day</td>
<td>Glucose availability and non-protein energy needs for mother and fetus</td>
</tr>
<tr>
<td>Protein</td>
<td>Adequate proportion relative to energy intake, but total intake limited in AN</td>
<td>71 g per day</td>
<td>Amino acid supply for maternal and fetal tissue production, maternal blood volume expansion and fluid balance</td>
</tr>
<tr>
<td>Fat (lipids)</td>
<td>Intake generally avoided or purposefully restricted</td>
<td>13 g per day of linoleic acid and 1.4 g per day of alpha-linolenic acid</td>
<td>Growth, development, and function of fetal nerve and brain tissue, cell membranes, and organs</td>
</tr>
<tr>
<td>Vitamins</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Folate</td>
<td>Poor intake and subclinical deficiency</td>
<td>600 mcg per day</td>
<td>Fetal neural tube formation</td>
</tr>
<tr>
<td>Pyridoxine (B(_6))</td>
<td>Poor intake and subclinical deficiency</td>
<td>1.9 mcg per day</td>
<td>Coenzyme for maternal energy metabolism</td>
</tr>
<tr>
<td>Cobalamin (B(_12))</td>
<td>Poor intake (especially in vegans) and subclinical deficiency</td>
<td>2.6 mcg per day</td>
<td>Required for maternal folate metabolism and DNA and RNA synthesis for fetal tissues</td>
</tr>
<tr>
<td>Vitamin A</td>
<td>Hypercarotenemia in AN due to catabolism</td>
<td>770 mcg retinal activity equivalents per day</td>
<td>Cellular differentiation for fetal tissue development</td>
</tr>
<tr>
<td>Minerals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calcium</td>
<td>In AN, skeletal calcium stores may be compromised</td>
<td>1,000 mcg per day</td>
<td>Fetal skeletal mineralization</td>
</tr>
<tr>
<td>Iron</td>
<td>Poor intake (especially in vegans)</td>
<td>27 mcg per day</td>
<td>Hemoglobin synthesis; support of maternal blood volume expansion</td>
</tr>
</tbody>
</table>

### Table 9.2
Nutrients of Special Concern in Women with Anorexia Nervosa (AN) or Bulimia Nervosa (BN) During Pregnancy

<table>
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<tr>
<th>Nutrient</th>
<th>Concern in AN or BN</th>
<th>Dietary Reference Intake&lt;sup&gt;a&lt;/sup&gt; during Pregnancy</th>
<th>Role during Pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Zinc</td>
<td>Poor intake (especially in vegans)</td>
<td>• 11 mg per day</td>
<td>• DNA and RNA synthesis and cofactor for enzymes</td>
</tr>
<tr>
<td>• Potassium</td>
<td>Hypokalemia due to purging and other compensatory behaviors</td>
<td>• 4.7 g per day</td>
<td>• Transmission of nerve impulses; major intracellular cation</td>
</tr>
<tr>
<td>• Sodium</td>
<td>Hyponatremia due to purging and other compensatory behaviors</td>
<td>• 1.5 g per day</td>
<td>• Transmission of nerve impulses; major extracellular cation</td>
</tr>
<tr>
<td>• Chloride</td>
<td>Hypochloremia due to purging and other compensatory behaviors</td>
<td>• 2.3 g per day</td>
<td>• Part of hydrochloric acid in stomach; transmission of nerve impulses; major extracellular anion</td>
</tr>
</tbody>
</table>


<sup>a</sup>From [28]

Caloric Needs

According to the Academy of Nutrition and Dietetics:

Generally pregnant women need 2200-2900 kcal/day. A gradual increase in calories as the baby grows is favorable.

- The first trimester does not typically require additional calories
- During the second trimester (13+ weeks gestation) an additional 340 kcal/day are recommended
- During the third trimester 450 additional kcal/day are recommended
- **Weight loss during pregnancy is not recommended.**
Determining Needs

- **Anorexia Nervosa**
  - 130% of Estimated Energy Needs
  - Initiate at 1200-1600 kcals depending on current intake
  - Advance 100-200 kcal, 1-2x times per week
  - Needs increase further in 2nd and 3rd trimester

- **Bulimia Nervosa**
  - 100-130% of Estimated Energy Needs
  - 2nd and 3rd trimester should match general guidelines if within a healthy weight range
Fluid Needs

- 3 liters of water daily (AI)
  - Met through fluids from beverages, and high moisture foods
  - ~10 cups/d in total beverage intake needed
Topics For Education

- Body weight gain and fetal development
- Menu Planning, food choices and portioning
- Food vs. Supplements
- Vegetarian needs
- Impact of substance use
- Exercise recommendations
- Morning sickness vs. self induced vomiting
- Managing common side effects
- Planning for lactation
- Energy/nutrient needs of lactation
Monitor/Evaluate

- Weight progress
- Adjustments of energy intake as appropriate
- Changes in ED behaviors or eating patterns
- Possible labs or finger-stick
  - Iron, glucose, electrolytes, dehydration, starvation
- Vital Signs Checked

- Consult with other professional within the multidisciplinary team
When Should a Higher Level of Care Be Recommended?

- Body weight less than 75% of expected weight
- Abnormal electrolytes (ie hypokalemia, hyponatremia)
- Dehydration
- CVD changes
- Prolonged restriction
- Uncontrolled B/P cycle
- Severe Depression
- Suicidal Ideation
Exercise Recommendations

The American College of Obstetrics and Gynecologists recommend 30 min of moderate exercise most if not daily throughout pregnancy for those without medical or obstetrical complications.

AN—weight dependent (preferably >85% IBW), medical supervision recommended
  * minimal exercise/low impact yoga/stretching
BN—behavior and weight dependent and preferably >85% IBW
BED—behavior and weight dependent, gradual increase in level of activity under medical supervision
Risks of Overexercise

- Hyperthermia

- Exercise causes blood to be redistributed from internal organs to skeletal muscle and as a result there can be a significant transient reduction in oxygen and nutrient delivery to the placental site.

- Risk of maternal injury due to falls

- Lower birth weight

- Premature contractions can potentially be induced by hormones stimulated by exercise

- All risks of overexercise that non-pregnant women are vulnerable to (stress fractures, strain of connective tissue, muscle atrophy)
Complications of Anorexia Nervosa

- Infant mortality rates x6 those of women without AN
- IGR/Smaller birth weight babies (80%)
- Increased risk of neural tube defects (caused by micronutrient deficiencies and diuretic usage)
- Anemia
- Premature labor
- ADHD
- Increased risk of PPD
- Difficulty nursing
Complications of Bulimia Nervosa

- Increased risk of miscarriage
- Higher preterm delivery
- Higher breech presentations
- Higher rates of C-Sections
- Risk of respiratory or cardiac irregularities
- Risk of lower APGAR scores
- Increased risk of gestational diabetes
- Increased risk of PPD
- Risks associated with AN and BED
Complications of Binge Eating Disorder

- Ø Access to Infertility Treatment if BMI >35
- Larger weight for gestational age babies
- Difficulty detection of prenatal complications due to interference of body fat with ultrasound technology
- Increased rates of stillbirth
- Increased rates of heart and neural tube defects
- Increased risk of c-section birth
- Longer time required to perform c-section which leads to increased risk of infection, anesthesia related complications and DVT
- Gestational Diabetes (which increases risk of type 2 diabetes later in life)
- Preeclampsia—in severe cases may be fatal for the woman, baby or both
- Microencephaly
Role of the Midwife/OB

- Identify those at risk or those who are struggling

- Psychoeducation around risks of an ED on the fetus, a woman’s caloric needs, exercise recommendations, and weight gain expectations during pregnancy

- Blind weights and/or discussion around weights in the office

- Supportive and non-shaming stance

- Referrals for ED treatment
≥57% of women with BN experience more severe symptoms postpartum that ever before
Post Partum Depression

Post Partum Depression Prevalence

- Active ED
- ED Hx
- General Pop
Postpartum Complications

- Poor episiotomy or incision healing
- Excessive concern with infant’s weight (>50% report fear of their child becoming or being overweight and 15% women with BN report restricting child’s intake before age of 1)
- Lactation Difficulties
- Detached and non interactive mealtime through toddlerhood
Mama Media Madness
Post Baby Body Workout Whirl

- Stroller Strides®
- Body Back®
- STROLLGA™—yoga-inspired stroller fitness
- Baby Weight™— “Use it to Lose it”
- Postnatal Yoga
Postpartum Triggering Comments

- “When are you due?”
- “Are you working on losing that baby weight?”

Or

- “You look great!”
- “How did you lose the weight so fast?”
- “Did you get stretch marks?”
Your body is not ruined; you're a goddamn tiger who earned her stripes.

Citymomsblog.com
I make milk...
What's YOUR superpower?
Lactation Nutrition

• Energy needs
  - According to the American Dietetic Association an additional 500 Kcal/day for first six months is recommended for women who breastfeed (e.g., 2,300–2,500 Kcal/day versus 1,800–2,000 for a moderately active non-pregnant, non-lactating women).
  - Ex: 69” Sedentary female: 1948-2134 kcals (BMI 18.5-24.9)
    • Low active: 2164-2372 kcals
    • Active: 2434-2670 kcals
    • Very Active: 2758-3028 kcals

• Fluid needs
Nursing Stressors

• Discomfort (physical and emotional)
• Feelings of failure as a woman if unable to feed child/Fear of judgment around use of formula
• >70% women with BN report lactation difficulties
• Low/Insufficient milk supply due to caloric restriction or excessive bingeing and purging
Nursing Cont.

- Supply Stress: Reglan, Domperidone, Mother’s Milk Tea, Fenugreek, and Lactation cookies, Oatmeal, etc

- Extreme or prolonged nursing/pumping

Don't cry over spilled milk. Unless it's breastmilk, in which case, cry a lot.

Somee Cards user card

Or…
MAN, THAT'S GROSS!
17% of children born to mothers with AN fail to thrive in their first year

- Negative mealtime interactions
- Rapid, forced feeds (mother may desire to end meal quickly due to fear the presence of food may trigger a binge)
- Failure to pack snacks
- Maternal reservations toward self-feeding (messy)

MOM FINDING TIME TO EAT WHEN TAKING CARE OF ACTIVE TOT
Clinical Implications
of Eating Disorders in Perinatal Period

• “How can she do that to an unborn child?”
• “What do I do or say when the rest of the group stare in horror?”
• “If this pregnancy doesn’t lead to remission, what will?”
• “How can she get pregnant while not taking care of herself when there are plenty of healthy women struggling to conceive?”
• “Can I file?”

NOTE:
• Self Assessment of Own Judgment
• Importance of Supervision
HELP!

• Lift the Shame— online support group. The second Sunday of each month from 4-5 p.m. PST (or 6-7 p.m. CST)

• *Does This Bump Make Me Look Fat?* by Claire Mysko & Magali Amadei

• Walden Behavioral Care LLC
There are relatively few studies and ever fewer conclusive studies on the relationship between eating disorders and pregnancy. Pregnancy can be a period of remission for many but not for all. Studies indicate risks for women with active symptoms but also indicate many women have successful, uncomplicated pregnancies. Postpartum can be a challenging time for all mothers but women with active eating disorders and/or histories of are at high risk for PPD and feeding difficulties with their infants.
Case Study – WBC

- Client is a 31 yo SCF with 15 year hx of an eating disorder- behaviors primarily include restriction and purging. She has not menstruated in 8-9 years
  - Pt has been hospitalized on WBC IP unit 4-5 times for ED
    - 2-3 prior psychiatric hospitalizations
  - Pt is 7 months pregnant, second pregnancy (18 month old son)
    - Pt is actively smoking cigarettes (15/day)
    - On food stamps $340-360
- Diagnosis: EDNOS (OSFED), Anxiety NOS, Pregnancy, Malnutrition
Case Study Continued

- Active behaviors: restricting (300 kcal/day), vomiting (4x/month)
  - Reports: dizziness, cold intolerance, heart palpitations, poor concentration and shortness of breath
- Admit weight: 154#, height: 69” BMI: 22.7 %IBW: 108%
  - Wt: 3 months prior: 132 #; 1 month prior: 142#
  - BP- 130/76 sitting 127/73 standing
  - Pulse – 94 sitting 101 standing
  - Labs: BUN 5 (L), Crea 0.46 (L), Albumin 2.9 (L), Alk Phos 170 (h), Mg 1.4 (L)

Rituals/Fear or Safe Foods

- Pt food rituals/rules
  - Eats with the same utensils, only will touch lips to utensils, foods can’t touch
- Safe foods:
  - Yogurt
  - Hummus
  - Applesauce
  - Occasionally: broccoli, pretzels or crackers
Case Study Cont’d

24 hr Recall Prior to Admit

• Dinner
  – Soup (broth based)
  – Yogurt or piece of bread with cheese

24 hr Recall In PHP

• Breakfast
  – Yogurt, granola, juice (fruit), Milk

• Snack
  – Applesauce or cheese stick and saltine crackers with water

• Lunch
  – Bread or saltine crackers, hummus (2/3 c), 14 oz apple juice or 8 oz milk and cheese stick

• Dinner
  – Soup (broth based) and crackers OR rice with carrots and a cheese stick

www.Progresso.com
Course of Treatment

Initial Interventions

• Take Prenatal vitamin daily
• Increase food intake – supervised meals/MP
• Weight Gain (1-2#/wk)
• Nutrition education
• Recommend magnesium supplement
• Meal planning

Ongoing Interventions

• Set goals weekly around total intake of MP
• Planned meal ideas, discussed other options
• Meal plan adjustments to increase total intake
• Recommended use of high calorie smoothies
• Nutrition Education
Case Study

• Barriers:
  – Ongoing fear of high caloric/fat/protein foods
  – Not receptive to education
    • Struggled with certain information provided
  – Lack of support around food intake outside of program
  – Fearful of weight gain
Summary

- Client gained a total of 6.6# while in PHP (4# over last 3 days)
- Food intake improved overall, still under recommended intake
  - Remained fearful of many foods and very limited with food selection
- Abnormal lab values continued
  - mag- 1.3 at discharge while on supplement, OB notified
- Client had been reporting contractions at least 1x/day over the 2 weeks prior to discharge (at 8 months)
- Client reports a continued desire to lose weight after childbirth
  - No shift in body image or thoughts regarding weight
First Pregnancy

- Previous Pregnancy: Highest weight- 169.6# (BMI- 25, %IBW-119%)
  - Admitted to PHP 5/7/12 at 5 ½ months pregnant after being on IP unit for 3 days
    - Primary ED behavior restriction
    - Smokes tobacco and marijuana
    - Finances: Food stamps – identified as stressful
    - Supports: BF of 3 years
    - 163 upon admit, discharged 157#

- Pt stepped up to Residential unit 6/1/12
  - Had lost 5.4 # while in PHP and was struggling to increase PO intake at home and in program
  - Improvement seen with food intake
  - Weight increased 6.8#
  - MP advanced to 3800 kcals
  - Tried more variety with food intake
  - Prenatal vitamin consistently

- Pt stepped down to PHP 7/3/12
  - On 3800 kcals, continued to restore weight
  - Wt increased ~ 5.5# over the next month
  - Food intake slowly decreased, mp adjusted to 3000 kcals (50-75% by end of tx)
  - Total Weight gain: 5# from initial weight
  - Wearing more form fitting clothing
Comparison

• Possible side effects from the eating disorder, marijuana use, and/or smoking seen in 18 month old son
  – ADHD
  – Poor Vision
  – Cognitive delays related to speech
    • Minimal speech at 18 months old

• Negatives of Second pregnancy compared to the first
  – Gained less weight
  – Had less nourishment
  – Sought treatment later in pregnancy

• Positives
  – Took prenatal vitamin throughout pregnancy
  – Agreed to take magnesium supplement consistently

• Second pregnancy – Healthy daughter, no possible side effect reported
References


• Bulik et al. (2009). Birth Outcomes in Women with Eating Disorders in the Norwegian Mother and Child Cohort Study (MoBa). International Journal of Eating Disorders 42 (1) pp. 9-18


Thank You

Something remarkable happens to our patients. They get better.