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Special Feature Article

Outpatient Treatment of Eating Disorders in Children and Adolescents: What is Effective treatment?—With a Focus on Collaboration with Local Medical Institutions and Educational Partnerships—

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Abstract

The prevalence of eating disorders in children and adolescents is increasing worldwide, even among those of different cultural backgrounds. The age of onset is becoming younger. In addition, the COVID-19 pandemic has affected young people both mentally and physically, and the number of teenage patients has increased markedly. The majority of eating disorders in children and adolescents are AN-R (anorexia nervosa, restricting type), but there are also a small number of ARFID (avoidant/restrictive food intake disorder) patients with no apparent desire to lose weight. The management of AN and ARFID typically involves outpatient treatment, but physical symptoms and accompanying psychiatric symptoms may require inpatient treatment. The number of children and adolescents with eating disorders is increasing, but pediatric institutions are not yet equipped to treat them. We report on our center's trial of a community-based medical consultation. The prognosis for eating disorders in children and adolescents is better than that in adults. However, even if weight is maintained, it is important to support the child's eating behavior as well as that of the child's family. The goal is to maintain

daily life. For elementary, middle, and high school students, in particular, collaboration with the school is essential for maintaining physical and mental health. Therefore, we discuss the role of schools in the outpatient treatment of eating disorders in children and adolescents.

Keywords: child and adolescent eating disorders, community health care consultation, school collaboration, anorexia nervosa, avoidant/restrictive food intake disorder

Introduction

Child and adolescent eating disorders (Ch-EDs) are showing global trends toward a younger onset age and an increase in the number of patients, regardless of cultural background.¹⁾²⁾²²⁾ Furthermore, the impact of the COVID-19 pandemic has been marked; in particular, the number of adolescents with eating disorders has doubled compared with pre-pandemic levels and become a social issue.⁴⁾²¹⁾

Under these circumstances, it is anticipated that rates of outpatient treatment for Ch-ED patients will increase further. The fundamentals of eating disorder treatment remain unchanged even in children: to establish and safely implement a comprehensive treatment system within the community that combines physical treatment, nutritional management, psychological therapy, pharmacotherapy, family support, and social participation. However, effective

outpatient treatment for patients with Ch-EDs has not yet been fully established, and it is considered that clinical settings are currently in a state of trial and error, involving various treatment approaches. Generally, early-onset cases are considered to have a better prognosis than adult-onset patients. However, for patients who are still in the process of physical and psychological development, it is known that persistent chronic malnutrition and psychological stress can lead to various problems in adulthood (such as delayed bone maturation and endocrine issues),¹¹⁾ and the importance of prevention, early detection, and early treatment of eating disorders is increasing.¹⁹⁾

In outpatient treatment, the goal is to improve malnutrition while taking the patient's developmental stage into account. In psychotherapy, Family-Based Treatment (FBT) is recommended by NICE guidelines¹²⁾ for

children and adolescents, and its adoption is progressing in Japan as well. However, despite the increasing number of Ch-EDs patients, the relevant systems at pediatric medical institutions have yet to be fully established, making it difficult for primary care physicians to decide whether to opt for out- or inpatient treatment.

This paper reports on the current status of community-based health care consultation implemented at the Child Mental Health Center, Saitama Medical Center, Dokkyo Medical University (hereinafter referred to as “the center”). Although the prognosis of patients with Ch-EDs is considered favorable compared with adult-onset cases, even after weight is maintained, long-term support, involving not only the patient’s eating behaviors but also the family, is often necessary. Maintaining daily life is crucial for recovery, and particularly for elementary, junior high, and high school students, school collaboration is considered essential for maintaining physical and mental health.¹⁸⁾

Based on the above, this report focuses on collaboration in community health care deemed necessary to promote the treatment of patients with Ch-EDs, as well as the role played by educational institutions.

I. Our Center’s Initiative for

Community-based Consultation

Our center is located in the eastern region of Saitama Prefecture, and serves a medical area with a population exceeding 1 million people. Pediatric specialists are engaged in medical practice at the center. Because we are geographically close not only to Saitama Prefecture but also Tokyo and Chiba Prefectures, we receive emergency consultations from a relatively wide geographic area. It is considered that the increasing number of pediatricians who demonstrate an understanding of the growing need for Ch-ED care is contributing to the rise in consultation cases. We report on the current status of our efforts to establish a community-based consultation system involving pediatricians committed to treating patients with eating disorders.⁸⁾¹⁰⁾

[Methods]

We conducted a retrospective study by extracting data from medical records regarding the characteristics of healthcare facilities that sought urgent consultations with our center between August 2020 and October 2021, as well as the subsequent course and diagnoses of patients after contact. Note that all initial visits to our center are, in principle, by appointment through the Medical Collaboration Office. “Emergency consultation” refers to cases in which patients under treatment

at other institutions have clinical problems, and attending physicians judge them to be urgent and directly consult physicians at our center without going through the Medical Collaboration Office.

Regarding ethical considerations, informed consent was obtained from research participants in accordance with the Declaration of Helsinki. Approval was obtained from the Clinical Research Ethics Review Committee of Dokkyo Medical University Saitama Medical Center (Research No.: 1880).

[Results]

1) Number of consultations

There were 59 emergency consultations, with a male-to-female ratio of 2:57. The majority of consultations (73%) were from regional medical support hospitals, including public and general hospitals, followed by clinics (19%) and university hospitals (7%).

2) Clinical presentation at the initial visit for the 59 cases referred via emergency consultation and 57 cases referred through the regular referral process (Table 1)

The male-to-female ratio for the 57 cases referred through the regular referral process was 8:49, and the median age was 13 years. The clinical subtypes were anorexia nervosa (AN) in 40 cases and avoidant/restrictive food

intake disorder (ARFID) in 17 cases; co-occurrence of autism spectrum disorder (ASD) was observed in 9 cases (15.8%). ASD comorbidity was noted in 14 cases (42.4%), which was significantly higher than in the general first-visit cohort (Fisher's exact test, $P < 0.05$). In addition, there were no differences in the median age or median standard body weight between the 13 cases that continued treatment at the referring medical institution (11 cases of AN, 1 case of ARFID, and 1 case with an unknown condition) and the 13 cases that continued treatment at other hospitals (9 cases of AN, 1 case of bulimia nervosa [BN], and 3 cases with unknown conditions).

3) Details of consultations

More than half of the consultations were conducted via telephone or email. Most consultations were urgent cases requiring the determination of admission eligibility. There were 57 patients referred through the Medical Collaboration Office via standard referral procedures; all had their initial outpatient visit at our center and continued treatment there. Of the 59 urgent consultations (handled via phone, email, etc.), 33 were those in which patients either had an initial outpatient visit at our center's temporary clinic or were transferred from the referring hospital and admitted directly.

There were 13 cases (10 inpatients, 3 outpatients) in which patients initially requested early admission to our center for treatment but, due to capacity constraints, we proposed continuing treatment at the referring institution while maintaining close communication with that institution. When treatment continued at the referring institution, consultations were primarily conducted via email, and we responded to communications from the attending physician as needed. In the initial phase, information exchange to confirm the disease subtype and physical condition was crucial; at that time, we applied the refeeding risk assessment used in initial treatment at our center as a reference.⁷⁾

[Discussion]

Herpertz-Dahlmann, B. recommended a comprehensive approach involving an “interdisciplinary team that takes the patient’s development into account” with extensive clinical experience in the treatment of children and adolescents with AN.⁶⁾ In the clinical management of AN patients in this age group, consideration must be given to developmental aspects, such as the co-occurrence of neurodevelopmental disorders. An interdisciplinary team is a medical model in which healthcare professionals from multiple specialties, such as child psychiatrists,

pediatricians, dietitians, and nurses, collaborate to manage patients’ health and provide treatment through a comprehensive approach. However, given the reality in Japan, primary care must inevitably be provided by non-specialists.

The following benefits of consultation were identified. Given the increasing number of pediatric patients, establishing a system where pediatricians responsible for primary care of eating disorder patients can provide community-based consultations offers significant benefits.

These include: (i) minimizing delays in patients receiving treatment, (ii) reducing the burden on patients and their families, (iii) ensuring that patients are in a physical condition suitable for psychological intervention when they visit a specialized medical facility following treatment at the referring institution, and (iv) providing patients and their families with a greater sense of security regarding treatment by standardizing the approach across multiple medical institutions.

A major benefit for healthcare providers is that pediatricians in general hospitals, who typically have few opportunities to treat patients with eating disorders, can gain experience by managing initial treatment themselves, rather than referring patients to

specialized facilities, and achieving treatment outcomes while receiving consultation. This is considered to deepen their understanding of eating disorders and broaden the pool of physicians who accept and provide care. The UK National Health Service (NHS) emphasizes the importance of a regional-level liaison system, arguing that community-based Ch-ED services should be established.¹⁵⁾ In the UK, access to care and waiting time standards for children and young people with eating disorders were published in 2015 and apply to children and young people up to the age of 19.

Due to the impact of the COVID-19 pandemic, it has been difficult for children and young people to receive timely treatment since 2020/21. Despite the NHS's recommendation that earlier treatment leads to better outcomes for patients with eating disorders, the goal that 95% of patients referred by 2020 should begin treatment within one week for urgent cases and within four weeks for non-urgent cases has not been met. In Japan as well, designated eating disorder support hospitals are being promoted as a prefectural-level initiative, but the situation remains unchanged, with such hospitals limited to only a few prefectures nationwide. It is hoped that infrastructure will be expanded nationwide in the future and consultation services for regional

medical institutions (targeted not only at physicians but all professionals involved in eating disorder care) will be enhanced.

II. Challenges in Reaching Treatment Completion: Insights from Outcomes of First-time Patients Receiving Our Center's Eating Disorder Care

We report on the outcomes of patients with eating disorders treated at our center. We examined data from 55 patients with anorexia nervosa (AN) who had their first outpatient visit between 2015 and 2017, focusing on age at the initial visit, age at treatment completion (or age at the final examination), duration of treatment, and outcomes (treatment completion, discontinuation, referral to another department, remission, partial remission, ongoing treatment, or complications). Remission was defined as recovery of both weight and eating behavior, while partial remission was defined as a state in which weight had recovered but psychological treatment was still required. The outcome of patients 4 to 6 years after their initial visit, including those still undergoing treatment, showed a remission rate (including partial remission) of 60%. Approximately half of the patients exhibited some form of complication, and the complication rate was higher in cases referred to other departments

(psychiatry, psychosomatic medicine). Furthermore, the reasons for referral to other departments were either due to psychological complications or a determination that the patient had reached the age of transition to adulthood. The median age at the end of treatment was 15.6 years. In many cases, symptoms entered remission coinciding with entry into high school, and it was considered that treatment concluded because the patients were able to adapt to high school life. In cases where treatment continued even after remission had been achieved, management focused on mental health issues other than the eating disorder (adjustment disorder: 20%, obsessive-compulsive disorder: 16.3%, ASD: 14.5%).

Since the primary settings for patients with childhood-onset eating disorders are school and home, the goal of treatment should not be limited to improving eating behaviors and weight; it must also consider stabilizing life at school and home, as well as improving family relationships. Therefore, it was considered that treatment termination should be approached with caution.¹⁶⁾²⁰⁾

III. The Importance of Collaboration Between Education and Healthcare for the Treatment of Eating Disorders in Children and Adolescents

For children and adolescents, school is the center of their lives outside the home. During outpatient care, we frequently encounter issues related to school. As a treatment team for outpatients, we considered the role that schools can play, as outlined below.

A key strength of the school environment is the presence of multiple staff members involved with the students, including homeroom teachers, club advisors, school nurses, and school counselors. Depending on the stage at which the patient begins treatment at a medical facility, the school can fulfill five distinct roles:

- 1) Gatekeeper in critical situations
- 2) A member of the family in the broadest sense
- 3) A supportive collaborator with the patient and family regarding adjustments to mealtime situations at school
- 4) A role in devising strategies to ensure that learning opportunities are not lost
- 5) A supportive environment for life after recovery and adolescent development (lives after recovery)

1. Gatekeeper during a crisis

Caregivers do not necessarily recognize eating disorders in children. We surveyed caregivers of eating disorder patients attending our center to identify who first noticed the child's eating disorder (caregivers, homeroom

teachers, school nurses, primary care physicians, etc.). The results showed that in 2013–2014, caregivers accounted for only 50% of the 92 patients, while school personnel accounted for 21% (school nurses: 15%, homeroom teachers: 4%, club advisors: 2%), and family doctors accounted for 17%. In a similar survey conducted from 2014 to 2018, the proportion of family members increased significantly, with caregivers accounting for 80% (mothers: 78%, fathers: 2%) of the 118 patients; however, school nurses still played a major role as identifiers, accounting for 11%.⁹⁾

Based on the above, it is clear that schools are an environment in which it is easier to detect the onset of eating disorders in children. School nurses, in particular, play a significant role; they not only conduct school health screenings but also sometimes become aware of the condition when consulted individually by homeroom teachers or club advisors regarding students' physical condition or school lunch consumption. In schools, when school nurses monitor children's health, recognize symptoms, explain the need for medical evaluation to the student and their family, and promote medical consultation, this contributes significantly to the early treatment of Ch-ED patients. To achieve this, accurate knowledge of eating disorders

and an understanding of patients are essential; the Japan Eating Disorders Association serves as a central point of contact, hosting the "Eating Disorder Gatekeeper Training Workshop for School Nurses" annually, which is of marked significance.

2. A member of the family in the broadest sense³⁾

Forsberg, S. et al. stated that when introducing treatment from an FBT perspective in an outpatient setting, in households where implementation is difficult, such as single-parent families or those lacking supervision during lunch, it is necessary for a trusted figure from the school (such as a school counselor, school nurse, or close teacher) to provide supervision for snack and lunch times.³⁾ It would likely be difficult to implement this approach directly in Japan. However, homeroom teachers and school nurses might be able to be involved with patients at school in ways similar to the "broad-family" members described by Forsberg et al.

3. Approaches to mealtime settings at school: the student and family as loose collaborators

Even if the relationship is not as deep as that of a "broad family," it is still possible for them to act as loose collaborators by, for example, making adjustments to the mealtime

environment. Even among students who are able to continue attending school, there are many who feel isolated in the classroom. At school, roles should be assigned to ensure that life outside of treatment, such as interacting with friends, participating in club activities, student council, and school events, is as fulfilling as possible.

4. The role of ensuring that learning opportunities are not lost

One point to keep in mind regarding outpatient treatment is that a treatment plan focused strictly on weight gain as the goal of behavioral restriction risks depriving patients who are motivated to attend school of their opportunity to receive an education. While maintaining weight is certainly important, if a patient's weight is at or above 80% of their standard body weight at discharge and their caloric intake is sufficiently maintained, we permit them to return to school early after discharge. Having the school nurse be responsible for weekly vital sign checks (temperature, heart rate, blood pressure) once a week at school can also help ensure stable school attendance, provided the patient does not refuse. Individual circumstances should also be taken into account. For children with low physical stamina or those who have difficulty adjusting, we recommend a phased return to school (e.g., attending

only in the morning, attending for just one hour in some cases, or returning home after just saying hello), returning home without eating school lunch, observing physical education classes, allowing them to bring a packed lunch even if they can attend until the afternoon, permitting them to eat lunch in the counseling or health room rather than the classroom, or allowing participation in events such as music festivals, sports days, field trips, overnight study trips, and school excursions. By establishing detailed conditions and fostering a shared understanding within the school through the school nurse, we can minimize inconsistencies in how involved teachers handle such situations.

Methods for sharing these conditions include: 1) indirect coordination, where the physician makes a request verbally or in writing through a parent; 2) direct coordination, where the physician makes a request directly to the school representative via a meeting or phone call; and 3) multidisciplinary coordination, where a meeting is held involving the school representative, physician, medical social worker (MSW), and administrative staff to make the request.¹⁷⁾ Unless there are specific reasons (such as bullying at school, deep distrust of the educational system, or the provision of an alternative setting

instead of attending school), continuing to attend school and study are considered to build the child's self-confidence, maintain a daily routine, and enhance the effectiveness of outpatient treatment. Since the COVID-19 pandemic, an increasing number of schools have adopted online classes; therefore, it would be useful to adjust arrangements so that the child can attend school within reasonable limits based on their physical condition, and participate in online classes when in-person attendance is difficult.

5. Support for life after recovery and adolescent development (lives after recovery)

School teachers need opportunities to learn specific methods for assisting students (referred to as “patients” in medical contexts) during mealtimes, as well as gain a deeper understanding of the illness (including its external manifestations). To achieve this, one approach is to arrange for the student's homeroom teacher or school nurse to attend outpatient appointments with the family's consent, providing an opportunity for direct information exchange with the attending physician.

Perhaps the time has come for us healthcare professionals to shift our perspective from the traditional problem-oriented view, that school maladjustment triggers or exacerbates

the illness, to a solution-oriented view, in which the school plays an appropriate role as a collaborator in treatment.

Conclusion

Overseas, there are reports comparing outcomes of “outpatient/day treatment” versus “specialized inpatient treatment for eating disorders” for children and adolescents aged 12 or older with AN. The results showed that there was almost no difference in weight gain after 12 months between the two approaches. Conversely, this suggests that outpatient treatment should be prioritized if the patient's physical condition permits it.⁵⁾

Regarding treatment for AN in children and adolescents in Japan, the Japanese Society of Psychosomatic Medicine has published treatment guidelines.¹⁴⁾ While these guidelines are practical for clinical use, when compared with treatment guidelines from other countries, such as Junior MARSIPAN (UK)⁷⁾ and NSW Eating Disorders Toolkit (New South Wales, Australia),¹³⁾ several points warrant consideration. These include a tendency to underestimate the frequency of monitoring during refeeding and severity classifications, as well as relatively low target caloric intake levels.

In light of these factors, it is necessary to revise the guidelines in the future

based on internationally accumulated evidence, while continuing to adapt them to the specific circumstances in Japan. The range of physicians treating child and adolescent patients is broad, including pediatricians, child psychiatrists, psychiatrists, and psychosomatic medicine specialists. Regardless of their specialty, it is expected that they will follow common treatment guidelines, gather information across disciplinary boundaries to enable safe, secure, and effective treatment, and establish outpatient treatment methods with high levels of evidence.

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表 1 相談を受けた件数と初診時の臨床像

	通常初診 n = 57	緊急相談 n = 59		
		緊急相談後当科初診 33 (56%)	相談側施設で継続 13 (22%)	他院受診提案 13 (22%)
性別 (男 : 女)	8 : 49	2 : 31	0 : 13	0 : 13
年齢中央値 (歳)	13 (6~21)	13 (6~15)	12.5 (10~15)	14 (10~16)
AN	40	23	11	9
ARFID	17	10	1	0
BN	0	0	0	1
不明	0	0	1	3
ASD 併存	9 (15.8%) [§]	14 (42.4%) [§]	不明	不明
%標準体重中央値 (不明 6 例除く)	75% (55~127)	72% (53~103)	68% (60~97)	74% (55~83)

[§] Fisher 正確確率検定 $P < 0.05$

Table 1: Number of consultations and clinical presentation at initial visit

Regular Initial Visit: n = 57

Emergency Consultation: n = 59

Initial Visit to Our Department Following Emergency Consultation: 33 (56%)

Treatment Continued at Referring Facility: 13 (22%)

Referral to Another Hospital: 13 (22%)

Sex (Male: Female)

Median Age (age)

AN

ARFID

BN

Unknown

Co-occurrence of ASD: 9 (15.8%)[§], 14 (42.4%)[§], Unknown, Unknown

Median Percentage of Standard Body Weight (excluding 6 cases where unknown)

[§]Fisher's exact probability test, $P < 0.05$