Nutritional aspects of Eating Disorders

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Outline

- Role of the dietitian within the ED team
- Nutritional response to starvation
- Metabolism and nutritional requirements
- Anthropometry
  - Why is weight so important in treatment and –recovery?
  - Children and Adolescent growth and development –what's normal
  - Weight parameters, calculation and tips
  - Recognising & measuring risk
- Dietary intake – typical vs ED
- Re-nourishment process
- Busting dietary myths

Eating Disorder Facts and Figures

- 70 million cases of ED's worldwide
- 90% are aged 12 – 25yrs
- BED is 3 times more common than AN and BN – 40% of those with BED are males
- Girls who diet frequently are 12 times more likely to binge as girls who don't
- 1/3 of non-overweight girls reported dieting
- Overweight girls are more likely to engage in extreme dieting behaviours
- 35% of normal dieters progress to pathological dieting, of which 20 – 25% progress to partial or full syndrome EDs
- Diet industry is a 50 billion dollar/yr industry

Dietetic Role

- Examine current nutritional status and identify deficits, refeeding syndrome risk
- Assess the risk of low weight on growth and development
- Gain info about eating behaviours & beliefs
- Provide nutritional guidance to achieve safe re-nourishment, weight restoration or maintenance, physical development, flexible and intuitive eating

Pathophysiology of starvation

1- Insufficient energy

↓ insulin ↑glucagon

2- Depleted glycogen stores in muscles and liver

3- Activation of hormone sensitive lipase.

4- Adipose tissue breakdown

5-↑ Fatty acids +glycerol delivered to the liver

→ ketone production

6- Gluconeogenesis

Amino acid and glycerol = glucose

Brain, retina and nephrons

7- Shift to ketone and glucose metabolism

8- Serum electrolytes maintained:

Bone and tissue catabolism

Increased renal tubular reabsorption

Dehydration

9- Muscle wasting – amino acid production

10- Autonomic nervous system disturbances – bradycardia, QT Interval prolongation.

Metabolism in starvation

- Healthy adolescents have very high energy requirements due to pubertal growth phase
- Low wt adolescents with AN have reduced requirements due to:
  - Depleted fat stores lead to:
  - Increase in cardiac vagal tone
  - Bradycardia
  - Hypotension
- Conservation of energy

Fuel used in starvation

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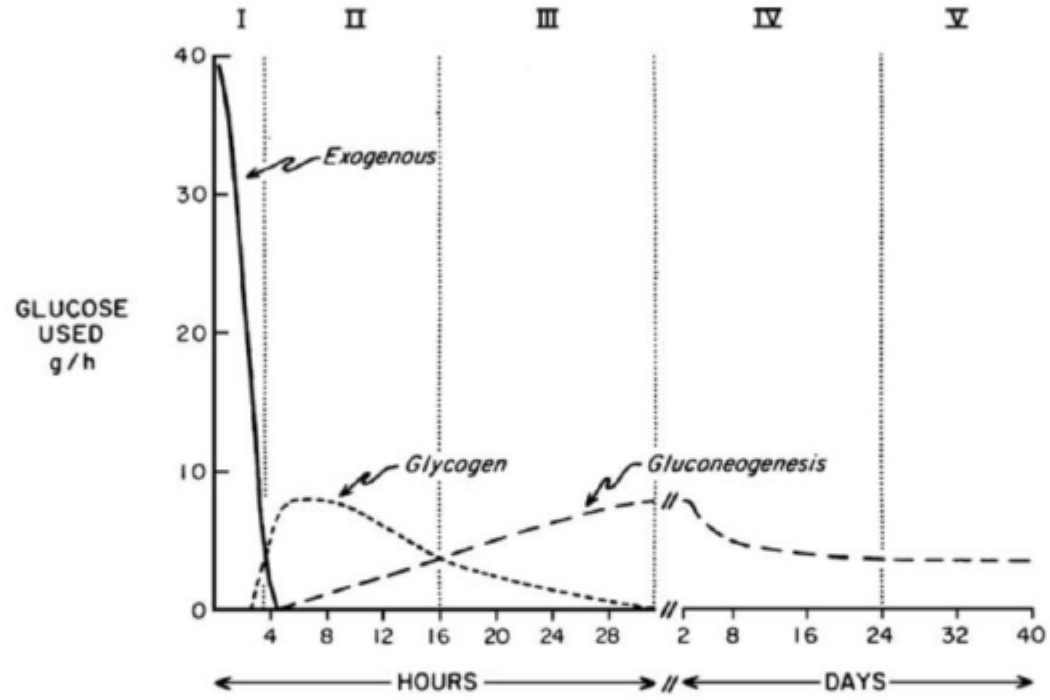

Stages of starvation.png

		(I)	(II)	(III)	(IV)	(V)
ORIGIN OF BLOOD GLUCOSE	:	Exogenous	Glycogen Hepatic gluconeogenesis	Hepatic gluconeogenesis Glycogen	Gluconeogenesis, hepatic and renal	Gluconeogenesis, hepatic and renal
TISSUES USING GLUCOSE	:	All	All except liver. Muscle and adipose tissue at diminished rates	All except liver. Muscle and adipose tissue at rates intermediate between II and IV	Brain, rbcs, renal medulla. Small amount by muscle	Brain at a diminished rate, rbcs, renal medulla
MAJOR FUEL OF BRAIN	:	Glucose	Glucose	Glucose	Glucose, ketone bodies	Ketone bodies, glucose

Figure 1 The five metabolic stages between the postabsorptive state and the near-steady state of prolonged starvation (62).

Ketones in starvation

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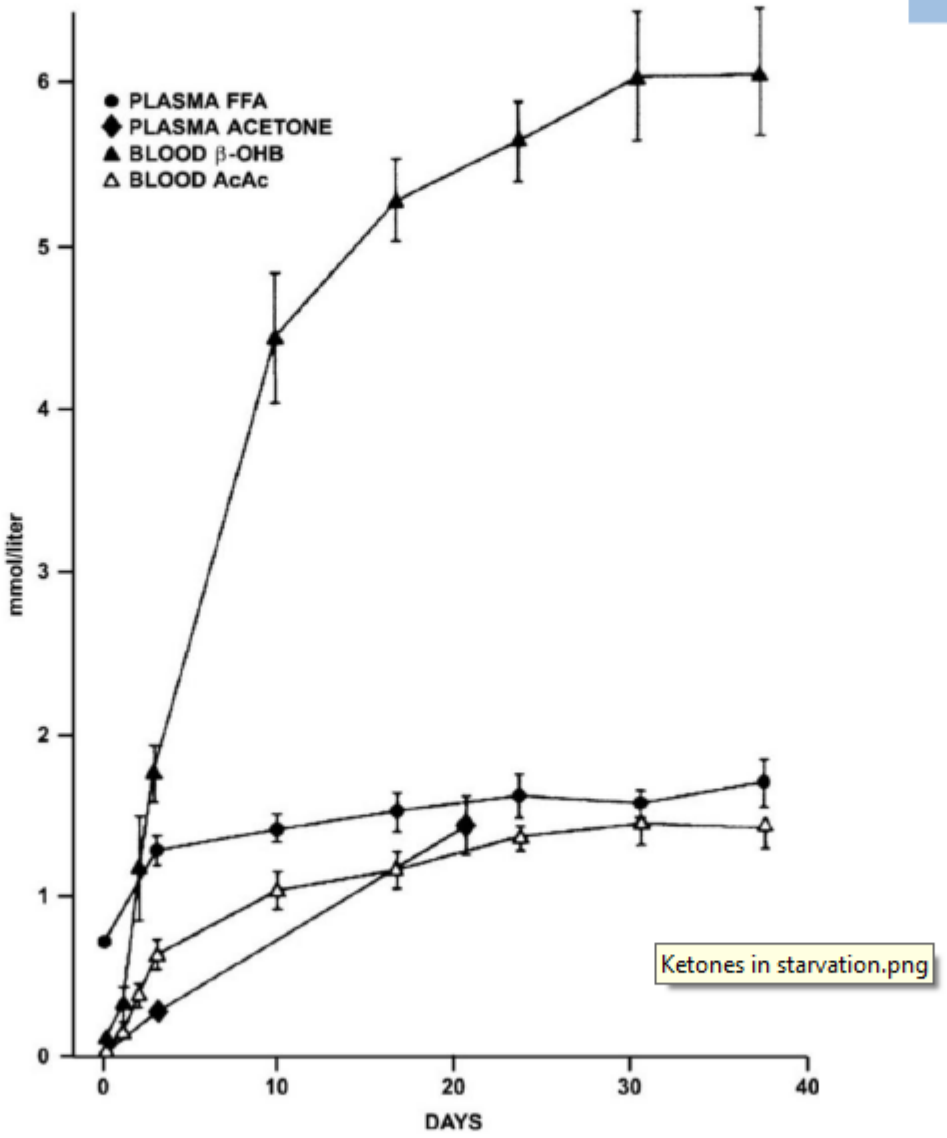
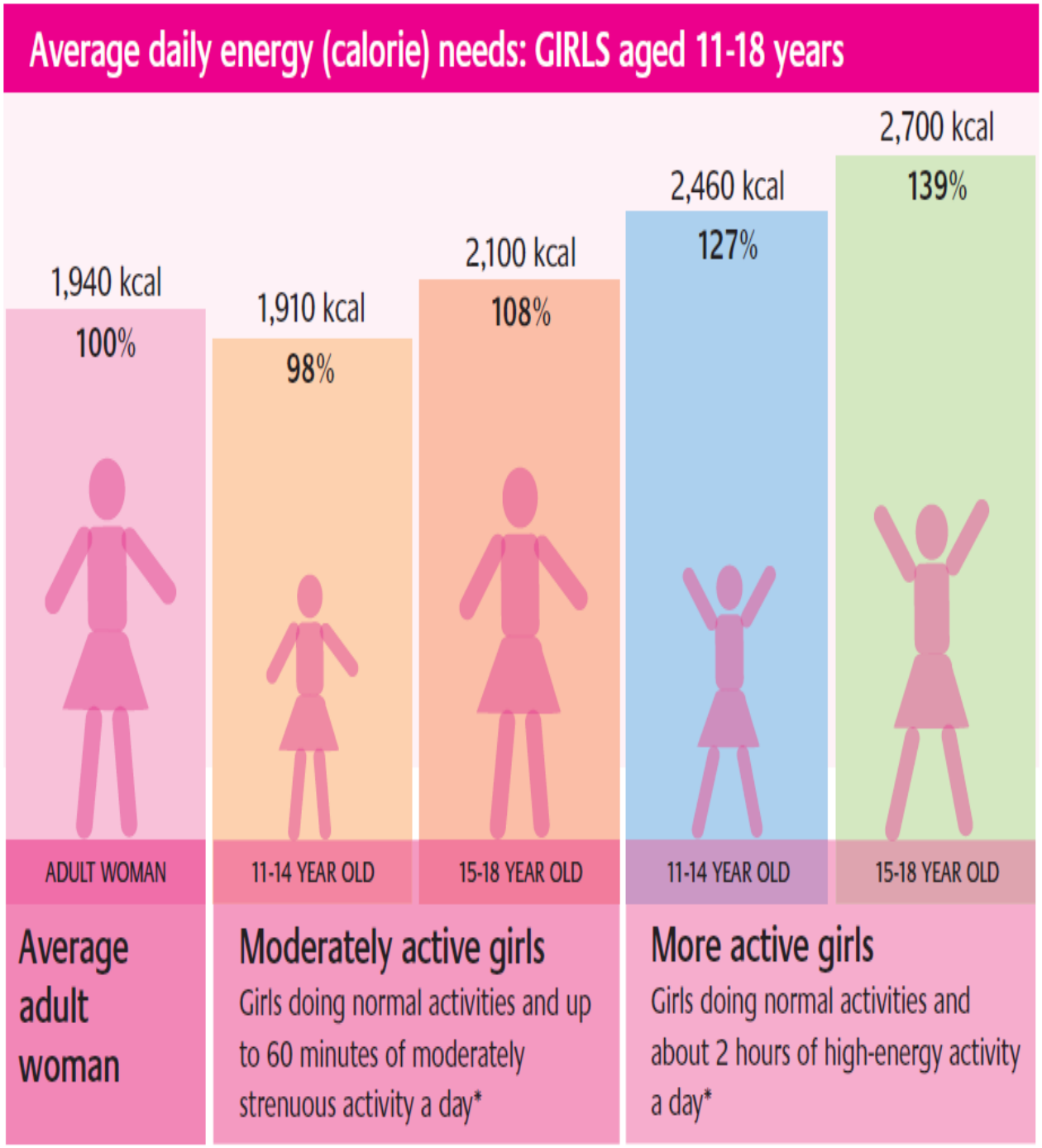


Figure 2 Concentrations of ketone bodies and plasma free fatty acids (FFA) in transition from the postabsorptive state to 4–6 weeks of starvation in a large number of subjects, male and female. Note the more than three orders of magnitude change in β-hydroxybutyrate and the doubling of FFA. Data courtesy of Dr. O. E. Owen.

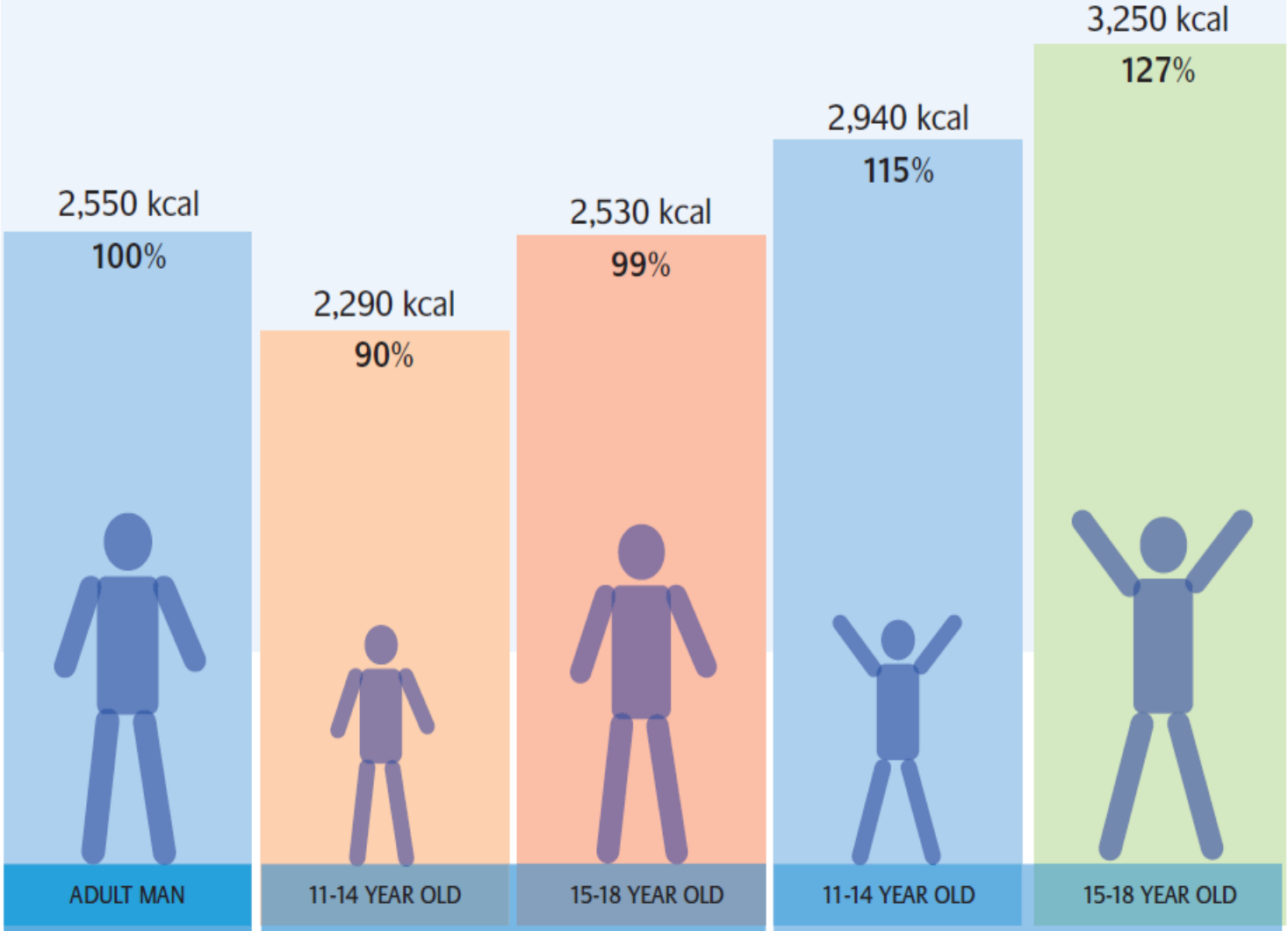
Nutritional Requirements in ED

- Increased in ED – 1.5 to 2 times higher
- 2 – 3 times higher than adults/parents in the home
- Brain MRI show comparisons between an anorexic brain and an individuals with alzheimers – brain substance loss, deficits are seen over time
- The YP can still be achieving well for now



The percentage figures indicate the energy (calorie) needs as a percentage of the energy needs of an average adult woman.

Average daily energy (calorie) needs: BOYS aged 11-18 years



The percentage figures indicate the energy (calorie) needs as a percentage of the energy needs of an average adult man.

Average adult man

Moderately active boys

Boys doing normal activities and up to 60 minutes of moderately strenuous activity a day*

More active boys

Boys doing normal activities and about 2 hours of high-energy activity a day*

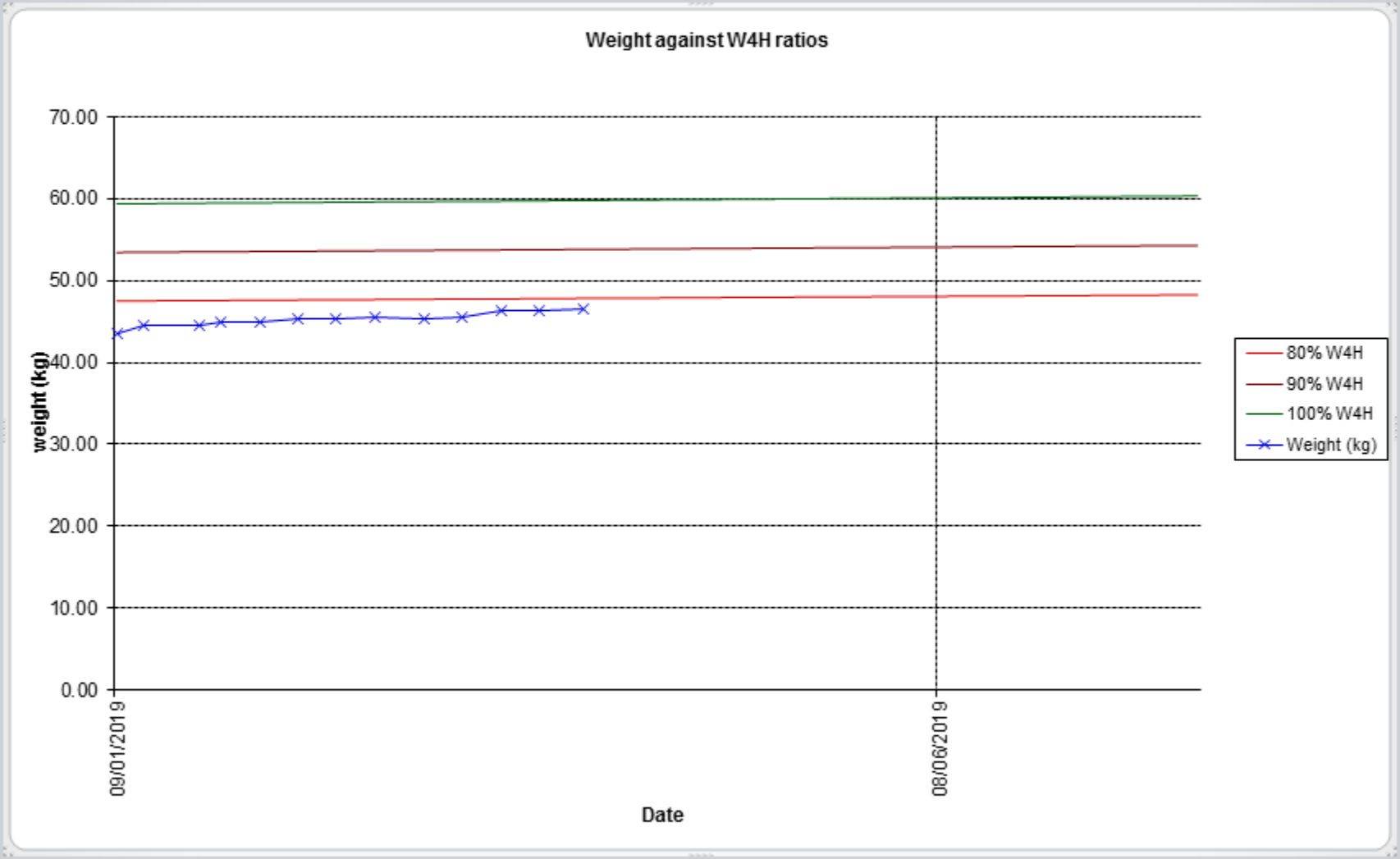
Anthropometry – Weight

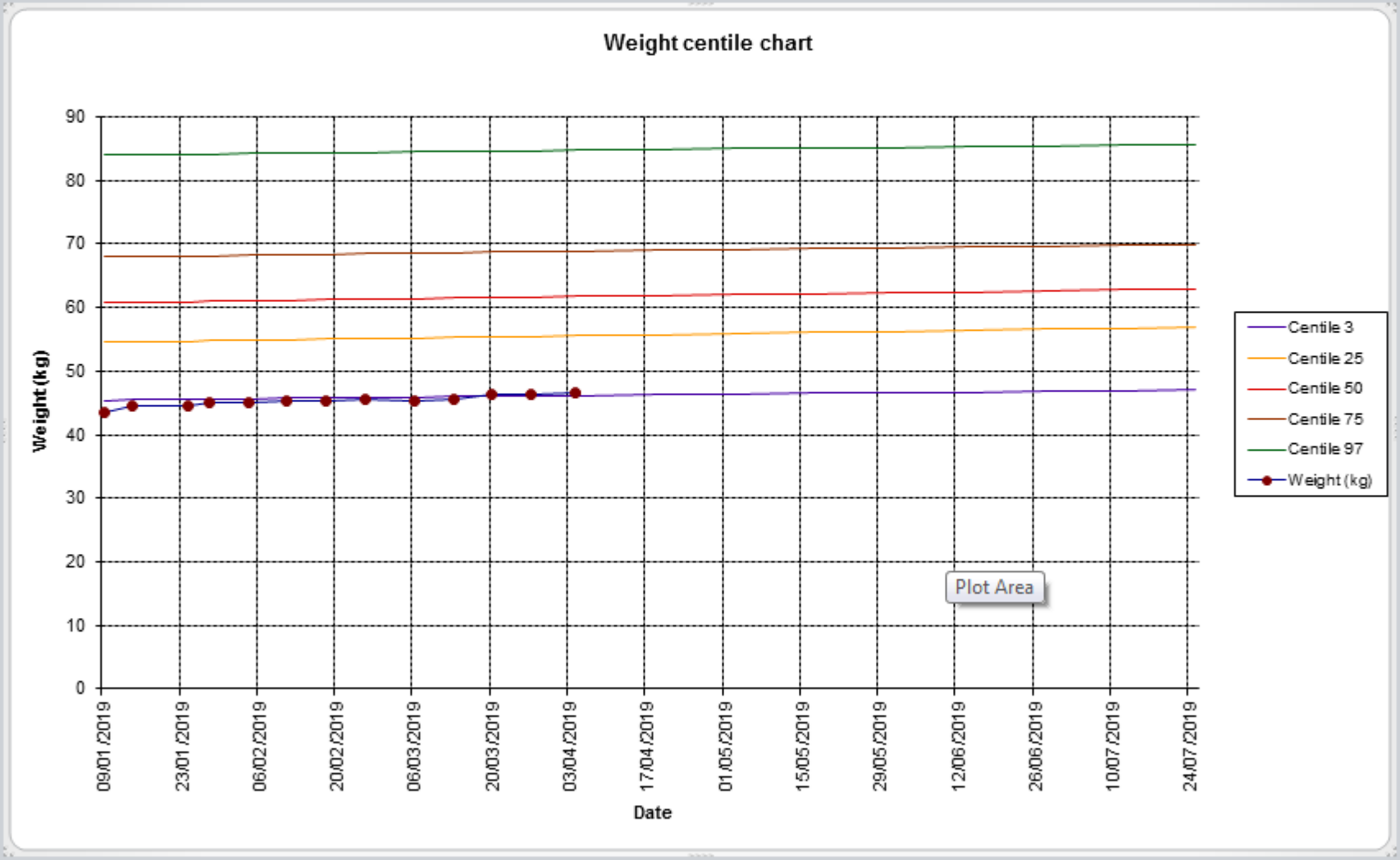
- Weight alone has limited use
  - Normal changes seen due to wt, ht and BMI throughout childhood and puberty
- Useful for tracking changes
- Cannot compare against population norms without taking into account ht, gender & age
- BMI centile charts
- Use %BMI calculator – www.marsipan.org.uk
  - Actual BMI/(median weight for age and gender) x100

Patient name: x

Date of birth: 30/12/2002 **sex:** male

Date of visit	Weight (kg)	Height (cm)	BMI	Weight centile	Height centile	BMI centile	Weight for height
09/01/2019	43.60	172.50	14.65	1.55	44.87	0.03	73.43
14/01/2019	44.60	172.50	14.99	2.21	44.64	0.10	75.08
24/01/2019	44.60	172.50	14.99	2.10	44.16	0.09	75.02
28/01/2019	45.00	172.50	15.12	2.38	43.97	0.14	75.67
04/02/2019	45.00	172.50	15.12	2.30	43.64	0.13	75.62
11/02/2019	45.40	172.50	15.26	2.57	43.31	0.19	76.25
18/02/2019	45.40	172.50	15.26	2.48	42.98	0.19	76.21
25/02/2019	45.60	172.50	15.32	2.58	42.66	0.22	76.50
06/03/2019	45.40	172.50	15.26	2.30	42.25	0.18	76.11
13/03/2019	45.60	172.50	15.32	2.39	41.94	0.21	76.40
20/03/2019	46.40	172.50	15.59	3.06	41.63	0.41	77.70
27/03/2019	46.40	172.50	15.59	2.97	41.32	0.40	77.66
04/04/2019	46.60	172.50	15.66	3.06	40.97	0.46	77.94


Weight against W4H ratios
70.00
60.00
50.00
40.00
30.00
20.00
10.00
0.00
weight (kg)
09/01/2019
08/06/2019
Date
80% W4H
90% W4H
100% W4H
Weight (kg)


Weight centile chart
Weight (kg)
90
80
70
60
50
40
30
20
10
0
09/01/2019
23/01/2019
06/02/2019
20/02/2019
06/03/2019
20/03/2019
03/04/2019
17/04/2019
01/05/2019
15/05/2019
29/05/2019
12/06/2019
26/06/2019
10/07/2019
24/07/2019
Date
Plot Area
Centile 3
Centile 25
Centile 50
Centile 75
Centile 97
Weight (kg)

50th Centile BMI values

age	boys	girls
years	Kg/m2	
9	16.037	16.399
9.25	16.125	16.515
9.5	16.219	16.637
9.75	16.318	16.765
10	16.423	16.898
10.25	16.533	17.036
10.5	16.648	17.179
10.75	16.768	17.327
11	16.892	17.478
11.25	17.02	17.634
11.5	17.154	17.793
11.75	17.291	17.954
12	17.433	18.117
12.25	17.579	18.281
12.5	17.729	18.446
12.75	17.881	18.61
13	18.037	18.772
13.25	18.194	18.932
13.5	18.354	19.09
13.75	18.514	19.244
14	18.675	19.395
14.25	18.836	19.542
14.5	18.997	19.684
14.75	19.158	19.822

age	boys	girls
years	Kg/m2	
15	19.317	19.955
15.25	19.475	20.083
15.5	19.632	20.206
15.75	19.786	20.324
16	19.938	20.438
16.25	20.087	20.547
16.5	20.234	20.652
16.75	20.378	20.751
17	20.519	20.847
17.25	20.656	20.938
17.5	20.791	21.026
17.75	20.923	21.11
18	21.052	21.19
18.25	21.178	21.267
18.5	21.301	21.342
18.75	21.422	21.413
19	21.54	21.482
19.25	21.655	21.548
19.5	21.768	21.612
19.75	21.878	21.674
20	21.986	21.735

BMI = weight in kg/ (height in metres)²

%mBMI = *(actual BMI/50th Centile BMI) x 100* [see chart]

Example

14.5 year old girl,

Weight: **30kg**

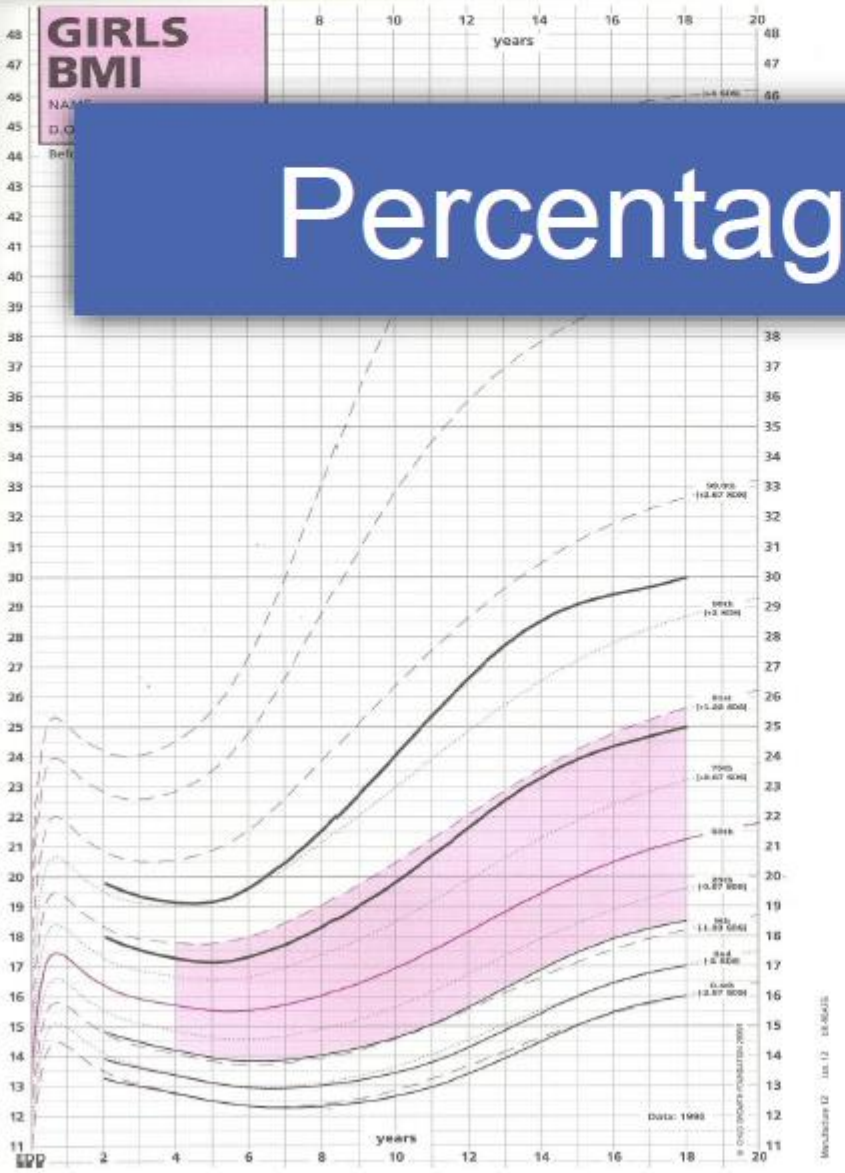
Height: **158cm**

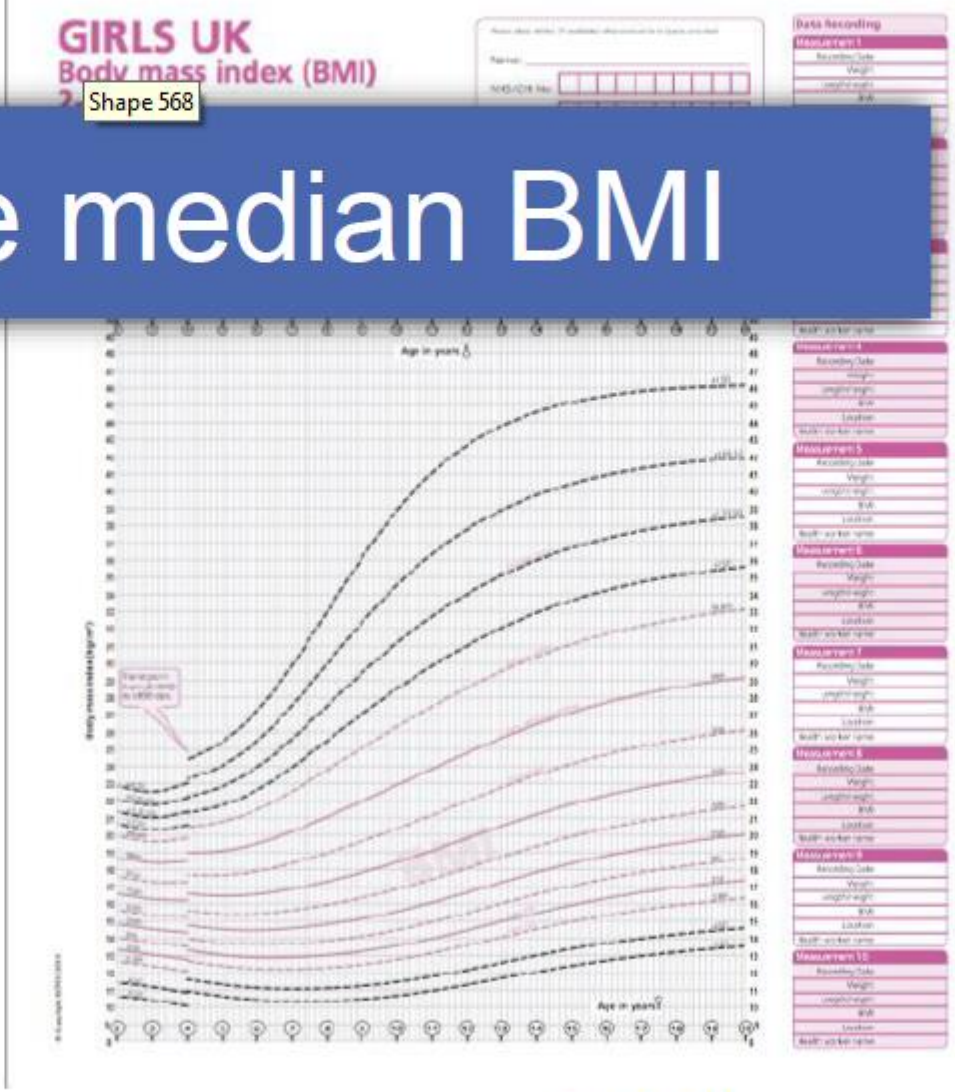
BMI: 30/(1.58x1.58) = **12kg/m²**

50th Centile BMI: **19.684 kg/m²**

%mBMI = (12/19.684 x100)

= **61%**





Percentage median BMI

Girls			Boys	
Weight change 50th Weight Centile	Net increase	Age	Weight change 50th Weight Centile	Net Increase
45 – 50kgs	5kgs	13– 14 yrs	43 – 49kgs	6kgs
50 – 53kgs	3kgs	14 – 15 yrs	49 – 55.5kgs	6.5kgs
53 – 55.5kgs	2.5kgs	15 – 16 yrs	55.5 – 61kgs	5.5kgs
55.5 – 57kgs	1.5kgs	16 – 17yrs	61 – 64.5kgs	3.5kgs
57 – 57.5kgs	0.5kgs	17 – 18yrs	64.5 – 67kgs	2.5kgs
Totals				
45 –57.5kgs	12.5kgs	13 – 18yrs	43 – 67kgs	24kgs

Adapted from the UK RCPCH Growth Charts (2012)

Weight – practical tips

- Same type of clothing
- Aim for same day and time of day
- No shoes
- Ask YP to attend bathroom before weighing
- Ensure nothing hidden in clothing
- Hair – bun style or wet
- Check timing of last meal
- Fluid loading

Fluid loading

- 1L = 1kg in weight gain
- YP can be consuming up to 5L/d
  - Early satiety
  - Decrease appetite
  - Induce vomiting
  - Alter weight
- Check volume consumed pre-weighing
- Check time of last bathroom visit, request YP attends bathroom pre-weighing
- May need to re-weigh post appointment

AQ15

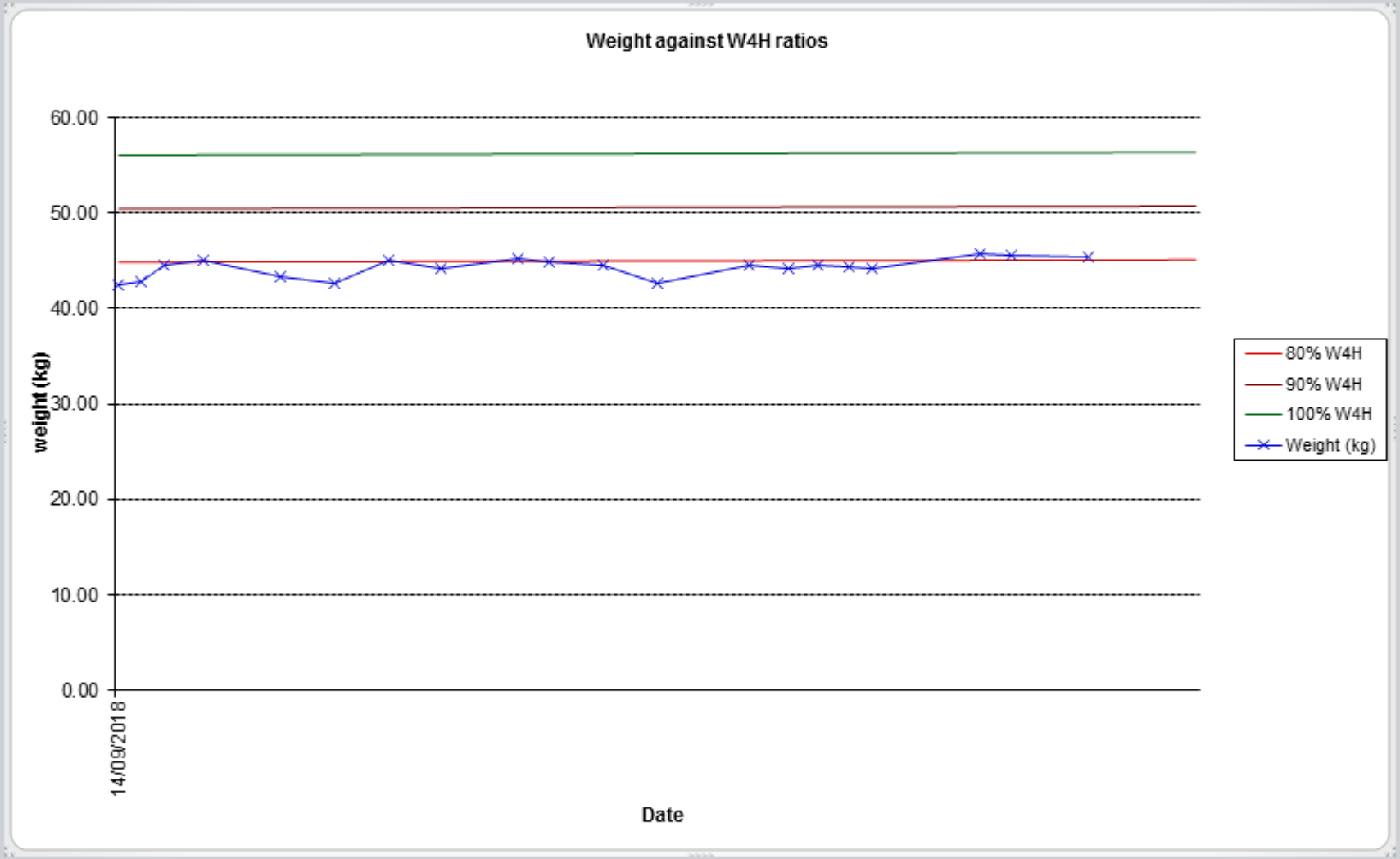
Weight4Height

Version 4.23 UK

Patient name: X

Date of birth: 01/08/2000 **sex:** female

Date of visit	Weight (kg)	Height (cm)	BMI	Weight centile	Height centile	BMI centile	Weight for height
14/09/2018	42.40	162.50	16.06	0.90	42.88	0.44	75.64
17/09/2018	42.80	162.50	16.21	1.11	42.87	0.58	76.35
20/09/2018	44.60	162.50	16.89	2.58	42.87	1.86	79.55
25/09/2018	45.00	162.50	17.04	3.04	42.86	2.31	80.25
05/10/2018	43.40	162.50	16.44	1.48	42.84	0.87	77.36
12/10/2018	42.60	162.50	16.13	0.99	42.82	0.49	75.92
19/10/2018	45.00	162.50	17.04	3.01	42.80	2.26	80.17
26/10/2018	44.20	162.50	16.74	2.13	42.79	1.41	78.72
05/11/2018	45.20	162.50	17.12	3.24	42.78	2.47	80.47
09/11/2018	44.80	162.50	16.97	2.74	42.78	1.98	79.75
16/11/2018	44.60	162.50	16.89	2.51	42.78	1.75	79.37
23/11/2018	42.60	162.50	16.13	0.96	42.78	0.46	75.79
05/12/2018	44.60	162.50	16.89	2.49	42.77	1.72	79.31
10/12/2018	44.20	162.50	16.74	2.08	42.76	1.35	78.58
14/12/2018	44.60	162.50	16.89	2.48	42.75	1.70	79.28
18/12/2018	44.40	162.50	16.81	2.27	42.74	1.51	78.92
21/12/2018	44.20	162.50	16.74	2.07	42.73	1.33	78.55
04/01/2019	45.80	162.50	17.34	4.00	42.71	3.18	81.35
08/01/2019	45.60	162.50	17.27	3.69	42.71	2.87	80.99
18/01/2019	45.40	162.50	17.19	3.40	42.71	2.56	80.60


Weight against W4H ratios
60.00
50.00
40.00
30.00
20.00
10.00
0.00
weight (kg)
14/09/2018
Date
80% W4H
90% W4H
100% W4H
Weight (kg)

MARSIPAN

% median BMI alone not enough

- Hudson et al. 2012: BMI indices alone are poor proxies for medical instability in early onset Eds. >40% of cases with medical instability had BMI >2nd centile.

- Medical instability can occur at any BMI threshold with weight loss

- Thorough clinical assessment, including cardiovascular observations, essential in any young person presenting with weight loss[1].

Hudson LD, Nicholls DE, Lynn RM, Viner RM (2012) Medical Instability and Growth of Children and Adolescents with Early Onset Eating Disorders)

Parameters	RED	AMBER	GREEN	BLUE
% median BMI	<70% (0.4th C)	70 – 80% (0.4th –2nd C)	80 – 85% (2nd – 9th C)	>85% (>9th C)
Weight loss	+1kg/wk x2wks	0.5 – 1kg/wk x 2wks	Up to 0.5kg/wk	Nil
Hydration	Fluid refusal Severe dehydration (10%) reduced urinary output, dry mouth, tachycardia	Severe fluid restriction moderate dehydration	Fluid restriciton mild dehydration (<5%)	Not clinically dehydrated
Biochemical abnormalities	Low K, PO4, Na, Ca, hypoglycaemia, hypoalbuminaemia	Low PO4, K, Na, Ca	None	None
Disordered eating	Acute food refusal 400-600kcals/d	Severe restriction, <50% daily requirement, purging	Moderate restriction bingeing	

Rate of weight loss

- Vital to establish same
- Risk Ax – Junior Marsipan
- Use drop in clothing size if unable to quantify
- GP weight hx
- Growth and development charts from early childhood
- Pictures pre-eating disorder (mobile phone)

Weight loss – watch out!

% Weight Loss

- 11yr old girl
- 30.2kg
- 25th Centile for wt
- 9th Centile for ht
- W4H= 95.9% BMI
- 1kg/wk loss x 3wks =9%
- Prev. wt 47kg, 160% BMI
- Actual weight loss
- 17kg x 16mths
- % wt loss = 36%

Rate of weight loss

- 12yr old girl
- 38kg
- 25th Centile for wt
- 50th Centile for ht
- W4H =90.7%
- 1kg/wk loss x 8 wks =17%
- Clinically signigficant

Blue for %BMI
Red for weight loss

Blue for %BMI
Red for weight loss

Dietary intake – getting it right

- Detailed account of past 3 days
- Food diary x 5/7, pre- appointment
- Try to avoid prompting
- Return to fill in the gaps
- Exact fluid intake
- Avoiding food groups – dairy/CHO/fat
- Skipping meals
- Stopping snacks

Dietary intake – getting it right

- How much of that did you eat?
- What type of milk/spread/crisps, Low fat option?
- Pattern of eating – ? Extended periods of fasting
- Kcals counting
- What was previous intake like 6, 9, 12 mths ago?
- Eating pattern and food choices pre Eating Disorder?
- Vegetarianism/veganism?
- Food rules

Fluid intake- ask!

- Quantify
  - Use examples – glass, water bottle, can
  - Is it a mug or a cup
  - How many glasses/cups?

- Timing
  - Pre-meals
  - On appointment day

Junior MaRSiPAN

- 11yr old girl
- ¼ of a slice of buttered toast at B + L + D = 160kcals
- 1actimel + 1 flavoured milk = 300mls & 270kcals
- Total intake =430kcals
- Meeting ~20% of energy needs

Red
Disordered eating
Hydration

- 12yr old girl
- 500kcals or less x 10d
- Acute food refusal x 2d
- Minimal fluid
- Clinical evidence of dehyrdration –dry mucus membranes
- PO4 0.88 (0.9 – 1.1)
- Tachycardia
- ?hypovolemia

Red
Disordered eating
Hydration
Biochemistry

What's normal?

- B: Cereal + milk, toast + peanut butter
- MM: Banana + yoghurt
- L: Chicken salad mayo sandwich + crisps + orange
- MA: scone with butter + jam, milky coffee
- D: spaghetti bolognaise, garlic bread x 3 pieces, salad + OJ
- S: Cereal + milk

Boys 15 -18 meeting
2530kcals/d

- B: Muesli with natural yoghurt + banana + OJ
- MM: apple
- L: wholemeal roll + tuna + mayo + sweetcorn
  Low fat yoghurt + water
- MA: tea with milk + 2 digestive biscuits
- D: Jacket potato with butter, chicken breast, veg + gravy + Ice-cream + water
- S: Fruit + water

Girls 15-18 meeting
2100kcals/d

What's normal?

- Snacking
- 83% of adolescents consume at least 1 snack/d
- Children snack ~3times/d
  - Consuming up to 27% of their energy needs in the form of desserts and sweetened drinks

Nutrition minefield

- Should I start slowly or dive straight in?
- Should I include my child in food decisions?
- Should I add more Carbohydrate?
- Is low fat milk ok?
- Is your child fearful of foods they used to love to eat?
- Why is my child eating only the same foods?
- Has the whole family changed to ‘healthy eating’?

Plate by plate

- **You are in charge of all meals and snacks √**
- **Challenge Food Rules √**
- Calorie counting x
- Food exchanges x
- Measuring/weighing food x

- Tools required: Dinner plate

- *Aim: Help you to re-nourish and restore a child's health in the least restrictive manner, achieve food freedom and lasting recovery.*

Step 1 –Choose a plate

- 10” / 25cm

Not suitable

Step 1 –Choose a plate

Suitable

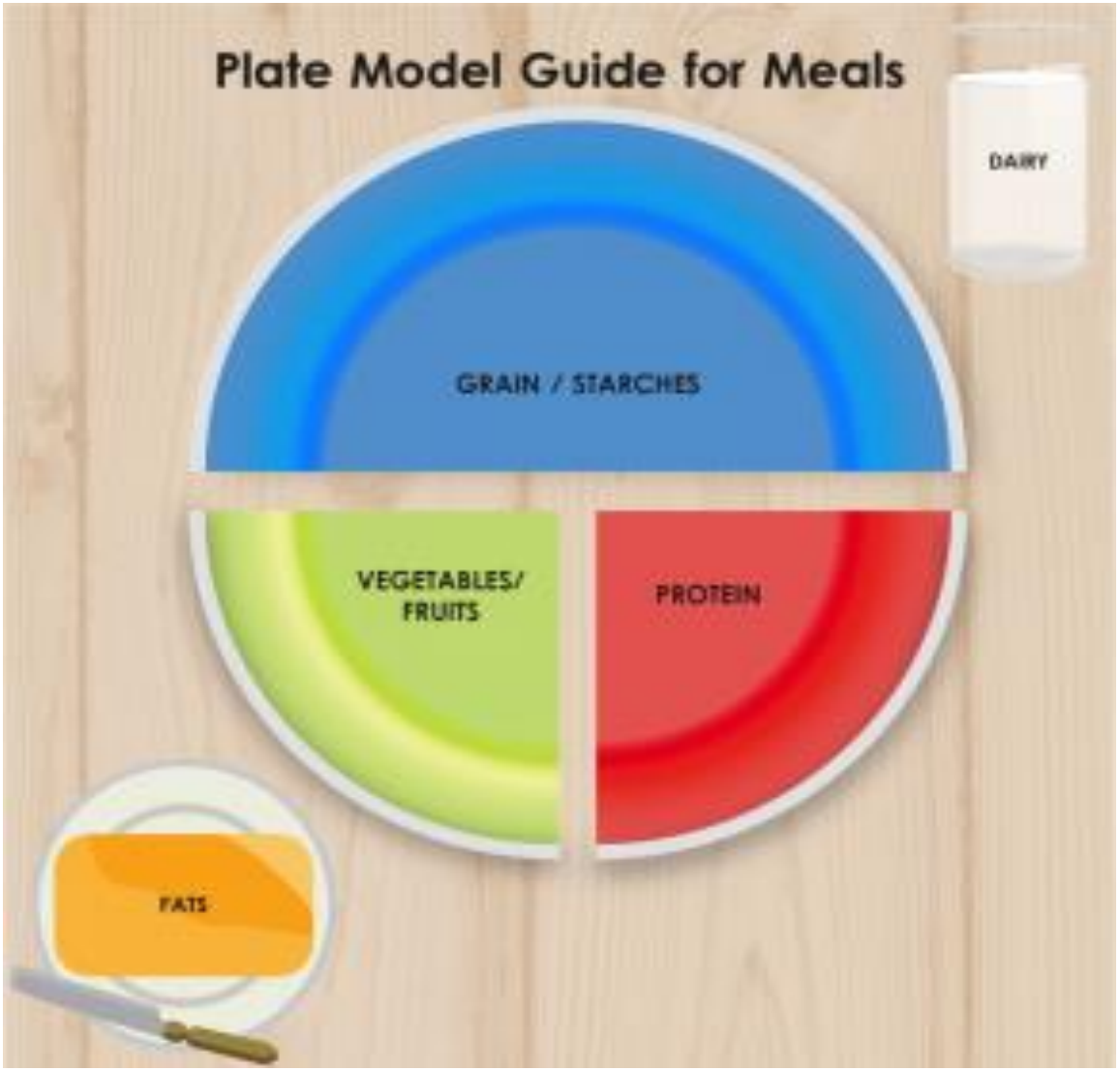


Plate Model Guide for Meals
DAIRY
GRAIN / STARCHES
VEGETABLES/
FRUITS
PROTEIN
FATS

Step 3 – Fill up the plate

Step 4 – Decide how many meals; how many snacks

- 3 meals/d
- 2 -3 snacks /d
  - Depending on the amount of snacks already consumed
  - Contain 2 -3 food groups
  - Don't use 2 of the same food group in 1 snack
  - Limit Fruit and Veg as snacks

Step 5 – Variety

- Important to challenge food rules
- Challenge Eating Disorder
- ‘Fear foods’

Step 6 – Review the plate

- Final check over of the plate
- Are you happy with the food choices?
- Does it encompass all 5 food groups (meal)?
- Does it encompass 2 -3 food groups (snack)?
- Is the plate full?
- Have you challenged your child?

Ex. of a diet history: 13yr old girl with AN

- B: nil
  - (doesn't have time)
- MM: apple + 2 satsumas water (250mls)
- L: nil
  - (doesn't like to eat in front of peers) finishes water bottle (700mls)
- MA: green tea + sugar free jelly + 6 strawberries
- D: sweet potato, grilled fish+ veg x 2+ 2 gls of water

  (nil butter, sauce added, prepares own dinner)
- S: dry crackers x 4 + 3 cups of green tea post dinner + 2 gls of water
  - Won't eat past 7pm

What's missing?

- Carbohydrate X 2/9 portions met
- Protein X 1/3 portions met
- Dairy X 0/4 portions met
- F&V √ 5/5 portions met

Requirements: E:2460kcals, P:41g, F: 2.1L

- Energy X 28% met, 700kcals
- Protein X 66% met, 27g
- Fluid X 145% met, 3L

ED behaviours

- Avoiding food groups – dairy + carbohydrate
- Nil snacks
- Increased fibre – ensuring 5 F&V /d
- Increased fluid intake
- Restricted dietary intake
- kcals counting, <1000kcals/d
- Green tea – increased metabolism myth
- Cut off for last meal
- Avoidance of fats, sauces, spreads

Avoidance behaviours

- Chop/shred/crumb food into small pieces
- Hide food under other food items
- Hide food under the table/napkin
- Feed a sibling
- Feed the family pet
- Place food in pockets/down clothes
- Arguing at mealtimes/creating a diversion
- Spoiling food deliberately/reheating
- Studying for prolonged periods of time

Minimising distress

- Choosing only pre-packaged foods with evident kcals
- Choosing foods with clear labelling
- Watching and inspecting food being prepared and cooked
- Ritualised behaviours

ED rules

- *max. 3 wheat containing foods a day*
- *must have at least 2 brown/wholemeal foods a day*
- *none of the exact same foods a day or two `relating' foods (like sweet potato and mixed root veg fries)*
- *max. 2 flour containing foods a day*
- *must have 1 dairy containing food daily (even if i don't want it)*
- *must have 1 plant based protein and 1 quorn/processed protein*

ED rules

- *must have max. 2 processed foods in a meal*
- *must eat a food higher in fat if I eat a food higher in protein (to not waste it)*
- *can only have one chocolate/chocolate flavoured food if i have only chocolate fortisips*
- *must eat DIFFERENT snacks/meals every day and cannot repeat the same meal the next day (unless porridge or cereal)*
- *if i have a higher calorie snack, then i must have a lower calorie meal (and swap)*
- *high calorie snacks/meals must only be eaten on days where i do more walking/exercise*

ED rules

- *max. 200 calories for morning snack (always lower)*
  max. 150 calories for afternoon snack
  (excluding fruit and soya milk)
- *i will add a wheat product (even if i don't want it) if i have more meals/snacks that don't contain wheat*
- *i must finish my foods at a time that ends with 0 or 5 (i will wait until the next time if i pass my planned time)*
- *i must finish half of my food 10 minutes before the time i plan to finish (not before)*
- *i cannot use the microwave for over 3 minutes altogether in a day (if i use it, i only put a food in for 20-30 seconds*

Dairy the facts!

Type	Protein (g)	Calcium (mg)	Energy (kcals)	Carbohydrate (g)	Sugars (g)	Fat (g)	Saturated Fat (g)
Almond drink	1.0g	240mg	48kcals	6.0g	6.0g	2.2g	0.2g
Soya	6.0g	240mg	78kcals	5.0g	5.0g	3.6g	0.6g
Soya light	4.0g	240mg	44kcals	0.2g	0.2g	2.4g	0.4g
Coconut drink	0.2g	240mg	40kcals	5.4g	3.8g	1.8g	1.8g
Oat drink	2.0g	240mg	90kcals	13g	8g	3.0g	0.4g
Lactofree	6.8g	252mg	114kcals	5.6g	5.6g	7.0g	4.4g
Lactofree Skimmed	7.2g	248mg	80kcals	6.0g	6.0g	3.0g	1.8g
Whole milk	6.8g	244mg	130kcals	9.4g	9.4g	7.2g	4.6g
Semi- skimmed milk	7.2g	248mg	100kcals	9.6g	9.6g	3.6g	2.2g
Skimmed milk	7.2g	258mg	78kcals	9.8g	9.8g	<1.0g	<0.2g

Dairy the facts!

- 7 x more protein in Dairy Milk compared to Almond or 35 x more than Coconut beverages
- Coconut drink – 100% of fat saturates
- Skimmed milk – least amount of fat, with all the protein and calcium
- B12 – 60% less in non-dairy drinks
- *A glass of milk provides:*
- 16% of your daily protein needs
  1% of your daily carbohydrate needs
  2% of your daily fat needs
  25% of your calcium needs

Dairy the facts!

- Calcium requirements increase dramatically from about the age of 11 years – pre-pubertal growth spurt.
- A lack of calcium can lead to poor mineralization of bones and low bone mineral density.
  - Osteopenia
  - Osteoporosis
- Once in a lifetime opportunity to build strong bones.
  - ~ 30% of all mineral deposited in our bones throughout life, occurs during adolescence
  - 90% of our adult skeleton is formed by the age of 18 and even earlier in girls.
  - Essential that enough calcium is received to allow this to happen.

Debunking diet myths!

Myth 1 – Skipping breakfast is a good way to start the day

- Causes irritability and tiredness
- Decreased concentration
- Increases thoughts about food

Myth 2 – No treats

- Adds to rule making
- Increases Eating Disorder control
- Necessary for teenagers to snack and havetreats

Debunking diet myths!

Myth 3 – Not eating before 3pm or past 6pm

- Calories cannot tell the time!
- Body digests food in the same way whatever the time
- Helpful to have a carbohydrate source before bedtime – aids with restorative sleep, help YP meet energy needs

Myth 4 – Coffee can help you lose weight

- Coffee does not contain any energy or fat burning properties.
- It does contain caffeine and drinking too much of it can lead to anxiety, sleeplessness and an increase in heart rate and blood pressure.

Debunking diet myths!

Myth 5 – Negative calorie foods – Some foods help burn more calories than they contain

- It has been suggested that eating some foods such as celery, grapefruit, lettuce and apple cider vinegar can actually help to burn calories.
- No research to suggest any foods burn more calories than they create.
- No foods can actually help you to burn fat.

Myth 6 – Carbs are fattening

- Low in fat
- High in vitamin B12
- Glucose – fuels the brain

Debunking diet myths!

Myth 7 – No snacking

- Necessary to meet high energy needs
- Typical teen eating, experimenting with foods, especially quick and easy meals
- Every 3hrs

Myth 8 – You are what you eat

- Not true!
- Well being and happiness is not is made up of what you do or do not eat.
- It can be damaged by eating too little and can affect how you view yourself.

Debunking diet myths!

Myth 9 – Eat low fat only products only

- Fat is essential –protect organs/ heat/ energy
- Body cannot synthesise Essential Fatty acids – must be ingested
- Necessary for heart health/ anti –inflammatory effect

Myth 10 – A gluten free diet is good for weight loss

- No evidence to suggest that removing gluten-containing foods from the diet will result in weight loss
- Only 1% of the population has coeliac disease and it is essential that they follow a gluten free diet
- Possible vitamin and mineral deficiency

Debunking diet myths!

Myth 11 – Drinking green tea raises metabolism

- Metabolism effect?
- A major review in 2012 of 18 studies involving 1,945 people found no significant effect of weight loss from drinking green tea.

Myth 12– Four x 100 calorie meals are better than one x 400 calorie meal

- Hungrier and tired
- Lead to food cravings

References

- J MaRSiPAN Management of Really Sick patients under 18 with Anorexia Nervosa 2015 (Summary)
- Refeeding guidelines for children and young people with feeding and eating disorders admitted to the Mildred Creak Unit at Great Ormond Street Hospital (2017)
- NICE guidelines: Eating Disorders: recognition and treatment (2017)
- CHEW – www.cwt-chew.org.uk