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Eating Disorders: Screening & Treatment for PCPs

Disorder	Definition	Common Comorbidities	Screening Tools Used	Typical Age of Onset	Key Medical Risks	First-Line Treatment Approaches
Anorexia Nervosa (AN)	Persistent restriction of energy intake leading to significantly low body weight for age/height, intense fear of gaining weight, and disturbance in valuation of weight/shape. Prevalence: ~0.3% High heritability (~50–60%)	Anxiety disorders, major depressive disorder, OCD, autism spectrum traits	*EDE-Q*, *SCOFF*, *EAT-26*, *EDE (interview)*	Adolescence to early adulthood (peak: teens)	Bradycardia, hypotension, electrolyte imbalance, osteoporosis, infertility, cardiac arrhythmias, highest mortality rate of psychiatric disorders	**Therapy & Nutritional: Nutritional rehabilitation + psychotherapy**; Family-Based Treatment (FBT) for adolescents; CBT-E for adults. **Medical monitoring is essential**; **Medications**: medications are adjunctive only
Bulimia Nervosa (BN)	Recurrent binge eating with compensatory behaviors (vomiting, laxatives, excessive exercise). Prevalence: ~0.9% Hgh heritability (~55-60%)	Depression, anxiety, substance use disorders	*EDE-Q*, *SCOFF*, *EAT-26*	Late adolescence to early adulthood	Electrolyte disturbances, esophageal tears, dental erosion, parotid swelling, cardiac arrhythmias	**Therapy & Nutritional: CBT-E** (first-line); nutritional normalization. Medical/dental monitoring. **Medications: SSRIs (fluoxetine)** often helpful as adjuncts.
Binge Eating Disorder (BED)	Recurrent binge eating with loss of control, without compensatory behaviors. Prevalence: ~1.6% Moderate heritability (~40–60%)	Depression, anxiety, PTSD, obesity, metabolic syndrome	*BEDS-7*, *EDE-Q*	Adulthood (often later than AN/BN)	Type 2 diabetes, hypertension, dyslipidemia, sleep apnea, cardiovascular disease	**Therapy & Nutritional: CBT or CBT-E;** interpersonal psychotherapy (IPT). Address metabolic comorbidities **Medications: Lisdexamfetamine** may be used.
Avoidant/ Restrictive Food Intake Disorder (ARFID)	Restrictive/avoidant intake causing weight loss, nutritional deficiency, or psychosocial impairment without weight/shape concerns. Prevalence: ~5-22% Emerging evidence; neurodevelopmental genetic overlap	Anxiety disorders, ASD, ADHD, GI disorders	*NIAS*, *PARDI-AR-Q*	Childhood most common, but can persist or present in adults	Growth failure, micronutrient deficiencies, dependence on supplements or tube feeding, delayed puberty	**Therapy & Nutritional: CBT-AR or exposure-based therapy**; nutritional rehabilitation; parent-supported feeding for youth; treat anxiety/sensory drivers

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Other Specified Feeding or Eating Disorder (OSFED)	Clinically significant eating-related dysfunction not meeting full criteria (e.g., atypical AN, subthreshold BED). Prevalence: Very common in clinical settings (40-50% of ED diagnoses) Heritability is likely similar to related full-threshold disorder	Depression, anxiety; varies by subtype	*EDE-Q*, *SCOFF*, *EAT-26*; *EDE interview*	Variable; mirrors related disorder	Medical risks comparable to full syndromes, especially in atypical AN (e.g., bradycardia despite normal weight)	**Therapy & Nutritional: Treat according to the closest full-threshold disorder** (often CBT-E); nutritional support; medical monitoring when indicated

Uselful Links

1. *NVPAL's Eating Disorder Guide*
2. *AACAP Facts for Families - Teenagers with Eating Disorders*
3. *National Association of Anorexia Nervosa & Associated Disorders*
4. *National Eating Disorders Association, provides information and referrals*

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ED Referral Decision Pathway for PCPs