# Perinatal Eating Disorders

Megan Riddle, MD, PhD

# Perinatal Eating Disorders

**Prevalence:**
The perinatal period carries increased risk for development of new eating disordered behaviors or recurrence of illness previously in remission. Rates in pregnancy: 0.6-11.5% Rates postpartum: Up to 12.8%

**Risk factors:**
· Personal or family history of eating disorders
· Psychiatric comorbidities
· Trauma history
· LGBTQ

**Differential:**
Anorexia nervosa (AN)
Bulimia nervosa (BN)
Binge eating disorder (BED)
Avoidant Restrictive Food Intake Disorder (ARFID)
Other Specified Feeding & Eating Disorder—includes atypical anorexia
Appetite changes secondary to depression
Hyperemesis gravidarum

**Assess Symptoms:** Frequency, duration, intensity
Restriction—Skipping meals/snacks? Portion sizes? Are others concerned about intake? Limiting types of food? Eating the same thing every day?
Bingeing—Frequency, amount, eating in secret?
Purging—Vomiting, laxatives, diuretics, diet pills, exercise?

**Medical complications:** Thorough screen for medical complications
AN/Atypical AN/ARFID: Organ dysfunction related to malnourishment
BN: Complications of purging, electrolyte abnormalities

**Pregnancy Complications:**
**AN:** hyperemesis, antepartum hemorrhage, preterm birth, microcephaly, SGA
**BN:** hyperemesis**,** preterm birth, microcephaly
**BED**: tobacco use, maternal hypertension, need for c-section, higher gestational weight for age
All: ↑ risk of postpartum depression & anxiety

**Screening:** Personal history of eating disorder (ED) is biggest risk factor for ED symptoms in pregnancy. Include standardized ED screener at intake, such as Eating Disorder Screen for Primary Care:

1. Are you satisfied with your eating patterns?
2. Do you ever eat in secret?
3. Does your weight affect the way you feel about yourself?
4. Have any members of your family suffered with an eating disorder?
5. Do you currently suffer with or have you ever suffered in the past with an eating disorder?

"No" to q1 = abnormal
"Yes" to q2-5 = abnormal
2 abnormal answers = positive screen. Further follow up recommended

**Interventions:** Depend on severity of illness, medical stability, psychiatric comorbidities, ability to modify behavior independently

· Referrals to registered dietitian with ED expertise, therapy, psychiatry
If medical complications of ED or interference with functioning, consider referral to a higher level of care
· Blinded weights with a focus on baby's growth rather than weight gain
· Meal plan with frequent meals throughout the day—even for individuals whose primary ED behavior is identified as bingeing and/or purging, restriction is often a part of this cycle
· Treat psychiatric comorbidities—depression, anxiety, OCD

**Birth control:**

Patients with EDs are at increased risk of unplanned pregnancy. Patients with amenorrhea/ oligomenorrhea patients may still be ovulating.

# Perinatal Eating Disorder Resources

**Patient resources:**

National Eating Disorder Association:

https://www.nationaleatingdisorders.org/pregnancy-and-eating-disorders

https://www.nationaleatingdisorders.org/blog/decentering-weight-in-prenatal-care

**Further reading:**

Kimmel MC, Ferguson EH, Zerwas S, Bulik CM, Meltzer-Brody S. Int J Eat Disord. Obstetric and gynecologic problems associated with eating disorders. 2016 Mar;49(3):260-75.

Mantel Ä, Hirschberg AL, Stephansson O. Association of Maternal Eating Disorders with Pregnancy and Neonatal Outcomes. JAMA Psychiatry. 2020 Mar 1;77(3):285-293.

Meltzer-Brody S, Zerwas S, Leserman J, Holle AV, Regis T, Bulik C. Eating disorders and trauma history in women with perinatal depression. J Womens Health (Larchmt). 2011 Jun;20(6):863-70.

Pettersson CB, Zandian M, Clinton D. Eating disorder symptoms pre- and postpartum. Arch Womens Ment Health. 2016 Aug;19(4):675-80.