obtaining DXA scans and t-test analyses comparing factors affecting whether or not to obtain a DXA for a male versus female patient.

Results: Of the 104 clinicians who completed the survey, 54% identified as more confident assessing bone mineral density in females, while 0% identified as more confident assessing males. The remaining clinicians were either equally confident assessing both sexes (33%) or unsure (12%). In terms of screening rates, a vast majority of clinicians reported not obtaining a DXA scan during initial clinic visits for both males and females (90% vs 83%, p=0.390). Fracture history, degree of malnutrition, and duration of illness were the top three factors considered by clinicians when determining whether or not to obtain a DXA scan for male patients. Amenorrhea, fracture history, and duration of illness were the top three factors for female patients. When comparing reasons for ordering DXA between male and female patients, there was no difference for the following factors: age (p=0.880), degree of malnutrition (p=0.095), amount of weight loss (p=0.357), fracture history (p=0.078), hormone labs (p=0.090), duration of illness (p=0.150) and other (p=0.750).

Conclusions: Findings support our hypothesis that clinicians feel more confident in assessing bone health in female compared to male patients with eating disorders. Despite this difference in confidence levels, there were no statistically significant differences in rates of obtaining DXA scans between the sexes nor in the factors influencing obtaining a scan. To our knowledge, this is the first study to examine specific clinician practices for assessing bone mineral density in patients with an eating disorder and the first to assess comfort level for obtaining a DXA scan. The findings suggest that more education and guidance on management of male patients may be needed to improve clinician confidence in assessing for decreased bone mineral density.

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HUNGRY HUNGRY BONES: ELECTROLYTE ABNORMALITIES IN THE PRESENCE OF SEVERE MALNUTRITION

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Purpose: Severe malnutrition in the presence of child maltreatment and anorexia nervosa (AN) can lead to significant effects on bones. We present a case of severe malnutrition from child maltreatment that developed into AN, osteoporosis , and persistent electrolyte abnormalities due to hungry bone syndrome (HBS).

Methods: We describe a 15-year-old female with a history of medical neglect presenting to the hospital after removal from mother's home. She presented with weakness, inability to sit up or ambulate, bilateral leg pain, and severe malnutrition. The patient stated that her family had been on a "vegan diet". The patient's daily diet was two to three bowls of a homemade vegetable soup and two oranges. The patient was on no medications; however, her mother had her drink Epsom salts and "liquid oxygen." The patient stated she felt "kinda slim." When asked further about weight, she asked if provider was referring to "blubber." She denied vomiting, diarrhea, constipation, hyper-exercise, or attempts to lose weight. She endorsed laxative use per mother's recommendation to eliminate "parasites". The patient performed "exercises" with mother's help including resistance band and isometric exercises. As the patient became weaker, mother increased the "exercises" for the patient to become "stronger"; mother pulled on the patient's legs with bands until the patient "felt the burn." Patient had been unable to walk for the past year. She used a chair to scoot and no longer sat down to urinate because it would "take too long." Patient's menstrual cycles had become infrequent the past year; last period was 5 days before presentation. The patient's exam revealed cachexia/temporal wasting, tachycardia, delayed capillary refill, inability to stand or ambulate, limited movement of lower extremities/hips, and inability to sit up comfortably. Patient's height was 146 cm; she was 63% of median estimated BMI. She had multiple rib and bilateral humerus, scapular, tibial, and metatarsal fractures. The patient was admitted and monitored for refeeding syndrome. She had an elevated parathyroid hormone level (761pg/ml), vitamin D deficiency, hypocalcemia (6.3mg/dl), and hypomagnesemia (1.5mg/dl), requiring daily management for weeks. The patient's DEXA scan was delayed due to the inability to lie flat. When obtained, DEXA demonstrated a total body Z score of -5.9 standard deviations below mean for age. Osteogenesis imperfecta panel was negative.

Results: HBS typically occurs post-parathyroidectomy and is defined by hypocalcemia with total serum calcium <2.1 mmol/L for more than 4 days due to a drop in parathyroid hormone (PTH). In our case, HBS began with secondary hyperparathyroidism after severe malnutrition; PTH increased bone resorption to maintain normal calcium levels. With refeeding, a sudden fall in PTH led to net calcium movement into bones, resulting in hypocalcemia. In patients with HBS, hypomagnesemia and hypophosphatemia may also be observed due to bone formation. Hypomagnesemia and hypocalcemia occurred for our patient and required continuous electrolyte replacement and supplementation.

Conclusions: Although rare, providers managing refeeding syndrome among severely malnourished patients should be aware of the risk of HBS and accelerated electrolyte consumption.

Sources of Support: https://www.ncbi.nlm.nih.gov/books/NBK562285/ https://utsouthwestern.pure.elsevier.com/en/publications/hungry-bone-syndrome https://www.researchgate.net/profile/Enver-Simsek/publication/24039472_Prolonged_Hungry_Bone_Syndrome_in_a_10-year-old_Child_with_Parathyroid-Adenoma.pdf https://www.sciencedirect.com/science/article/pii/S8756328207005613?casa_token=mkAXnPw1_WYAAAAA:z9khjYhdB-YPaH0Qe1MQBvQ8XGuzh6kh6DDl8n9mltcIlDlOGLQJa8qTl4aS2qh5Wcq9aFMalg.

163.

EVALUATION OF EATING DISORDER THOUGHTS AND BEHAVIORS DURING ADMISSION AT A DAY TREATMENT PROGRAM FOR ADOLESCENT PATIENTS

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Purpose: The aim of this study is to examine outcomes associated with attendance at an eating disorder day treatment program using preexisting chart data from November 2017 through March 2019. Demographic and clinical factors were analyzed in association with patient outcomes and two validated self-report measures: the Revised Children's Anxiety and Depression Scale (RCADS), which looks at the frequency of various symptoms of anxiety and low mood, and Difficulties in Emotion Regulation Scale (DERS), which examines subjective emotional dysregulation.