



# Acute Severe eating Disorder ( ASED )

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## Abstract -

Acute severe eating disorders (ASED) in children and adolescents present a significant threat to physical health and normal growth and development. This abstract highlights the rapid medical decompensation, including cardiac dysfunction, electrolyte imbalances, and bone mineral density loss, that can occur in this vulnerable population. Early identification, prompt medical stabilization, and age-appropriate nutritional rehabilitation are critical to mitigate these risks and promote healthy growth trajectories. Further research is needed to optimize pediatric-specific treatment protocols and address the long-term sequelae of ASED on bone health and pubertal development.

## Introduction –

Acute severe eating disorders (ASED) in children and adolescents represent a critical and life-threatening medical emergency. Characterized by rapid weight loss, physiological instability, and significant psychological distress, ASED requires immediate intervention to prevent potentially devastating consequences, including cardiac dysfunction, organ failure, and even death. This [paper/presentation/discussion] will explore the complexities of ASED in pediatric patients, focusing on the critical need for early recognition, prompt medical stabilization, and specialized treatment to improve outcomes.

## Pathogenesis –

### 1. Genetic and Biological Predisposition:

- **Family History:** Individuals with a family history of eating disorders, mood disorders, anxiety disorders, or obsessive-compulsive disorder are at increased risk.
- **Temperament:** Certain temperamental traits, such as perfectionism, negative emotionality, and behavioral inhibition, may increase vulnerability.
- **Neurobiological Factors:** Research suggests alterations in neurotransmitter systems (e.g., serotonin, dopamine) and brain structure and function may contribute to the development of eating disorders.

## 2. Psychological Vulnerabilities:

- **Body Image Dissatisfaction:** Negative perceptions of body shape and size are a significant risk factor.
- **Low Self-Esteem:** Feelings of inadequacy and worthlessness can contribute to disordered eating behaviors.
- **Perfectionism:** An excessive need for control and a drive for unattainable standards can fuel restrictive eating.
- **Anxiety and Depression:** These comorbid conditions are common and can exacerbate eating disorder symptoms.
- **Trauma:** A history of trauma, abuse, or adverse childhood experiences can increase vulnerability.

## 3. Social and Environmental Influences:

- **Societal Pressures:** Exposure to cultural ideals of thinness and media portrayals of unrealistic body standards can contribute to body image dissatisfaction.
- **Peer Influences:** Social pressure from peers to diet or conform to certain body shapes can trigger or reinforce disordered eating behaviors.
- **Family Dynamics:** Family factors, such as enmeshment, rigidity, and conflict, may contribute to the development of eating disorders.
- **Weight Stigma:** Experiencing weight-based discrimination or teasing can negatively impact body image and self-esteem.
- **Trauma:** A history of bullying can also have a significant impact on social acceptance and development of ASED.

## 4. Maladaptive Eating Behaviors and Physiological Consequences:

- **Dietary Restriction:** Restricting calorie intake leads to weight loss, metabolic adaptations (e.g., decreased resting metabolic rate), and neuroendocrine changes (e.g., decreased thyroid hormone levels).
- **Purging Behaviors:** Self-induced vomiting, laxative abuse, and excessive exercise can lead to electrolyte imbalances, dehydration, and gastrointestinal complications.
- **Binge Eating:** Episodes of uncontrolled overeating can be followed by compensatory behaviors (e.g., purging, restriction) to prevent weight gain.
- **Malnutrition:** Prolonged malnutrition leads to a cascade of physiological consequences, including muscle wasting, cardiac dysfunction, bone mineral density loss, immune system impairment, and cognitive deficits.

## 5. Positive Feedback Loops:

- **Reinforcement:** Initially, restrictive eating or weight loss may be positively reinforced by feelings of control, accomplishment, or social approval.
- **Addictive Nature:** As the eating disorder progresses, these behaviors can become compulsive and addictive, driven by neurobiological changes and psychological dependence.
- **Distorted Thinking:** Over time, eating disorder cognitions become entrenched and resistant to change, perpetuating the cycle of disordered eating.

## Eating Disorders Prevention Starts in the First Year of Life: The Key Role of Families

The foundation for the emergence of an eating disorder can take root even within the first year of life, and the guidance provided by parents and family can significantly influence the onset or absence of such disorders. Feeding a child represents an important form of communication between the parents and the child, a process essential to the child's growth. The surrounding milieu must respond readily to the child's needs, aiding in organizing the influx of diverse stimuli, thus enabling the child to comprehend and decipher them. Until this mastery is attained, the child struggles with an amalgamation of impulses and needs, and, without proper guidance, confusion arises, blurring the line between biological and emotional experiences.18-20

When parents sense the infant's need for nutrition, often conveyed through cries, and offer him or her food, the child learns to distinguish the feeling of hunger from other tensions and needs. However, if the adult's response is suboptimal, leading to persistent misinterpretation, such as assuming the child is hungry, cold, or fatigued when not, the result will be a situation of confusion and bewilderment. Consequently, the child fails to grasp the management of nourishment-related needs, distinguish hunger from other emotional tensions, recognize the demarcation between hunger and satisfaction, or discern nutritional requirements from other forms of discomfort or tension. Early negative and confusing experiences undermine the ability to recognize hunger and satiety signals, preventing the child from distinguishing the desire for food from other unpleasant signals that are related to other conflicts and problems.

Food should be offered when infants are genuinely and physically hungry and should never be used as a reward or wielded as a punitive tool. Infants should not be forced to eat when they refuse, nor should parents place undue emphasis on eating, especially when the child tends to show opposition. Parents, family, or caretakers thus play a decisive role in helping the child develop an appropriate sensitivity to the hunger impulse, so that he or she recognizes it as an accurate .

### Anorexia nervosa

An unrelenting determination to shed pounds by limiting food intake and/or engaging in excessive physical activity, even when the individual is already underweight. This behavior stems from a skewed perception of one's body, where young individuals perceive themselves as overweight or obese despite evidence to the contrary. Consequently, a profound apprehension about gaining weight ensues. The convictions associated with anorexia nervosa are so potent that they create substantial obstacles for the individual to consume an appropriate and nourishing quantity of food, resulting in persistent malnutrition. This state of malnutrition can lead to severe medical repercussions.

### Atypical anorexia nervosa (AAN)

A youth experiencing atypical anorexia nervosa has undergone substantial weight loss and exhibits all the characteristics typical of anorexia nervosa. Nevertheless, their body weight falls within the normal range or surpasses it. The medical and psychological repercussions associated with atypical anorexia nervosa are equally severe in comparison to those of classic anorexia nervosa.

## Bulimia nervosa

A repetitive occurrences of binge eating (rapidly consuming an excessively large quantity of food) accompanied by a sensation of lacking command over this eating behavior. Subsequently, actions are taken to prevent weight gain, including actions like vomiting (purging), misusing laxatives, or engaging in excessive exercise. Individuals affected by bulimia nervosa also tend to harbor harsh self-judgment concerning their bodily form, dimensions, and weight.

## Binge-eating disorder

Recurrent instances of indulging in excessive eating. Such episodes are defined by both of the subsequent criteria: within a specific timeframe (eg, 2 hours), consuming a quantity of food significantly surpassing what the majority of individuals would ingest in a similar timeframe and comparable situation, combined with a sensation of inability to manage or restrain the excessive eating during that period.

These binge-eating episodes involve  $\geq 3$  of the subsequent actions: consuming food considerably faster than usual, eating until reaching an uncomfortably full state, ingesting substantial quantities of food when not experiencing hunger, eating in solitude due to embarrassment about the excessive consumption, and experiencing emotions of guilt, disgust, or sadness afterward.

On average, these episodes of binge eating take place at least once a week for a duration of 3 months. The instances of binge eating are not linked with the utilization of inappropriate compensatory practices as observed in bulimia nervosa, and they do not solely occur within the context of either bulimia nervosa or anorexia nervosa.

## Avoidant restrictive food intake disorder

An irregular eating pattern (ie, apparent disinterest in eating or food, avoidance based on sensory aspects of food, or anxiety about adverse effects of eating). It is characterized by continuous failure to fulfill appropriate nutritional and/or energy requirements, as manifested by any of the following: substantial weight reduction or, in the case of children, failure to achieve anticipated growth and/or weight gain; notable nutritional deficiency; reliance on enteral feeding or oral nutritional supplements; significant disruption to psychosocial well-being.

This disturbance cannot be more suitably explained by the absence of accessible food or by a culturally accepted practice. The eating disruption cannot be attributed to a concurrent medical condition, nor can it be more reasonably accounted for by another mental disorder. If the eating disturbance arises within the context of another condition or disorder, the intensity of the eating disturbance surpasses what is typically linked with the said condition or disorder. This avoidance may lead to a failure to gain weight, nutritional deficiencies, or significant impairment in the young person's life. For example, they may be unable to socialize with others if food is involved.

## Conclusion –

Eating disorders, which can be the manifestations of symptoms and conditions that accompany and express deep pain, and often anxiety, fear, and insecurity,<sup>21</sup> are not a new phenomenon. In recent years, many causes have contributed to a significant increase of this condition in the population under the age of 18. However, their incidence in this age group has increased yet further, alarmingly coincidentally with the COVI<sup>19</sup> pandemic. Several studies have linked the harmful socioeconomic effects of the pandemic to a significant increase of eating disorders.<sup>16,17</sup> These findings suggest that special attention should be paid to prevent the onset and effects of eating disorders during and after periods of severe social distress, which in addition to other negative effects may trigger the development of this serious condition.

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