

# Eating for 2: Managing eating disorders in pregnancy

Clinician knowledge of complications and risks specific to disordered eating and pregnancy can affect outcomes for both mother and baby

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Eating disorders affect nearly 1% of US adults,<sup>1</sup> and disordered eating, or unspecified eating disorder, affects at least 1% of all pregnancies.<sup>2</sup> Among 739 pregnant women assessed with the Eating Disorder Diagnostic scale, 7.5% of patients met criteria for an eating disorder, with 8.8% of women reporting binge eating and 2.3% of pregnant women engaging in regular compensatory behaviors. In fact, 23.4% of the study population expressed concerns about pregnancy-related weight gain and body shape.<sup>3</sup> Eating disorders during pregnancy are more common than previously thought, and they create unique clinical challenges for obstetric providers.

### Types of eating disorders

There are 3 major types of eating disorders: anorexia nervosa, bulimia nervosa, and binge eating disorder, with significant fluidity existing between all 3 conditions.

**Anorexia nervosa** is a condition in which an individual believes he or she is significantly overweight despite being underweight.

Patients with anorexia nervosa often restrict food intake and have compulsive rituals around eating and exercise, leading to weight loss and starvation.<sup>4</sup>

**Bulimia nervosa** is marked by intensive dieting, uncontrolled episodes of overeating, and compensatory behaviors.<sup>4</sup> Compensatory behaviors include self-induced vomiting; excessive exercise; and misuse of laxatives, diuretics, or other medications.

**Binge eating disorder** is classified as recurrent episodes of uncontrolled overeating without compensatory purging behaviors, leading to excessive weight gain.<sup>4</sup>

### Eating disorders and pregnancy

Pregnancy can impact the course of pre-existing eating disorders, and women also can develop symptoms of eating disorders for the first time during pregnancy. This is clinically significant as there are both maternal and fetal consequences to a mother's disordered eating.

The risks of anorexia nervosa include vitamin deficiencies (vitamin B12/folate), dehydration leading to renal injury and electrolyte imbalances, hypoglycemia, abnormal lipid profiles, cardiac arrhythmia, and even death. The mortality rate of patients with anorexia nervosa may approach 10%; however, death during pregnancy is quite rare.<sup>2</sup> Bulimia nervosa also carries the risks of protein and vitamin deficiencies, hypoglycemia and hyperglycemia, and death, with mortality estimated at 7% for those with a 5-year history

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**FAST  
TRACK**

*The nausea of pregnancy can serve as a trigger for women with a history of purging behaviors*

of the illness. However, death in pregnancy due to the condition is again quite rare.<sup>5</sup>

Eating disorders can cause significant maternal and fetal complications during pregnancy and postpartum.

**Maternal complications.** When women with eating disorders become pregnant, they have increased risks of some pregnancy complications. Approximately 10% to 25% of pregnant women with eating disorders develop hyperemesis gravidarum.<sup>6</sup> The nausea can serve as a trigger for a woman with an eating disorder, particularly among women with a history of purging behaviors.

Cesarean delivery is more common among women with eating disorders, which may be due to preexisting fetal compromise, leading to poor tolerance of labor, or to clinicians perceiving these pregnancies as higher risk.<sup>7</sup>

It is well known that eating disorders are highly comorbid with depression and other

psychiatric conditions. In fact, 30% to 40% of women with an eating disorder develop symptoms of postpartum depression.<sup>8</sup>

**Fetal risks and complications.** Excessive caloric restriction and dieting can lead to folate deficiency, which in turn increases the risk of neural tube defects. Such defects are more common among women with eating disorders.<sup>9</sup> Intrauterine growth restriction also can be a concern, most likely because of maternal malnutrition and poor maternal weight gain.<sup>10</sup> In addition, women with eating disorders are more likely to have a preterm delivery or experience perinatal mortality or stillbirth.<sup>10</sup>

Bulimia nervosa is associated with low birthweight, while anorexia nervosa is associated with the very premature birth, low birthweight, and perinatal death.<sup>11</sup> Eating disorders during pregnancy can have long-term psychological impacts on children, including increased likelihood of childhood hyperactivity, conduct, and adjustment disorder.<sup>12</sup>

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## How to start a conversation with a patient once you suspect an eating disorder

When a patient presents showing concerning signs or symptoms of an eating disorder, it is best to start by giving her a validated assessment tool. Normalize this questioning as routine amongst populations of obstetric patients. If concerning behaviors are identified, it is best to have an open and honest conversation with the patient about her history and current disordered eating behaviors, including restrictive, bingeing, or purging. It is also important to address concerns and fears about pregnancy and its associated triggers. If patients are willing to accept care, it is best to connect them with a multidisciplinary treatment team, including psychiatry, nutrition, obstetrics, and social work.

### FAST TRACK

*If you suspect an eating disorder, normalize the questions of a validated assessment tool (such as the SCOFF questionnaire) as routine amongst obstetric patients*

### Assessing patients for an eating disorder

Diagnosis of eating disorders is an interview-guided process using clinical criteria of the *Diagnostic and Statistical Manual of Mental Disorders, 5th edition*.<sup>4</sup> The Eating Disorder Examination is a semi-structured interview composed of 4 subsections (restraint, eating concern, shape concern, and weight concern). The interview's aim is to assess the psychopathology associated with eating disorders, and it is used in research settings rather than clinically.

**Clinical diagnosis.** The SCOFF questionnaire is a quick, validated tool that can be used to clinically assess for an eating disorder.<sup>13</sup> It is composed of 5 questions, with a positive test resulting from 2 yes answers:

1. Do you make yourself sick because you feel uncomfortably full?
2. Do you worry that you have lost control over how much you eat?
3. Have you recently lost more than one stone (14 lb) in a 3-month period?
4. Do you believe yourself to be fat when others say you are too thin?
5. Would you say that food dominates your life?

**Referral.** Patients for whom you have a concern for any eating disorder should be referred to a psychiatrist for formal diagnosis. Integrated multidisciplinary care of pregnant patients with eating disorders is necessary to

improve maternal and fetal outcomes. Care teams should include obstetricians or maternal-fetal medicine clinicians experienced in caring for patients with eating disorders, psychiatrists, psychologists, nutritionists, and social workers. General treatment principles require an assessment for appropriate setting of intervention, which depends on presentation severity, assessment of nutritional status, treatment of psychiatric comorbidity, and psychotherapeutic intervention.

### Overall management strategy

The initial treatment strategy for pregnant women with eating disorders should involve evaluating for severe illness and life-threatening complications of the specific disorder. All patients should be screened for suicidal ideation, severe malnutrition, electrolyte abnormalities, dehydration, hemodynamic instability, and cardiac arrhythmia. Patients with any of these severe features should be admitted for medical hospitalization and psychiatric evaluation.<sup>14</sup> Patients that are hospitalized should be watched closely for refeeding syndrome—potentially life threatening metabolic disturbances that occur when nutrition is reinstated to patients who are severely malnourished.

Patients without severe features or acute life-threatening complications can be managed safely on an outpatient basis with close medical monitoring. Psychiatric providers should be involved to assess for treatment needs including psychotherapy and psychotropic medications. There are numerous pharmacologic options available for patients, with the use of selective serotonin reuptake inhibitors (SSRIs) most common. While SSRI use has been controversial in pregnancy in the past, the risks of untreated illness carry risk to the mother and unborn child that outweigh the small risks associated with SSRI exposure in pregnancy.<sup>15</sup>

Women should have established care with a nutritionist or dietician who can ensure adequate counseling regarding meal planning and multivitamin supplementation. The numerous food restrictions in pregnancy, such as avoidance of unpasteurized cheese or deli meats,

may be triggering for many patients with a history of restrictive eating.

One of the greatest difficulties for women with disordered eating in pregnancy revolves around weight gain. Many patients find the various measurements of pregnancy (maternal weight gain, fetal weight, fetal heart rate, and fundal height) triggering, which can make appropriate maternal and fetal weight gain in pregnancy very challenging. One strategy for managing this includes using fetal weight and growth as a surrogate for appropriate maternal gestational weight gain. One other strategy involves blind weights, where the woman is turned away from the scale so her weight is not disclosed to her. Patients often will not be able to achieve the expected 28 to 40 lb of pregnancy weight gain. It is best to have an open, honest conversation in early pregnancy to discuss how she would like to address weight in her pregnancy.

### Postpregnancy concerns

Patients with eating disorders are at high risk of relapse in the postpartum period, even if they are able to achieve full remission in pregnancy. Rapid postpartum weight loss may be a sign of disordered eating. Postpartum depression also is a concern, and women should be followed closely for surveillance of symptoms. Finally, postpartum contraception is extremely important. The menstrual irregularities that are common among

## A case of bulimia prepregnancy

A 38-year-old woman (G1) at 32 weeks' gestation presents for a routine visit. Her bulimia had been in relatively good control until the nausea of pregnancy triggered a return to purging behaviors. She reports searching her online medical record for any recording of weights, and has now started restrictive eating because a routine recent growth scan revealed the baby to be in the 80th percentile for growth. She is concerned about her mood, and thinks she may be depressed. Because her bulimia was present before pregnancy, during her pregnancy she is followed by a multidisciplinary team, including maternal-fetal medicine, perinatal psychiatry, and nutrition. At pregnancy, she elected for outpatient day program management during her pregnancy.

women with eating disorders along with common misconceptions regarding fertility in the postpartum period increase the risk of unplanned pregnancy.

### Remain cognizant of eating disorders

A clear surveillance plan early in the pregnancy that is developed in conjunction with the patient and her care team is crucial in improving maternal and fetal outcomes among women with an eating disorder. Clinician knowledge of complications and risks specific to disordered eating and pregnancy can affect outcomes for both mother and baby. ●

### FAST TRACK

*Women with a history of eating disorders should be followed postpartum for rapid weight loss and signs of depression*

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