

# Beyond Bulimia and Anorexia

One in 300 adolescents and young adults in western culture have an eating disorder. But Elissa Gittes, MD, Developmental and Behavioral Sciences, believes that the true figures are under reported.

"We are seeing a higher incidence of eating disorders, but not specifically bulimia or anorexia," says Dr. Gittes, who coordinates the Eating Disorders Clinic at Children's Mercy South as part of her services to teenagers. "The increase is in the category labeled Eating Disorders Not Otherwise Specified (EDNOS)."

These patients often have concerns about their body weight or shape. They may not be bulimic or anorexic, but by restricting their intake or exercising excessively, they may be affecting their ability to go through puberty normally. And an increasing number of males have eating disorder symptoms. In fact, the incidence of males with anorexia nervosa, which used to be one in 10, is now one in six, as reported by a recent study from Canada.

"Unless you ask about eating disorder symptoms or body image and weight concerns, you will not uncover an eating disorder in the adolescent patient," says Dr. Gittes.

The Children's Mercy Eating Disorders Clinic focuses on the medical or biological issues of eating disorders, but Dr. Gittes also sees teens for nutritional evaluations, sports exams, and adolescent issues unrelated to eating disorders.

For more information on the clinic, contact Dr. Gittes at (913) 696-8220.



By restricting intake and exercising aggressively, teens are affecting their ability to go through puberty normally, according to Elissa Gittes, MD (photo, right).

# Physician's Update

May 2004

## Do You Hear What I Hear?

Trevor with Jennifer Paul, audiologist.



**D**elayed speech and language skills. Lower grades. Difficulty attending to tasks. Trouble performing in a background of noise.

These are just some of the challenges faced by children with mild hearing loss.

Though universal hearing screening is now required at birth in both Missouri and Kansas, hearing problems still may go undetected.

Trevor was only 3 when his parents first became concerned about his possible hearing problem. Initial testing showed no problem, but his parents' concerns continued to grow. After consulting with their physician, they had Trevor tested again when he was 6, this time at Children's Mercy. A hearing loss was detected and Trevor was fitted for hearing aids approved by his family's insurance plan.

Even when detected, treating hearing loss is not always as simple as fitting a hearing aid. "Younger children are not always aware or able to express their degree of hearing loss," says Cynthia Jacobsen, PhD, director of Hearing and Speech. "Behaviorally, they won't sit still for tests the same as adults. And they don't tolerate things – like hearing aids – in their ear as well as adults."

Patient compliance is also an issue. Trevor found behind the ear hearing aids uncomfortable and embarrassing, so he stopped wearing them. When his hearing difficulties began to affect his school work, his teacher and school nurse contacted his parents.

Trevor was taken back to Children's Mercy. Fortunately, Trevor's insurance coverage had changed and this time he was fitted for in-the-ear hearing aids. The programmed hearing aids give Trevor better control of the sounds he hears and because they fit completely in his ear, they are more comfortable – and less embarrassing to wear.

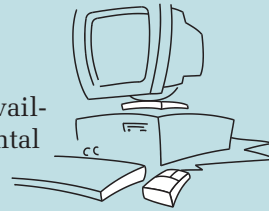
"We work closely with the child and family showing them how it works, what it can do, and how to take care of it," says Jennifer Paul, audiologist.

Although hearing aids are not covered by many insurance plans, hearing aid scholarships are available for patients who do not have benefits through private insurance and are ineligible for Medicaid.

Hearing testing and services are available at Children's Mercy Hospital, Children's Mercy South and Children's Mercy Northland. For more information on Children's Mercy hearing and speech services, call 816-234-3677 or toll-free 888-239-8152.

## Online Newsletters

Physician's Update, as well as Genetics, Pharmacy, Adolescent Medicine, Laboratory and Clinical Pharmacology newsletters are available on-line to keep you up-to-date on current news and departmental changes. Just visit our Web site at [www.childrens-mercy.org](http://www.childrens-mercy.org).



Physician's Update is produced monthly by Community Relations and Physician Services. For more information, contact Shawn Arni, (816) 346-1371 or e-mail to [sarni@cmh.edu](mailto:sarni@cmh.edu).



Visit the Children's Mercy Web site: [www.childrens-mercy.org](http://www.childrens-mercy.org)

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May 2004

## New Doc

**Christine Moser, PsyD**  
Developmental and Behavioral Sciences  
(816) 234-3674  
Clinical Psychologist

**Doctor in Psychology:** Clinical Psychology, California School of Professional Psychology, Alameda, CA, 1999  
**Fellowship:** Clinical Psychology Fellow, Child and Family Track, The Pederson Krag Center, Huntington, NY 2000  
**Licensure:** Kansas, 2001; Missouri, 2001  
**Specialty Interests:** evaluation of a broad range of both internalizing and externalizing childhood disorders



## Physician Access Line (816) 234-3700 / (800) 800-7300

Physicians and their staff may call the pediatric nurses at the Physician Access line to make a specialty referral, schedule a first time appointment, or request a consult.

## Hot Topics AOM Guidelines

Among infants and children in the United States, the greatest use of antimicrobial therapy is for the treatment of otitis media. With the recent publication of a clinical practice guideline, the American Academy of Pediatrics and the American Academy of Family Physicians hope to modify this practice and reduce antibiotic use. The guideline was developed following a comprehensive review of evidence-based literature that suggested limited effectiveness of antibiotics in the treatment of acute otitis media (AOM). The guideline suggests that some children with AOM need not be treated with antimicrobial agents.

The guideline focuses on accurate and consistent diagnosis of AOM including: 1) the acute onset of symptoms, 2) the presence of middle ear effusion (confirmed by pneumatic otoscopy and supplemented by tympanometry and/or acoustic reflectometry), and 3) erythema of the tympanic membrane or distinct otalgia. Diagnostic strategies should be maximized to document middle ear effusion. Consideration of the certainty of diagnosis should be incorporated into the formation of a management plan. The prevention of AOM through reduction of risk factors is also addressed.

Recommendations emphasize pain management, especially during the first 24 hours. An "observation option" is offered for selected children for 48 to 72 hours with management limited to symptomatic relief. Observation provides an opportunity for improvement without antimicrobial treatment. This option is limited to otherwise healthy children 6 months to 2 years of age with non-severe illness (mild otalgia and fever <39°) and an uncertain diagnosis and to children 2 years and older without severe symptoms or with an uncertain diagnosis. Follow-up communication or reevaluation must also be assured. Institution of antimicrobial therapy should be considered if there is worsening of illness or no improvement in 48 to 72 hours.

If antimicrobial therapy is indicated, Amoxicillin (80-90 mg/kg/day) is recommended as first-line treatment of AOM. Amoxicillin-clavulanate (90 mg/kg/day of amoxicillin) should be used for patients with severe illness, where H.influenzae and M. catarhalis coverage is desired, and for treatment failure following initial amoxicillin therapy.

The guideline, including literature support, tables, and algorithms, is posted on the AAP and AAFP websites: [www.aap.org](http://www.aap.org); [www.aafp.org/x26481.xml](http://www.aafp.org/x26481.xml).

Denise Bratcher, DO  
Infectious Disease

## Who's At Risk? Hearing And Speech-Language Risk Registry

Physicians are increasingly under pressure to screen for a variety of possible developmental problems, including hearing, speech and language disorders.

Fortunately, epidemiological studies have shown that high-risk registries are nearly as accurate as direct screening. If a physician identifies a child through a risk registry, the physician can predict 55 percent of the children with poor hearing and communication and 76 percent of those with normal communication.

Communication difficulties that indicate the need for testing and formal evaluation include: poor intelligibility, problems expressing ideas, and expression limited to words or short phrases.

Family history factors of childhood hearing loss and a first degree relative with a speech or language concern will predict about 35 percent of children who will have a problem in hearing, speech, or language.

Certain problems occur frequently in the health histories of children diagnosed with hearing, speech and language problems. A hearing test is indicated in children with perinatal asphyxia, craniofacial anomalies, low birth weight, and ototoxicity.

A review of the health histories of 100

patients seen in Hearing and Speech at Children's Mercy Hospital revealed the following problems occurring in 25 percent of patients:

- Feeding difficulties
- Breathing difficulties
- Sleep disturbance and snoring
- Ear infections
- Allergies
- Stomach aches
- Pneumonia and upper respiratory infections, bronchitis and RSV
- Irritability or over/under reaction to sights and sounds
- Bowel and bladder concerns

When there are frequent upper respiratory concerns and ear infections, conductive hearing loss is frequently present. The other concerns listed above frequently accompany a host of communication disorders. Children with the above medical and health concerns should be monitored closely at the 2-year well-child check.

If you have questions about a specific patient, contact me at [cjacobsen@cmh.edu](mailto:cjacobsen@cmh.edu).

Cynthia Jacobsen, PhD  
Director, Hearing and Speech

## News Briefs

### Asthma Attack Guideline Changes

The Contact Center has recently reviewed its Asthma Attack guideline with the help of the Asthma and Allergy Clinic. The standard guidelines were modified and approved by the Contact Center Physician Advisory Board.

Guideline changes include:

- Inclusion of the Asthma Action Plan (AAP) in the guideline. The guideline can be used for patients with or without an AAP.
- Administering a test dose of the rescue medicine in the form of three back-to-back nebulizer treatments or three MDI doses if an AAP is present.
- Increasing the MDI dose from the previous two puffs to two to six puffs.

- Disposition questions added to make allowances for parents seek the direction of a physician to initiate care at home.
- In the care advice, the use of a humidifier has been removed.

For more information, call the Contact Center at (816) 234-3147.

### New Orthopaedic Clinic

Children's Mercy has opened a new Orthopaedic Clinic at Children's Mercy Northland, 501 NW Barry Road, Kansas City, MO.

Mark Sinclair, MD, Orthopaedic Surgery, will see patients from 8 a.m. to noon each Wednesday at the clinic.

To make a referral, call (816) 234-3700.

