Methods: This study is a retrospective cohort study, conducted by chart review of 50 patients with restrictive eating disorders enrolled in the Eating Disorder Day Treatment Program. We evaluated how patient demographic and clinical factors (e.g. diagnosis, disorder behaviors, age, gender, race, ethnicity, patient comorbidities, baseline RCADS and DERS scores) associate with patient outcomes (e.g. rate of weight change), and tested correlation between both RCADS and DERS scores and weight over time. We also performed a sub-analysis for weight change outcome among anorexia nervosa vs. atypical anorexia nervosa and avoidant restrictive food intake disorder types. Outcome variables include change in weight over time, length of stay, disposition (success: discharge to a lower level of care; unsuccessful: to a higher level of care), and changes in RCADS and DERS over admission to the program.
Results: The median weight change was 7.28 (IQR: 2.65-11.35) pounds weight gain with median BMI increase of 1.71, and the median length of stay was 39.50 days (IQR: 23.00-61.00). Both weekday phases (M-W and W-F) had statistically significantly greater estimated gains in weight than weekends ($p < 0.0001$). The data indicate that most patients' weights follow a positive linear trend over time with some differences in slope. The first DERS median score was 2.71 (IQR: 1.86-3.33) and the last DERS median score was unchanged at 2.71 (IQR: 1.75-3.36). The first RCADS T-score was 53 (IQR: 40-68), and last RCADS T-score 49.5 (IQR: 38-67). These first and last scores are all in the subclinical range, and plots of DERS scores and RCADS scores indicate that survey results do not follow a clear path over time. For DERS and RCADS scores, there were several clinical and demographic correlates that had statistically significant interaction effects with time, however the effect sizes were small.
Conclusions: Weight outcomes showed that the Eating Disorder Day Treatment Program was successful in having most patients with a history of restrictive eating achieve good weight gain and increase in BMI, with greater increases in weight during the weekdays while receiving services. However, despite some small interactions between time and baseline variables, the DERS and RCADS scoring showed no statistically significant correlation with weight change or time during admission, and first and last scores of the DERS and RCADS were within normal range. Thus, our study did not demonstrate changes in emotional dysregulation or anxiety/depression during the course of admission, despite an overall upward trend in weight. Further research into the severity of these symptoms across treatment levels may suggest that cognitions and depression/anxiety change later in treatment than hypothesized.
Sources of Support: None.

RESEARCH POSTER PRESENTATION II: EATING DISORDER/LGBTQ

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CLINICAL CHARACTERISTICS OF SEXUAL MINORITY YOUTH HOSPITALIZED FOR AN EATING DISORDER

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Purpose: Sexual minority youth (SMY) identify as, but not limited to, lesbian, gay, or bisexual. SMY are at increased risk for eating disorders which may lead to serious medical complications and death. It is important to understand characteristics of SMY with eating disorders to inform optimal medical management and ensure health equity for this vulnerable population. The purpose of this study was to describe clinical characteristics among SMY admitted to an inpatient eating disorders program.
Methods: A retrospective chart review was conducted of 601 patients, aged 9 to 25 years, admitted to a large inpatient eating disorders program between May 2012 and August 2020. Those who did not have their sexual orientation listed in their electronic medical record (EMR) were excluded from the study (n=114). Data including age, sex assigned at birth, sexual orientation, eating disorder diagnosis, percent median body mass index (% mBMI) at admission, and vital signs at admission was collected. In this study, SMY were defined as lesbian, gay, bisexual, queer, unsure/questioning, pansexual, and asexual. Fisher's exact, Chi square, and t-tests were conducted to examine potential differences in clinical characteristics between SMY and heterosexual youth.
Results: Among the sample of 487 patients, mean age was 15.6 years (SD 2.7), 83.4% (n=406) were assigned female at birth, and 16.6% (n=81) were assigned male at birth. SMY made up 21.1% (n=103) of our sample. Among SMY, 73.8% were diagnosed with anorexia nervosa (includes restricting, binge/purge, and atypical subtypes) compared to 74.2% of heterosexual youth (p=0.87). There was no difference in anorexia nervosa subtypes between groups (p=0.24). Percent mBMI at admission of male SMY was 85.9 (SD 15.5) vs 86.3 (SD 14.3) in male heterosexual youth (p=0.93). Percent mBMI in female SMY was 91.0 (SD 15.6) vs 87.0 (SD 13.0) in heterosexual females (p=0.013). 19.4% SMY (n=20) had a heart rate less than 50 beats per minute upon admission vs 27.3% (n=105) of heterosexual youth (p=0.10). 3.9% SMY (n=4) had systolic blood pressure (SBP) less than 90 mmHg on admission vs 3.4% (n=13) heterosexual youth (p=0.77). There were no SMY that had diastolic blood pressure (DBP) less than 45 mmHg on admission vs 0.26% (n=1) of heterosexual youth (p=1.00). When stratified by sex assigned at birth, there was no difference in SMY males and heterosexual males in pulse less than 50 (p=0.72) or SBP less than 90 (p=0.14). There was no difference between female SMY and female heterosexuals in pulse less than 50 (p=0.13), SBP less than 90 (p=1.00), or DBP less than 45 (p=1.00).
Conclusions: SMY females had a higher %mBMI on admission, however their vital sign abnormalities did not differ from heterosexual females. This suggests that although SMY females are admitted at a higher weight, they have equally severe vital sign instability as their heterosexual female peers and thus, should be monitored for additional medical complications.
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RESEARCH POSTER PRESENTATION II: EATING DISORDER

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RENAL FUNCTION IN PATIENTS HOSPITALIZED WITH ANOREXIA NERVOSA UNDERGOING MEDICAL STABILIZATION: FINDINGS FROM THE STUDY OF REFEEDING TO OPTIMIZE INPATIENT GAINS (STRONG)

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