

RESEARCH ARTICLE

Medical Nutrition Therapy and Nutritional Rehabilitation in Hospitalised Patients Affected by Eating Disorders

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ABSTRACT

Objective: Hospitalised patients with eating disorders (EDs) often present with severe malnutrition, electrolyte imbalances, and metabolic complications that require specialised nutritional approaches. This consensus aimed to develop evidence-informed, expert-driven recommendations for the nutritional management of hospitalised patients with EDs, addressing risk stratification, caloric progression, refeeding protocols, formulation selection, supplementation and long-term monitoring.

Methods: An eight-expert panel conducted a modified Delphi process in two online rating rounds. One hundred six statements were formulated across 12 thematic sections and evaluated on a 5-point Likert scale ($\geq 85\%$ accepted, 80%–84.9% revised, $< 80\%$ rejected). Revised statements were re-evaluated in Round 2 and, if necessary, finalised at an online meeting.

Results: Of the 106 original statements, 89 (84.0%) reached immediate consensus, 14 (13.2%) required revision, and three (2.8%) were eliminated. Ten revised statements exceeded the $\geq 85\%$ threshold in Round 2, one was rejected, and three 'pending' statements were approved in a conclusive online meeting. The final statements span key domains of inpatient care of EDs, including comprehensive nutritional assessment, stepwise refeeding regimens, careful electrolyte and biochemical monitoring, personalised approaches for those at high risk of refeeding syndrome and tailored considerations for paediatric and perinatal populations.

Discussion: The final consensus statements provide a structured framework for the nutritional rehabilitation of hospitalised patients with EDs, emphasising balanced yet flexible refeeding protocols, vigilant metabolic monitoring, ethical considerations in limited-capacity cases, and continuity of care through discharge and relapse prevention. By aligning clinical practice with specialist insight and existing guidelines, these recommendations aim to standardise and enhance inpatient ED management.

Highlights

- Provides a Delphi-based expert consensus on inpatient nutritional rehabilitation for EDs.
- Includes recommendations tailored to special populations (e.g., adolescents, medically complex or high-risk patients).
- Offers practical, risk-stratified guidance bridging existing guidelines and adaptable to general medical wards.

1 | Introduction

Eating disorders (EDs), including anorexia nervosa (AN), bulimia nervosa (BN), binge-eating disorder (BED) and avoidant/restrictive food intake disorder (ARFID), are severe psychiatric conditions with profound nutritional, metabolic and medical consequences. This consensus specifically addresses acute medical hospitalisation, where patients are admitted for the management of clinical and nutritional instability. Hospitalised patients with EDs most commonly present with severe malnutrition, which represents the primary driver of admission; less frequently, electrolyte disturbances without overt malnutrition may be seen in BN. In all cases, admission requires a highly specialised approach to nutritional rehabilitation (RCPSYCH [n.d.](#); da Silva et al. [2020](#)). These patients also experience higher rates of hospital readmission, often due to inadequate refeeding strategies, nutritional relapse, or insufficient follow-up care (Lopes et al. [2023](#); Ridout et al. [2016](#); Golden et al. [2013](#)).

The COVID-19 pandemic has exacerbated these challenges, leading to a notable increase in the incidence and severity of EDs (Nagata, Grandis, et al. [2022](#); Irish et al. [2022](#); Harshman et al. [2019](#)). This surge has placed substantial pressure on healthcare systems, which were largely unprepared to manage the nutritional complexities of patients with EDs in the hospital setting (Garber et al. [2016](#)). While existing guidelines (e.g., MEED [RCPSYCH [n.d.](#)], RANZCP [Hay et al. [2014](#)], NICE NG69 [National Guideline Alliance [UK] [2017](#)], APA [Crone et al. [2023](#)], Percorso Lilla [Ministero della Salute [2021](#)]) provide general recommendations for acute management, they offer limited practical guidance on inpatient nutritional rehabilitation, particularly regarding the selection of enteral formulations, refeeding protocols, and biochemical monitoring strategies (Gómez Candela et al. [2018a](#); Rocks et al. [2014](#)). Moreover, where emergencies are addressed, the perspective is often primarily medical (admission criteria, vital stability, acute risk), with the nutritional dimension under-represented. Our consensus specifically integrates this nutritional perspective across both acute stabilisation and the subsequent rehabilitation phase, bridging the period from admission to discharge.

Despite international guidelines recognising inpatient care as essential for severe cases, the nutritional management of hospitalised patients remains highly variable. There is no unified approach to key aspects such as risk stratification, caloric progression, selection of enteral formulations, and biochemical monitoring strategies. Previous studies have highlighted clinical

variability and a lack of standardised protocols, contributing to discrepancies in patient outcomes (RCPSYCH [n.d.](#); Golden et al. [2013](#)). Given the rising hospitalisation rates for EDs and the lack of structured nutritional guidelines, this intersocietal consensus was developed to provide expert-driven recommendations, synthesising evidence and clinical experience into a structured decision-making framework. The consensus specifically addresses key areas of variability in inpatient management of EDs, including nutritional assessment, formulation selection, and refeeding strategies, aiming to optimise risk-based protocols, promote safe weight restoration, and improve monitoring practices to prevent complications such as RS.

2 | Materials and Methods

The consensus process began with the identification of 12 key thematic areas and the formulation of 30 guiding questions (Box 1), which served as the foundation for statement development. To ensure that the statements were grounded in existing evidence, a structured literature search was conducted in Medline and Embase using predefined search strings. This process informed the discussion and helped identify key references to support the statements. In total, 108 sources were referenced in the final consensus document. The consensus was designed to address both adults and children/adolescents. Specific statements were developed to distinguish between these populations whenever age, developmental stage or ethical-legal aspects (e.g., parental consent, degree of coercion) influenced clinical management.

BOX 1 | Thematic areas and guiding questions for consensus development.

I. Assessment and diagnosis:

- What key nutritional assessment should be conducted upon admission for hospitalised patients with EDs?
- How do healthcare professionals determine the appropriate level of medical nutrition therapy (MNT) for each patient based on their specific diagnosis and symptoms?

II. Refeeding and weight restoration:

- What is RS and what precautions are taken to prevent it during nutritional rehabilitation?
- How is the rate of weight gain monitored and adjusted to ensure patient safety and optimal recovery?
- How can RS be treated after its diagnosis?

III. Meal planning and dietary interventions:

- How are meal plans designed to meet the individual needs of patients with different EDs (e.g., AN, BN, BED)?
- What is the role of assisted meals? Which professionals could be involved?

IV. Oral nutritional supplements (ONS):

- What roles do ONS play in the nutritional rehabilitation of patients with EDs? When might they be recommended?

- How are the appropriate type and dosage of ONS determined for each patient?
- What are some strategies to encourage the acceptance and consumption of ONS, especially for patients who may be resistant to them?

V. Nasogastric tube (NGT) feeding:

- In what specific situations might NGT feeding be considered for a patient with EDs? What are the potential benefits and risks associated with this intervention?
- How is the decision made to initiate or discontinue NGT feeding? What factors are considered in this process?
- What are the nutritional considerations when providing NGT feeding? How are the specific formula and feeding schedule determined?
- How do healthcare professionals address the psychological and emotional impact of NGT feeding on the patient? What strategies are used to promote acceptance and cooperation?

VI. Enteral nutrition (EN) versus parenteral nutrition (PN):

- What are the key differences between enteral and parenteral nutrition? In what circumstances might one be preferred over the other for a patient with EDs?
- How can healthcare professionals address the potential psychological and emotional challenges associated with the use of PN in patients with EDs, and what strategies can be employed to support their overall well-being during this intervention?
- What type of PN should be used?
- How is the transition from EN or PN to oral feeding facilitated? What steps are taken to ensure a safe and successful transition?

VII. Nutrition education and counselling:

- What topics are typically covered in nutrition education sessions for hospitalised patients with EDs?
- How do healthcare professionals address the psychological and emotional aspects of food and eating during nutrition counselling?

VIII. Monitoring and evaluation:

- What are the key indicators used to monitor the effectiveness of MNT in hospitalised patients with EDs?
- How is the transition from inpatient to outpatient nutrition care managed to ensure continued progress and prevent relapse?

IX. Specialised populations:

- How are the nutritional needs of adolescents and children with EDs addressed in the hospital setting?
- What considerations are important when providing MNT for pregnant or breastfeeding women with EDs?

X. Ethical and legal considerations:

- How do healthcare professionals balance the principles of patient autonomy and beneficence when providing

nutrition care for patients with EDs who may resist treatment?

- What are the legal and ethical implications of using involuntary feeding or other restrictive measures in the treatment of severe EDs?

XI. Interdisciplinary collaboration:

- How do registered dietitians collaborate with other healthcare professionals (e.g., physicians, psychiatrists, nurses, therapists) to provide comprehensive care for hospitalised patients with EDs?
- What is the role of family members or caregivers in supporting the MNT process?

XII. Long-term outcomes:

- What are the long-term nutritional goals for patients recovering from EDs?
- How can healthcare professionals promote sustainable dietary habits and a healthy relationship with food after discharge?

The 12 thematic areas and corresponding guiding questions that structured the development of consensus statements on inpatient MNT for EDs. These questions informed the systematic literature search and statement formulation process.

2.1 | Study Design

This study employed a modified Delphi methodology to develop expert-driven recommendations for the nutritional management of hospitalised patients with EDs. The Delphi method is a structured process using iterative rounds of expert evaluation to reach a consensus on areas of clinical uncertainty. An initial set of 106 statements was developed from a comprehensive review of key literature, national and international guidelines (NICE NG69, RANZCP, MEED-RCPsych, APA, and the Italian Ministry of Health's Percorso Lilla). These statements were organised into 12 thematic sections including nutritional assessment, refeeding protocols, EN and PN, supplementation strategies and long-term monitoring (for the full list, see Box 1).

The Delphi process consisted of two online rounds (via Google Forms), with panellists rating statements on a 5-point Likert scale (1 = completely disagree; 5 = completely agree). In addition to calculating each statement's mean and standard deviation (SD), median, and interquartile range (IQR) were recorded to examine the distribution of responses and any notable variability. We further noted instances where statements needed merging or elimination based on panellists' feedback, in addition to purely numerical thresholds. The primary criterion for acceptance was based on the proportion of panellists who selected a rating of ≥ 4 or $\geq 80\%$ accordance.

2.2 | Expert Panel

The expert panel comprised eight specialists, nominated by five national scientific societies committed to advancing clinical

practice, research and treatment protocols in the multidisciplinary management of EDs: SINPE (Società Italiana di Nutrizione Artificiale e Metabolismo), ASAND (Associazione Scientifica Alimentazione Nutrizione e Dietetica), SIGENP (Società Italiana di Gastroenterologia, Epatologia e Nutrizione Pediatrica), SIRIDAP (Società Italiana di Riabilitazione Interdisciplinare Disturbi Alimentari e del Peso) and SISDCA (Società Italiana per lo Studio dei Disturbi del Comportamento Alimentare). Panellists were chosen based on recognised leadership or specialised expertise in inpatient ED management. The panel included six physicians (with specialisations in clinical nutrition, gastroenterology, psychiatry, and paediatrics) and two registered dietitians, all with extensive clinical experience in inpatient ED management. To maintain objectivity, participation was anonymous, and panellists independently completed both Delphi rounds. While all eight experts participated in Round 1, six remained active in Round 2, yielding a 75% retention rate. However, all panellists took part in the final online meeting, ensuring that the ultimate consensus reflected the perspectives of the entire expert group.

2.3 | Delphi Rounds

Two iterative rounds of structured evaluation and anonymous feedback were conducted via Google Forms. In Round 1, experts rated 106 statements across 12 thematic sections. Each statement's mean, SD, median, and IQR were assessed, along with the proportion of panellists giving a score of ≥ 4 or $\geq 80\%$ (see Supporting Information S1: Table S1). Statements achieving at least 85% of ratings ≥ 4 at the conclusion of Round 1 were accepted without modification. Those receiving between 80% and 84.9% of ratings ≥ 4 were designated for revision (hereafter referred to as 'pending revision'), and any statement below 80% was eliminated unless panellists requested reformulation due to phrasing or content concerns, in which case a revised statement was reintroduced. Consequently, 89 statements (84.0%) met the $\geq 85\%$ threshold and were accepted outright, 14 statements (13.2%) required revision (either due to the 80%–84.9% agreement range or based on expert comments) and three statements (2.8%) were eliminated, one of which (statement 2.8) was merged into statement 2.6 to consolidate recommendations (for the original text, see Supporting Information S1: Table S2).

After revisions, the 14 updated statements were re-evaluated in Round 2. Of these, 10 reached the $\geq 85\%$ threshold and were accepted, while one was removed due to persistent disagreement. The remaining three statements were classified as

pending revision and were deemed to require further discussion at the online expert meeting, during which all previously accepted statements would also be reviewed to ensure consistency across the final consensus document.

Throughout the process, both numerical scores and qualitative feedback from panellists guided statement refinement. Where necessary, statements were revised to enhance clarity and coherence, with two statements merged to eliminate redundancy (Figure 1).

3 | Results

The final consensus statements were organised into 12 thematic sections, each addressing a critical aspect of inpatient MNT for EDs.

3.1 | Nutritional Assessments and Diagnosis

Ten statements addressing the comprehensive nutritional assessment of hospitalised patients with EDs were evaluated by the expert panel (Table 1). Nine statements (S1.1, S1.3–S1.10) achieved immediate consensus in Round 1, with acceptance rates ranging from 87.5% to 97.5%. Statement S1.2 initially reached 82.5% agreement in Round 1 and was subsequently revised according to panellists' comments, ultimately gaining 90% agreement in Round 2. The high agreement rates indicate a robust alignment among experts on the foundational elements of inpatient nutritional assessment for patients with EDs.

3.2 | Refeeding and Weight Restoration

Nine statements (S2.1–S2.9) addressed best practices for refeeding protocols, monitoring for RS, and recommended weight restoration targets in hospitalised patients with EDs. Overall, six statements (S2.1–S2.4, S2.7 and S2.9) secured immediate consensus in Round 1, with acceptance rates ranging from 87.5% to 97.5%. Statements S2.6 and S2.8 were merged after Round 1 to form a single revised statement (S2.6), approved in Round 2 by 93.3% of experts (Table 1). Statement S2.5 reached 75% in Round 1, was revised, and ultimately obtained 80% in Round 2. Further discussion in the online meeting led the panel to clarify that the recommended weekly weight-gain goals should be considered as guiding targets rather than strict standards, acknowledging that they may not be consistently attainable in every clinical scenario.

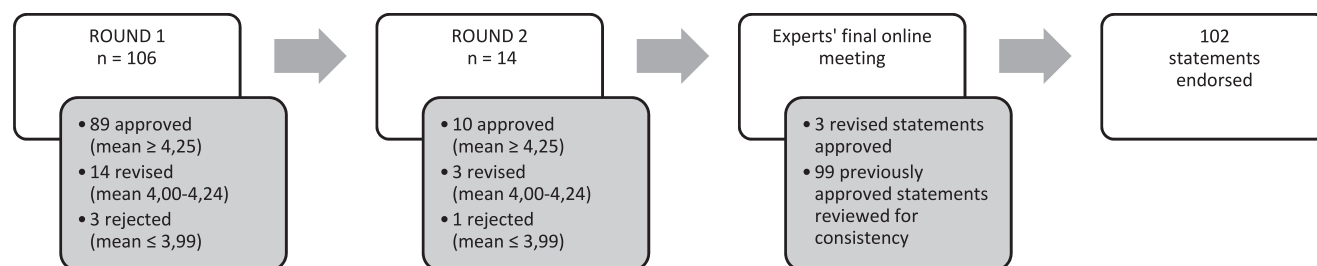


FIGURE 1 | Delphi process flowchart. Summary of the iterative rounds and expert meeting outcomes leading to the final endorsement of consensus statements.

TABLE 1 | Consensus statements on Sections 1–3.

Section 1. Nutritional assessments and diagnosis	
S1.1	A thorough dietary assessment, including a detailed history of eating and dysfunctional behaviours (restriction, binge eating, compensatory behaviours), is essential upon admission and should be integrated with an evaluation of metabolic and electrolyte status (Ridout et al. 2016; National Guideline Alliance [UK] 2017; Ministero della Salute 2021; Gómez Candela et al. 2018a; Białek-Dratwa et al. 2022; Gómez Candela et al. 2018b).
S1.2	In addition to weight, height and BMI (or %BMI or weight-, height-, BMI-z-score for age in children and adolescents), the use of additional anthropometric markers (mid upper arm circumference (MUAC), adductor pollicis skinfold thickness) is recommended to promptly identify muscle mass loss in severe malnutrition cases. Where available, bioelectrical impedance analysis (BIA) may provide additional insights into body composition and muscle mass depletion, although its reliability in severe malnutrition requires cautious interpretation. Although these assessments can trigger distress in patients with EDs and are therefore sometimes avoided in clinical practice, their collection, whenever feasible, remains essential for clinical safety and should be performed with sensitivity to patient needs (RCPSYCH n.d.; Hay et al. 2014; Soto-Célix et al. 2019; Dumitriu et al. 2025).
S1.3	Laboratory evaluations should include electrolytes (especially phosphorus, potassium and magnesium), vitamins/micronutrients (vitamin D, thiamine, selenium, zinc) as well as baseline assessments of protein synthesis (albumin and prealbumin). Repeated monitoring is essential to promptly identify the risk of refeeding syndrome and other complications. Monitoring frequency should be stratified: Phosphorus, potassium, and magnesium require frequent and systematic reassessment during early refeeding, while repeat testing of other indices should be performed selectively, with timing determined by clinical judgement (RCPSYCH n.d.; Ridout et al. 2016; Nagata, Grandis, et al. 2022; Strumila et al. 2022).
S1.4	In AN, an initial liver assessment (transaminases, albumin, bilirubin) is necessary to exclude complications from malnutrition or rapid refeeding (Gómez Candela et al. 2018a; Rosen et al. 2017).
S1.5	In ARFID cases, nutritional assessment should explore specific types of avoided foods and their possible reasons (aversive, sensory or phobic-anxious) to develop a personalised dietary plan and a potential gradual exposure strategy (Białek-Dratwa et al. 2022).
S1.6	The choice of refeeding regimen is based on the degree of malnutrition and medical instability; in high-risk cases (BMI < 13, severe electrolyte imbalances), a more cautious and gradual approach is recommended, supplemented with phosphorus, magnesium, thiamine and multivitamins (da Silva et al. 2020; Ridout et al. 2016; National Guideline Alliance [UK] 2017; Ministero della Salute 2021; Gómez Candela et al. 2018a, 2018b).
S1.7	In EDs with malnutrition-related liver disease, MNT should prioritise controlled refeeding and adequate protein intake, with monitoring of transaminases and albumin to detect hypertransaminasemia or steatotic-hepatic complications (Gómez Candela et al. 2018a, 2018b; Rosen et al. 2017).
S1.8	MNT in AN and BN should integrate a structured meal plan with psychoeducational and behavioural interventions; in BN and BED, efforts should also focus on meal regularity and managing binge episodes and compensatory behaviours (Gómez Candela et al. 2018a, 2018b; Crook 2014).
S1.9	In adolescent patients hospitalised for EDs, a higher starting calorie protocol can accelerate weight recovery. Such protocols, if tolerated by the patient, must always be accompanied by frequent laboratory and clinical monitoring to mitigate the risk of RS. Similar approaches may also be applied in adults, with risk stratification based on the severity of malnutrition (RCPSYCH n.d.; Lopes et al. 2023; Roman et al. 2024; Staab et al. 2022).
S1.10	In individuals with ARFID, MNT requires highly personalised approaches, including potential texture modifications and gradual exposure interventions to new food categories, in synergy with psychological treatments (CBT-AR, family psychoeducation; Hay et al. 2014; Białek-Dratwa et al. 2022; Willmott et al. 2024).
Section 2. Refeeding and weight restoration	
S2.1	RS is characterised by a rapid intracellular shift of phosphorus, potassium and magnesium, accompanied by potentially life-threatening metabolic alterations that occur when malnourished individuals receive an overly rapid caloric refeeding (RCPSYCH n.d.; da Silva et al. 2020; National Guideline Alliance [UK] 2017; Crook 2014; Yoshiuchi et al. 2022).

(Continues)

TABLE 1 | (Continued)

S2.2	Prevention of RS requires (a) biochemical and clinical assessment (including phosphorus, potassium, magnesium and thiamine) upon admission, (b) gradual caloric reintroduction, and, in vulnerable patients, (c) prophylactic supplementation with electrolytes and vitamins (especially thiamine) according to standardised protocols (da Silva et al. 2020; Garber et al. 2016; Ministero della Salute 2021; Crook 2014; Gallagher et al. 2022).
S2.3	In patients at high risk of RS (BMI < 13, hypophosphatemia, rapid weight loss > 10% over a few weeks, or comorbidities such as infections or heart failure), frequent monitoring (initially several times per day, then daily) of electrolytes and vital parameters is essential. Caloric intake should be adjusted, and supplementation with phosphorus, potassium, and magnesium should be implemented promptly (da Silva et al. 2020; Hay et al. 2014; Rocks et al. 2014; Gallagher et al. 2022).
S2.4	Close monitoring of weight (2–3 times per week), vital signs, and fluid status guides the pace of energy provision, aiming to avoid both underfeeding (which prolongs malnutrition) and refeeding complications (e.g., electrolyte imbalances; RCPSYCH n.d.; Yoshiuchi et al. 2022; Gallagher et al. 2022).
S2.5	The desired rate of weight gain for hospitalised patients depends on clinical severity: An increase of 0.5–1.0 kg per week in adults and 1.0–1.5 kg per week in adolescents is recommended, provided there are no complications. These targets ensure a balance between medical safety and a structured pace of recovery, while requiring individualised adjustments according to patient response and metabolic stability (RCPSYCH n.d.; Golden et al. 2013; Garber et al. 2016; National Guideline Alliance [UK] 2017; Crone et al. 2023; Rocks et al. 2014; Hofer et al. 2014).
S2.6	To safely accelerate caloric intake in at-risk inpatients, initial energy provision typically starts from 10 to 20 kcal/kg/day, up to a maximum of 1000–1600 kcal/day, depending on individual weight, clinical stability, and risk factors. Caloric increments of 200–400 kcal should be introduced at regular intervals, but the timing may vary based on metabolic tolerance, electrolyte stability, and psychological response. Continuous monitoring of cardiac, metabolic, and psychological parameters is essential, requiring multidisciplinary collaboration among physicians, dietitians, psychiatrists and dedicated nursing staff. The team evaluates the risk-benefit balance throughout the process, ensuring a structured yet flexible approach to refeeding (da Silva et al. 2020; Lopes et al. 2023; Golden et al. 2013; Garber et al. 2016; Hay et al. 2014; Hofer et al. 2014; Matthews et al. 2018; Brodie et al. 2024).
S2.7	In cases of confirmed RS, caloric intake is temporarily reduced, and intensive supplementation of phosphorus, potassium, and magnesium (oral or intravenous) is provided, along with thiamine and multivitamins, following standardised protocols for both adult and paediatric patients (da Silva et al. 2020; Crook 2014; Gallagher et al. 2022).
S2.8	Psychological support and psychoeducational measures can be critical, as the onset or worsening of anxiety and fear of weight gain are common. Integrating medical-nutritional intervention with emotional support strategies enhances treatment adherence (RCPSYCH n.d.; Crone et al. 2023; Yoshiuchi et al. 2022).
Section 3. Meal planning and dietary interventions	
S3.1	Meal plans for AN typically start with a structured schedule of three meals and two to three snacks per day, focusing on gradual caloric increases, individualised dietary plans and patient tolerability. In higher refeeding risk or severely underweight patients, initial intake may begin at 10–20 kcal/kg/day, up to a maximum of 1000–1600 kcal/day. For moderate-risk patients, an initial target of 30–35 kcal/kg/day (approximately 1200–1600 kcal/day) may be appropriate. In all cases, balanced macronutrient distribution and adequate micronutrient supplementation are essential, alongside close monitoring of metabolic and psychological parameters (Hay et al. 2014; National Guideline Alliance [UK] 2017; Crone et al. 2023; Ministero della Salute 2021; Pettersson et al. 2021).
S3.2	In BN and BED, meal planning prioritises regular eating patterns (three balanced meals and structured snacks) to break the binge-purge cycle, emphasise satiety, and stabilise blood glucose levels, alongside psychoeducation on triggers and portion control (RCPSYCH n.d.; Hay et al. 2014; Crone et al. 2023; Turner 2023).
S3.3	Adjustments in total daily caloric intake should reflect each patient's clinical status, metabolic risk, and psychological readiness, with collaborative input from dietitians, physicians, and mental health clinicians. For instance, higher-calorie protocols (e.g., 1600–2200 kcal/day) may be used if refeeding risks (e.g., RS) are well-controlled (National Guideline Alliance [UK] 2017; Crone et al. 2023; Ministero della Salute 2021; Matthews et al. 2018; Pettersson et al. 2021).

(Continues)

TABLE 1 | (Continued)

S3.4	Meal plans need individualised adaptations (e.g., to accommodate sensory sensitivities in ARFID or strongly held beliefs about 'safe' foods) to promote adherence, minimise anxiety, and facilitate progressive normalisation of dietary intake (Hay et al. 2014; National Guideline Alliance [UK] 2017; Crone et al. 2023; Turner 2023; Fonseca et al. 2024).
S3.5	Close monitoring of electrolytes, weight trends, and any GI intolerance is critical to ensure that incremental caloric increases do not exacerbate medical instability, especially in severe AN or when using rapid refeeding approaches (RCPSYCH n.d.; National Guideline Alliance [UK] 2017; Matthews-Rensch et al. 2023; Garber et al. 2013).
S3.6	Assisted meals (or supported meals) involve trained staff or caregivers offering in-person guidance, encouragement, and supervision during mealtimes to address anxiety, prevent compensatory behaviours (e.g., purging), and ensure adequate nutritional intake (Hay et al. 2014; Crone et al. 2023; Pettersson et al. 2021; Turner 2023).
S3.7	Professionals involved in assisted meals typically include nurses with specialised eating disorder training, dietitians who develop the meal plan, and mental health clinicians (e.g., psychologists, psychotherapists) providing in-the-moment coping strategies or anxiety management techniques (RCPSYCH n.d.; National Guideline Alliance [UK] 2017; Matthews-Rensch et al. 2023; Davén et al. 2025).
S3.8	In some settings, meal support groups are facilitated by a dietitian, whose advanced competencies in nutritional rehabilitation and eating behaviour management are fundamental for effective guidance. Dietitians play a central role in modelling appropriate portion sizes, eating pace, and addressing food-related misconceptions. In settings where a dietitian is not available, a nurse or another trained professional may assume this role to provide structured support. The presence of a mental health professional further enhances the intervention by addressing emergent distress and maintaining a therapeutic milieu (Crone et al. 2023; Ministero della Salute 2021; Pettersson et al. 2021; Falcoski et al. 2024).
S3.9	Family involvement in assisted meals may be encouraged, particularly for adolescents, to reinforce treatment goals at home and maintain consistency between hospital and outpatient environments (Hay et al. 2014; National Guideline Alliance [UK] 2017; Turner 2023).
S3.10	If nasogastric or enteral feeding is required, assisted meals may coexist with partial oral intake. Structured feeding protocols and staff training (e.g., de-escalation techniques) are crucial to manage resistance or distress (National Guideline Alliance [UK] 2017; Crone et al. 2023; Matthews-Rensch et al. 2023).

Note: Final approved consensus statements on 3.1 nutritional assessment and diagnosis, 3.2 refeeding and weight restoration and 3.3 meal planning and dietary interventions in hospitalised patients with EDs. Statements reflect the final wording approved after the Delphi process. Supporting references are provided. Detailed acceptance rates and statistical data are available in the Supporting Information S1.

Ultimately, eight statements were approved for this section. Overall, the experts reaffirmed the importance of cautious yet progressive refeeding protocols, rigorous monitoring to prevent refeeding syndrome, and comprehensive psychosocial support for hospitalised patients with EDs.

Overall, this section highlights strong consensus on the necessity of structured meal plans, especially in AN, BN and BED, alongside assisted-meal protocols that incorporate both nutrition and psychosocial support.

3.3 | Meal Planning and Dietary Interventions

Ten statements (S3.1–S3.10) addressed the design of meal plans, the role of assisted meals, and behavioural interventions for hospitalised patients with EDs (Table 1). Eight statements (S3.2–S3.7, S3.9, S3.10) gained immediate consensus ($\geq 85\%$ agreement), with acceptance rates ranging from 87.5% to 97.5%. Two statements were revised after Round 1 feedback and reassessed in Round 2. S3.8 was updated to underscore the central role of a dietitian or other qualified professional in leading meal support. S3.1, which initially focused on a meal schedule of three meals and two to three snacks per day in AN, was expanded to include caloric guidelines tailored to refeeding risk level (e.g., 10–20 kcal/kg/day for high-risk and 30–35 kcal/kg/day for moderate-risk patients). It reached 83.3% agreement, leading to a final revision during the online meeting to emphasise the necessity of individualised dietary plans.

3.4 | Oral Nutritional Supplements (ONS)

Twelve statements (S4.1–S4.12) were originally drafted to address the role of ONS in bridging caloric gaps, supporting weight restoration, and managing specific micronutrient needs in hospitalised patients with EDs. After Round 1, S4.3 was eliminated, leaving 11 statements. To improve clarity in the final layout (see Table 2), the statement formerly labelled S4.8 was renumbered as S4.7. Ten statements reached immediate consensus ($\geq 85\%$ agreement), while the newly labelled S4.7 (focusing on micronutrient-specific ONS) progressed from 72.5% agreement in Round 1 to 83.33% (mean 4.17, SD 0.69) in Round 2. Despite remaining below the 85% threshold, revisions specified that such supplements should be employed in cases of diagnosed deficiencies or targeted clinical goals (e.g., appetite stimulation, immune support), guided by clinical assessments and current evidence. During the online expert meeting, these refinements were further discussed and

TABLE 2 | Consensus statements on Sections 4–6.

Section 4. Oral nutritional supplements (ONS)	
S4.1	ONS serve as a safe and controlled means of bridging caloric gaps in malnourished patients with EDs (especially in AN), ensuring a more predictable intake of protein, calories (e.g., 200–400 kcal/serving) and micronutrients when oral dietary intake alone is insufficient (RCPSYCH n.d. ; Hay et al. 2014 ; Crone et al. 2023 ; Trovato et al. 2022).
S4.2	ONS are typically recommended during early refeeding or ‘plateau phases’ in weight restoration, particularly if the patient experiences extreme fear of normal portion sizes or if ongoing GI discomfort and psychological distress limit adequate oral intake (National Guideline Alliance [UK] 2017 ; Ministero della Salute 2021 ; Gentile et al. 2010 ; Marzola et al. 2013).
S4.3	ONS can reduce reliance on NGT feeding in some instances, minimising patient distress. However, if ONS alone cannot meet caloric goals and the patient is at medical risk, enteral (NGT) feeding should be considered (RCPSYCH n.d. ; National Guideline Alliance [UK] 2017 ; Bendall and Taylor 2023 ; Martini et al. 2024).
S4.4	To select the appropriate ONS formulation, a multidisciplinary team (physician, dietitian, mental health professional) assesses factors such as taste preferences, caloric density (commonly 1–1.5 kcal/mL) and macronutrient ratio. The goal is to match the patient’s unique needs and address any co-morbidities (e.g., lactose intolerance; RCPSYCH n.d. ; Ministero della Salute 2021 ; Gentile et al. 2010 ; Bahat et al. 2023).
S4.5	Dosage is typically incrementally titrated based on the patient’s daily nutritional shortfall. For instance, 1–2 servings/day (200–800 kcal total) may be introduced initially, then adjusted weekly in response to weight trends, metabolic risk (e.g., RS), and GI tolerance (Hay et al. 2014 ; National Guideline Alliance [UK] 2017 ; Trovato et al. 2022).
S4.6	Monitoring includes regular checks of weight, electrolytes, potential GI side effects (bloating, constipation), and psychological responses, ensuring that ONS dosage supports steady weight restoration without causing undue anxiety or fluid/electrolyte imbalances (RCPSYCH n.d. ; Crone et al. 2023 ; Bahat et al. 2023).
S4.7	Micronutrient-specific ONS, such as zinc-enriched formulas, may be considered in cases of diagnosed deficiencies or when specific clinical goals, like appetite stimulation or immune function support, are identified. For instance, zinc plays a role in modulating appetite and mood, and its supplementation has been associated with improvements in these areas. However, routine use of such supplements should be guided by clinical assessments and current evidence, acknowledging that further research is needed to establish standardised protocols (Hay et al. 2014 ; Suzuki et al. 2011 ; Su and Birmingham 2002 ; Mitchell et al. 2023 ; Hermens et al. 2020).
S4.8	Offering a choice of flavours and textures (e.g., shakes vs. puddings) and providing these supplements in a non-threatening manner can reduce aversion and increase long-term adherence (Crone et al. 2023 ; Ministero della Salute 2021 ; Trovato et al. 2022).
S4.9	Engaging the patient in decision-making, such as discussing ONS goals and timing, enhances autonomy and can help alleviate the sense of being ‘forced’ to eat. Combining ONS with motivational interviewing techniques further improves acceptance (RCPSYCH n.d. ; National Guideline Alliance [UK] 2017 ; Gentile et al. 2010).
S4.10	Scheduled ONS alongside regular meals (rather than replacing meals) ensures that patients continue to practice normal eating patterns. Encouraging small incremental sips throughout the day can be less overwhelming than consuming a full supplement at once (Hay et al. 2014 ; Rizzo et al. 2019).
S4.11	Supportive meal therapy, with or without a healthcare provider or family member present, is most effectively led by a dietitian, who provides reassurance about portion sizes, clarifies misconceptions, and offers real-time psychological coping strategies for anxiety related to calorie intake. When a dietitian is unavailable, a nurse or another trained professional may facilitate meal support to ensure adherence to nutritional goals. Structured involvement of family members can further reinforce mealtime stability and reduce distress (Crone et al. 2023 ; Ministero della Salute 2021 ; Forsberg and Lock 2015).
Section 5. Nasogastric tube (NGT) feeding	
S5.1	NGT feeding is considered when a patient with severe AN or other restrictive ED cannot meet essential caloric needs orally, or when medical instability (e.g., rapid weight loss, RS risk) necessitates a predictable and controlled nutrient supply (RCPSYCH n.d. ; National Guideline Alliance [UK] 2017 ; Crone et al. 2023 ; Kells and Kelly-Weeder 2016).

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TABLE 2 | (Continued)

S5.2	Potential benefits of NGT feeding include improved nutritional status, reduced stress around meal portioning, and the potential avoidance of total parenteral nutrition (TPN). Risks encompass nasal/oesophageal discomfort, psychological distress, and the possibility of RS if not carefully monitored. Electrolyte imbalances, particularly hypophosphatemia, hypomagnesaemia, and hypokalaemia, require close surveillance (Hay et al. 2014; Rizzo et al. 2019; Kells et al. 2022; Braude et al. 2020).
S5.3	For patients with comorbid psychiatric conditions who consistently refuse or are unable to maintain oral intake, NGT feeding can avert critical undernutrition and expedite medical stabilisation. However, it should be weighed against the risk of trauma or coercion if introduced without proper psychosocial support (Ministero della Salute 2021; Kells and Kelly-Weeder 2016; Braude et al. 2020).
S5.4	A multidisciplinary consensus (including mental health, paediatrics/internal medicine and dietetics) is essential before NGT feeding initiation, incorporating medical risk (e.g., BMI < 13 in adults), ongoing weight trajectory, motivation, and capacity to engage in oral nutrition (RCPSYCH n.d.; Crone et al. 2023; Gordon et al. 2024).
S5.5	Decision factors for discontinuing NGT feeding include consistent demonstration of adequate oral intake (> 80% of daily energy needs) for at least several days, stable electrolytes, and reduced psychological distress around meals (National Guideline Alliance [UK] 2017; Martini et al. 2024; Kells and Kelly-Weeder 2016; Braude et al. 2020).
S5.6	Frequent reassessment of clinical markers (e.g., electrolyte panels) and psychological readiness is critical. A stepwise transition from partial NGT feeds (e.g., overnight EN + daytime oral meals) to full oral feeding fosters patient autonomy and skill building (Hay et al. 2014; Crone et al. 2023; Marzola et al. 2013; Bendall and Taylor 2023).
S5.7	Enteral formulas used for NGT feeding in patients with EDs typically provide 1–1.5 kcal/mL and are selected based on protein density, micronutrient profile, and gastrointestinal tolerability. In cases of delayed gastric emptying or severe gastrointestinal discomfort, semi-elemental or elemental formulas may be preferred to enhance digestion and absorption. Rather than diluting standard formulas, adjusting the feeding volume or frequency can be a safer strategy to manage tolerance while maintaining adequate caloric intake (National Guideline Alliance [UK] 2017; Rizzo et al. 2019; Savino 2018).
S5.8	A combined approach integrating NGT feeding with partial oral intake can support the restoration of normal eating patterns while preserving gastrointestinal function. Dietitians should adjust the total caloric intake and its distribution between NGT and oral intake on a case-by-case basis, guided by weight trends and individual metabolic response. While an ideal weight gain target of 0.5–1.0 kg per week is often referenced, adjustments should be made according to the patient's clinical status, tolerance, and overall treatment goals (Hay et al. 2014; Ministero della Salute 2021; Martini et al. 2024; Rizzo et al. 2019; Kells and Kelly-Weeder 2016).
S5.9	Explaining the rationale for NGT feeding in a compassionate, step-by-step manner, emphasising safety and the interim nature of the intervention, helps reduce patient fear and fosters trust (RCPSYCH n.d.; Crone et al. 2023; Amianto et al. 2024).
S5.10	Use of supportive psychotherapy and motivational interviewing is key, complemented by clear behavioural contracts that frame NGT feeding as a collaborative effort rather than a punitive measure (National Guideline Alliance [UK] 2017; Ang et al. 2019; Denison-Day et al. 2018).
S5.11	Involvement of nursing staff trained in mental health and dietetics enables consistent reassurance, addressing body image distress, and counteracting misconceptions around forced feeding. Whenever feasible, giving patients small choices (e.g., timing of feed administration) can increase their sense of autonomy (Hay et al. 2014; Martini et al. 2024; Braude et al. 2020).
S5.12	Regular multidisciplinary reviews with the patient and carers reduce feelings of isolation. Early involvement of family and social supports in NGT feeding decisions can mitigate stigma and improve adherence to treatment plans (Ministero della Salute 2021; Gordon et al. 2024; Amianto et al. 2024).
Section 6. Enteral nutrition (EN) versus parenteral nutrition (PN)	
S6.1	EN refers to delivering nutrients into the gut via a feeding tube (e.g., NGT) when the gastrointestinal tract is functional, while PN involves intravenous administration of nutrients, bypassing the GI tract entirely (RCPSYCH n.d.; da Silva et al. 2020; Gómez Candela et al. 2018a; Hoo et al. 2023)
S6.2	EN is generally preferred whenever possible in patients with EDs, because it supports gut integrity, reduces infection risk and can more closely mimic normal feeding patterns. PN may be reserved for extreme

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TABLE 2 | (Continued)

	circumstances, such as severe GI intolerance or post-operative complications in which the GI tract is not usable (National Guideline Alliance [UK] 2017; Crone et al. 2023; Hoo et al. 2023).
S6.3	In AN with advanced undernutrition, EN offers better psychological integration, maintaining a link to normal digestive processes. PN typically poses greater risk of infection, electrolyte shifts, and requires a more invasive central or peripheral IV line (da Silva et al. 2020; Hay et al. 2014; Ministero della Salute 2021; Amianto et al. 2024; Castro Alija et al. 2022).
S6.4	Explaining PN's rationale and expected duration to the patient and family reduces fear and fosters collaboration, particularly crucial in EDs where the sense of control around food is central to the illness (RCPSYCH n.d.; Crone et al. 2023; Amianto et al. 2024; Ang et al. 2019; Lascar et al. 2021).
S6.5	A dedicated multidisciplinary team, including dietitians, mental health nurses, and psychologists, should provide consistent psychoeducation and emotional support. This ensures that PN is perceived as a life-saving bridge rather than a punitive measure. (RCPSYCH n.d.; Hay et al. 2014; Hoo et al. 2023; Castro Alija et al. 2022)
S6.6	When PN is deemed necessary for a patient with in patients with EDs, a balanced parenteral formulation with moderate carbohydrate load (e.g., ≤ 50–60% of total kcal), adequate protein (~15–20%), and lipids (~20–30%) is recommended to reduce RS risk (RCPSYCH n.d.; da Silva et al. 2020; Hay et al. 2014; Crook 2014; Hoo et al. 2023).
S6.7	Standard PN solutions typically provide a caloric density of 1–1.2 kcal/mL, reflecting balanced ratios of carbohydrates, lipids and amino acids. However, regimen adjustments must be tailored to each patient's baseline nutritional status, metabolic demands, and organ function, particularly hepatic and renal. Ongoing biochemical monitoring is critical to optimise nutritional support and mitigate risks such as RS (da Silva et al. 2020; Hay et al. 2014; Ministero della Salute 2021; Crook 2014; Lascar et al. 2021).
S6.8	Vitamin, mineral, and electrolyte supplementation (particularly phosphate, potassium, magnesium) must be rigorously managed in PN regimens for patients with EDs, given the high risk of refeeding complications (da Silva et al. 2020; National Guideline Alliance [UK] 2017; Gómez Candela et al. 2018a; Crook 2014; Gallagher et al. 2022; Castro Alija et al. 2022).
S6.9	A gradual step-down approach, moving from exclusive EN/PN to partial oral intake (possibly starting with nutritionally complete ONS or small frequent meals), allows patients to adapt physiologically and psychologically, mitigating relapse risks (RCPSYCH n.d.; Hay et al. 2014; Hoo et al. 2023).
S6.10	Concurrent psychosocial interventions, including meal coaching, assisted meals, and cognitive restructuring, reinforce normal eating patterns and help the patient build confidence in oral intake (National Guideline Alliance [UK] 2017; Crone et al. 2023; Willmott et al. 2024; Davén et al. 2025; Castro Alija et al. 2022).
S6.11	Frequent review of weight trends, blood biochemistry, and mental state ensures safe progression during nutritional rehabilitation. If indicators of refeeding syndrome (e.g., falling phosphate levels) appear, adjustments to caloric intake-such as temporarily slowing the rate of increase or modifying macronutrient composition-may be necessary before fully resuming oral feeding. Close monitoring and proactive management of electrolytes, particularly phosphate, potassium, and magnesium, are essential to prevent complications (da Silva et al. 2020; Hay et al. 2014; Ministero della Salute 2021; Gómez Candela et al. 2018a; Crook 2014; Gallagher et al. 2022).
S6.12	Structured relapse-prevention plans, both written and verbal, are an essential component of the continuum of care. These plans should be developed collaboratively within the care pathway and include clear steps for patients and caregivers to follow in case of decreased intake or increased psychological distress after EN/PN withdrawal. Monitoring and adjustments should be conducted under clinical supervision to prevent self-management and ensure timely intervention by the healthcare team (RCPSYCH n.d.; Willmott et al. 2024; Lascar et al. 2021).

Note: Final approved consensus statements on 3.4 Oral Nutritional Supplements (ONS), 3.5 Nasogastric Tube (NGT) Feeding, and 3.6 EN versus PN in hospitalised patients with EDs. Statements reflect the final wording approved after the Delphi process. Supporting references are provided. Detailed acceptance rates and statistical data are available in the Supporting Information S1.

ultimately resulted in S4.7's final approval. Table 4 thus presents the 10 immediately accepted statements plus the revised and approved version of S4.7. Overall, the panel recognised ONS as a valuable adjunct in preventing underfeeding, mitigating NGT reliance, and addressing specific micronutrient deficits.

3.5 | Nasogastric Tube (NGT) Feeding

Thirteen statements (S5.1–S5.13) were originally drafted to address NGT feeding in hospitalised patients with restrictive EDs. After Round 1, S5.8 was eliminated, leaving 12 statements. For consistency in the final layout (see Table 2), the statement

formerly known as S5.9 now appears as S5.8. While 11 statements secured immediate consensus ($\geq 85\%$ agreement), S5.7 and the newly designated S5.8 underwent additional revision before ultimately achieving consensus in Round 2. Overall, the panel strongly endorsed NGT feeding as a viable intervention when oral intake alone fails to meet medical safety thresholds, particularly in cases with a high risk of refeeding syndrome or rapid weight loss.

3.6 | Enteral Nutrition (EN) Versus Parenteral Nutrition (PN)

Thirteen statements (S6.1–S6.13) addressed considerations for choosing EN or PN in severely malnourished patients with EDs, alongside strategies for monitoring, transitioning, and relapse prevention. Eleven statements attained $\geq 85\%$ agreement, one (S6.6) was eliminated due to persistent disagreement, and two (S6.12, S6.13) were revised, re-evaluated and ultimately accepted in Round 2 (Table 2).

Taken together, these statements highlight the panel's preference for EN in ED patients wherever feasible, given its physiological benefits and comparatively lower risk profile. They underscore the need for vigilant clinical and biochemical monitoring for refeeding syndrome, collaborative communication among healthcare professionals, and structured relapse-prevention strategies to ensure safe and sustainable nutritional rehabilitation.

3.7 | Nutrition Education and Counselling

Seven statements (S7.1–S7.7) addressed the importance of targeted nutrition education and counselling strategies for hospitalised patients with EDs (Table 3). All seven exceeded the 85% agreement threshold in Round 1, with acceptance rates ranging from 87.5% to 95.0%.

Overall, the panel concurred that nutrition education and counselling should be patient-centred, addressing both the biological and emotional underpinnings of EDs. The high acceptance rates reflect consensus that structured psychoeducation and supportive counselling techniques are integral to any inpatient management strategy.

3.8 | Monitoring and Evaluation of Medical Nutrition Therapy (MNT)

Seven statements (S8.1–S8.7) detailed approaches to monitoring treatment efficacy, coordinating inpatient-outpatient transitions, and preventing relapse in patients receiving MNT. All statements but one exceeded the 85% consensus threshold outright, with acceptance rates ranging from 85% to 97.5%. Statement S8.5 scored an 82.5% agreement among experts, improving to 86.7% after revision and re-evaluation in Round 2. Overall, the panel strongly supported a robust monitoring framework that integrates medical, nutritional, and psychological assessments, with particular attention to potential

refeeding complications. The high acceptance rate ($\geq 80\%$) across statements reflects a consensus that effective coordination between inpatient and outpatient care, complemented by regular assessments of physical and mental health, is pivotal in maintaining recovery gains and minimising the likelihood of relapse (Table 3).

3.9 | Specialised Populations: Children, Adolescents, Pregnant, and Breastfeeding Women With EDs

Seven statements (S9.1–S9.7) addressed tailored nutritional strategies for specialised populations, each group facing distinct physiological and psychosocial challenges related to EDs. All statements surpassed the 85% agreement threshold in Round 1 except for S9.3, which was revised and subsequently approved with 90% agreement in Round 2.

Overall, the panel reached clear consensus on the importance of tailored nutritional protocols for paediatric and perinatal populations with EDs, emphasising individualised caloric prescriptions, careful monitoring for refeeding complications, and robust interdisciplinary collaboration to address growth, development and maternal-foetal health (Table 4).

3.10 | Ethical and Legal Considerations in the Treatment of EDs

Six statements (S10.1–S10.6) concentrated the balance between patient autonomy, decision-making capacity, and the duty of care in managing severe EDs. All statements attained consensus ($\geq 85\%$) in Round 1 (range: 87.5%–97.5%).

Overall, the panel's consensus highlights the ethical obligation to protect patients at imminent risk while striving for the least intrusive interventions and ensuring transparent communication. The high acceptance rates reflect a unified endorsement of carefully navigated legal and ethical frameworks in ED treatment, fostering ongoing dialogue among healthcare teams, patients, and families (Table 5).

3.11 | Interdisciplinary Collaboration in the Treatment of Hospitalised Patients With EDs

Six statements (S11.1–S11.6) addressed the importance of collaboration among dietitians, physicians, mental health professionals, nurses, and caregivers. All statements achieved $\geq 90\%$ agreement in Round 1, with some reaching 97.5%–100% consensus, indicating strong endorsement of a team-based model for managing complex feeding and psychological needs in inpatients with EDs.

The panel's unanimous agreement across all six statements underscores a collective recognition that comprehensive interdisciplinary collaboration, encompassing dietitians, mental health practitioners, nursing staff, and family members, is essential for the effective management of hospitalised patients with EDs (Table 5).

TABLE 3 | Consensus statements on Sections 7 and 8.

Section 7. Nutrition education and counselling	
S7.1	Core sessions should focus on basic macronutrients (carbohydrates, proteins, fats) and essential micronutrients (vitamins, minerals), explaining their roles in cellular repair, immune function, and overall metabolic stability, as well as the risks linked to chronic under- or over-consumption (RCPSYCH n.d.; National Guideline Alliance [UK] 2017; Cairns and Milne 2006; American Dietetic Association 2001; Heruc et al. 2020; Academy for Eating Disorders n.d.).
S7.2	Patients benefit from structured guidance on meal patterns, portion sizes, and the physiological rationale behind regular meal/snack intervals, emphasising how consistent intake supports both short-term medical stabilisation and long-term metabolic recovery (RCPSYCH n.d.; Hay et al. 2014; National Guideline Alliance [UK] 2017; Heruc et al. 2020; Academy for Eating Disorders n.d.; Yang et al. 2023).
S7.3	Psychological education on RS is crucial in helping patients understand why blood tests, electrolyte monitoring, and gradual caloric escalation are necessary to ensure safe and effective refeeding. Clear communication from the care team is essential to address patients' potential concerns about the pace of refeeding and prevent misunderstandings that may lead to requests for excessive caloric increases (RCPSYCH n.d.; da Silva et al. 2020; Garber et al. 2016; Crone et al. 2023; Ministero della Salute 2021).
S7.4	Comprehensive nutritional psychoeducation includes debunking myths about 'good versus bad' foods, addressing distorted beliefs about weight and body image, and explaining how balanced nutrition aligns with emotional regulation and relapse prevention (Hay et al. 2014; American Dietetic Association 2001; Heruc et al. 2020; Academy for Eating Disorders n.d.; Loria et al. 2009).
S7.5	To tackle emotional barriers to eating, counselling sessions incorporate motivational interviewing and compassion-focused strategies, helping patients redefine personal goals around food while respecting their fears and anxieties (RCPSYCH n.d.; Academy for Eating Disorders n.d.; Yang et al. 2023).
S7.6	Collaborative and individualised nutrition counselling addresses the emotional impact of food choices by validating the patient's distress, reinforcing body-mind connectedness, and leveraging family/carers support to build healthier cognitive and behavioural responses to eating (National Guideline Alliance [UK] 2017; Ministero della Salute 2021; Cairns and Milne 2006; Heruc et al. 2020).
S7.7	Interdisciplinary sessions, involving dietitians, psychologists, and nursing staff, ensure that the psychological drivers of food avoidance or binge-purge cycles are simultaneously addressed alongside evidence-based nutritional recommendations for long-term recovery (RCPSYCH n.d.; Hay et al. 2014; American Dietetic Association 2001).
Section 8. Monitoring and evaluation of medical nutrition therapy	
S8.1	Key indicators for monitoring MNT effectiveness include: (1) weight restoration trajectory (e.g., weekly weight gain of 0.5–1.0 kg), (2) electrolyte stability (K^+ , phosphate, Mg^{2+}), (3) vital signs (heart rate, blood pressure) and (4) behavioural markers (reductions in compulsive exercise, binge/purge frequency; RCPSYCH n.d.; Ridout et al. 2016; National Guideline Alliance [UK] 2017; Harris et al. 2023).
S8.2	Frequent BMI checks (targeting a safe range, typically BMI ≥ 18.5 for adults or appropriate centile for adolescents) and normalised eating patterns (e.g., intake of 3 balanced meals and 2–3 snacks) serve as quantitative proxies for recovery and effectiveness of nutritional interventions (Hay et al. 2014; McMaster et al. 2022; Redgrave et al. 2015).
S8.3	Laboratory assessments are essential for monitoring the safety and efficacy of nutritional interventions. Initial focus should be on markers of refeeding risk, such as phosphate, K^+ and Mg^{2+} , along with liver function (e.g., transaminases), lipid profiles and protein status (albumin, prealbumin) to track systemic recovery. Regular assessment of pericardial effusion, body composition, and weight trends complements metabolic correction. Testing frequency is typically higher during the initial stabilisation phase (2–3 times per week) and gradually reduced as clinical stability improves (RCPSYCH n.d.; Ridout et al. 2016; Redgrave et al. 2015; Abed et al. 2014).
S8.4	To evaluate psychological readiness for discharge and outpatient follow-up, we track (1) symptom monitoring (mood, self-harm, body image), (2) adherence to meal plans and (3) participation in therapy sessions-ensuring the patient can maintain gains and self-manage triggers (National Guideline Alliance [UK] 2017; Gianini et al. 2016; Puls et al. 2020).
S8.5	Coordination between inpatient and outpatient services should involve a structured transition plan, ideally incorporating dietetic supervision and regular monitoring of intake and weight trends. While access to consistent follow-up services varies across settings, feasible strategies may include scheduled weigh-ins, remote check-ins, or structured self-help tools to support relapse prevention. The level of follow-up should be adapted based on the availability of local resources and the patient's individual risk factors, ensuring that clinical oversight remains accessible even when direct care is limited (Irish et al. 2022; Hay et al. 2014; Vollert et al. 2019; Clark Bryan et al. 2024).

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TABLE 3 | (Continued)

S8.6	Before discharge, a multidisciplinary case conference (including dietitians, medical team, mental health professionals) outlines individualised follow-up, specifying frequency of monitoring, re-evaluation of BMI/physical parameters and criteria for readmission if deterioration occurs (RCPSYCH n.d. ; Ministero della Salute 2021 ; Wild et al. 2009).
S8.7	In complex cases (e.g., severe comorbidities, repeated relapses), partial hospitalisation or day-treatment programs can bridge inpatient and outpatient care by offering structured mealtime support, group therapy, and close medical monitoring to consolidate gains (RCPSYCH n.d. ; Alberti et al. 2013 ; Hotta et al. 2014 ; Simpson et al. 2021).

Note: Final approved consensus statements on 3.7 nutrition education and counselling and 3.8 monitoring and evaluation of MNT in hospitalised patients with EDs. Statements reflect the final wording approved after the Delphi process. Supporting references are provided. Detailed acceptance rates and statistical data are available in the Supporting Information [S1](#).

3.12 | Long-Term Outcomes in Eating Disorder Recovery

Six statements (S12.1–S12.6) focused on sustaining remission and preventing relapse after hospital discharge. All statements surpassed the 85% agreement threshold in Round 1 (87.5%–95% acceptance), reinforcing strong consensus on the necessity of long-term nutritional and psychosocial strategies.

Collectively, the panel strongly supported comprehensive and sustained post-discharge interventions that target both nutritional sufficiency and psychosocial resilience, aiming to minimise relapse risk and promote lasting recovery (Table [5](#)).

4 | Discussion

The rationale behind this consensus arose from the pressing need to provide clinicians with practical, evidence-informed guidance on inpatient MNT for EDs. Despite existing guidelines and literature, hospital-based practitioners often face inconsistencies or gaps in recommendations, particularly concerning specific refeeding protocols, caloric increments, and monitoring strategies. In certain cases, guidelines propose aggressive caloric starts (e.g., 1600 kcal/day or more) or rigid targets (e.g., three meals and two snacks daily) that can be challenging to implement in patients who struggle to meet even minimal intake requirements. These discrepancies between idealised guidelines and the realities of clinical practice underscore why a specialised expert consensus is vital.

Our panel deliberately focused on inpatient management, where the risk of life-threatening complications (e.g., refeeding syndrome) is highest and where daily, closely monitored interventions are required. Because such care often mandates decisions beyond the scope of outpatient protocols, we felt it essential to convene an exclusively specialist panel to reconcile recommended practices with real-world constraints. The resulting statements seek to bridge the gap between what guidelines aspire to achieve and what is feasible and clinically justified in an acute-care hospital context.

4.1 | Comparison to Previous Delphi-Based Studies and Existing Guidelines

To our knowledge, this is one of the first Delphi-based studies to generate consensus-driven recommendations targeting the entire trajectory of inpatient ED management, from admission

to post-discharge follow-up. Previous Delphi efforts, such as McMaster's study on outpatient dietetic treatment or O'Brien's work involving both providers and recipients of paediatric inpatient care, have offered valuable perspectives but focus on different settings or broader stakeholder panels (McMaster et al. [2020](#); O'Brien et al. [2018](#)). By contrast, we concentrated on critical inpatient issues (e.g., risk-based refeeding, nasogastric feeding, specialised populations) and engaged a small, highly qualified panel of ED clinicians rather than including non-specialist or lay participants. While this narrower panel may limit generalisability, it leverages deep expertise to arrive at robust, clinically relevant consensus statements that address the unique demands of hospital-based ED management.

A high proportion of our endorsed statements aligns with recognised best practices in ED care as found in guidelines from organisations like the APA, NICE and others. The emphasis on multidisciplinary collaboration (S11.1–S11.6), gradual but closely monitored refeeding (S1.6, S2.1–S2.4), and vigilant electrolyte tracking (S2.1–S2.3) reflects core principles already described in the literature. However, our expert consensus adds more granular detail (e.g., recommended caloric increments, criteria for transitioning between enteral and oral intake) that can further support clinicians in day-to-day decision-making. This level of specificity, particularly with regard to high-risk cases, addresses a well-documented gap in existing guidelines, which often lack practical, inpatient-focused protocols.

4.2 | Additional Statements and Eliminations

While most statements reached immediate consensus, a small subset required further refinement. For example, S2.5 (weight-gain targets for adults vs. adolescents), S3.1 (caloric ranges for AN) and S4.7 (the role of micronutrient-specific ONS) each earned strong support but did not surpass the 85% threshold. These items reflect contexts where clinical protocols vary based on patient complexity or limited data, particularly regarding specialised supplementation. During the final online meeting, each was revised again to resolve lingering ambiguities, and all were subsequently approved.

Conversely, three statements did not meet the minimum 80% threshold and were eliminated: S4.3 (routine ONS in BN/BED), S5.8 (conservative nasogastric feeding initiation) and S6.6 (cognitive-behavioural methods in PN). Panellists noted that these topics are insufficiently supported by existing evidence in the inpatient setting, and rather than dismissing their relevance

TABLE 4 | Consensus statements on Section 9.

Section 9. Specialised populations: children, adolescents, pregnant and breastfeeding women with EDs	
S9.1	In hospitalised children and adolescents with EDs, age- and weight-adjusted energy needs are crucial for implementation of safe re-alimentation strategies. Paediatric BMI percentiles or growth charts are the basis for setting growth restoration goals and maintaining normal developmental trajectories (RCPSYCH n.d. ; Rocks et al. 2014 ; Rome et al. 2003 ; Tanner 2023).
S9.2	Accelerated refeeding can be safe for many underweight adolescents when monitored closely for electrolyte shifts (especially phosphate, potassium, magnesium). Frequent clinical assessments (e.g., daily weights, bi-weekly labs) help detect and prevent refeeding complications (Nagata, Bojorquez-Ramirez, et al. 2022 ; Haas et al. 2021 ; O'Connor and Nicholls 2013 ; Cuntz et al. 2022).
S9.3	When selecting enteral feeds for paediatric patients, clinicians should choose between semi-elemental or polymeric formulas based on the child's tolerance, ensuring adequate protein intake and essential nutrient support for catch-up growth. Indirect calorimetry (IC), when available, can aid in refining caloric prescriptions to meet individualised metabolic demands (RCPSYCH n.d. ; Trovato et al. 2022 ; Rome et al. 2003 ; Haas et al. 2021 ; Schebendach et al. 1995).
S9.4	Therapeutic meal planning in adolescents involves collaboration between dietitians, mental health professionals, and families to address developmental needs (e.g., supporting bone mass accrual, puberty) and psychosocial factors (family mealtimes, school transitions; Harshman et al. 2019 ; Pettersson et al. 2021 ; Rome et al. 2003).
S9.5	Pregnant women with EDs require early antenatal nutritional screening, focusing on adequate weight gain curves, micronutrient supplementation (folate, iron, vitamin D), and vigilant surveillance of foetal growth to mitigate risks such as low birth weight (RCPSYCH n.d. ; Diamanti et al. 2008 ; Galbally et al. 2022).
S9.6	In breastfeeding mothers with active EDs, a caloric surplus of approximately 450–500 kcal/day above baseline requirements is typically recommended to meet both maternal and lactational energy demands. This may need to be adjusted further in cases of preexisting nutritional deficits. Close monitoring of maternal nutrient intakes (protein, calcium, essential fats, and micronutrients) is critical to support adequate milk quality and postpartum recovery (RCPSYCH n.d. ; Rome et al. 2003 ; Galbally et al. 2022 ; Hadigan et al. 2000 ; Kaß et al. 2021).
S9.7	Because of heightened physiological demands in pregnancy and lactation, specialised teams (including obstetrics, dietetics, and mental health) coordinate to manage risk of relapse, ensuring frequent check-ins and psychosocial support for any refeeding or body image challenges (RCPSYCH n.d. ; Diamanti et al. 2008 ; Galbally et al. 2022 ; Hadigan et al. 2000 ; Ward 2008).

Note: Final approved consensus statements on 3.9 specialised populations: children, adolescents, pregnant and breastfeeding women with EDs in hospitalised patients with EDs. Statements reflect the final wording approved after the Delphi process. Supporting references are provided. Detailed acceptance rates and statistical data are available in the Supporting Information [S1](#).

outright, determined that current data did not support their inclusion in this consensus.

4.3 | Strengths, Limitations and Future Directions

A key strength of this work lies in its expert-to-expert design, which reconciles existing guidelines with the daily realities of inpatient care. By focusing on practical challenges, such as implementing structured refeeding protocols in severely malnourished patients or tailoring high-calorie meal plans for those who can barely tolerate minimal intake, the panel produced recommendations that bridge theoretical best practices and clinical feasibility. The resulting statements offer concrete, step-by-step guidance for medical teams managing the most acute stages of EDs, where evidence-based specifics are often lacking. We acknowledge that models of care and service organisation vary internationally; clinicians are therefore encouraged to adapt

the framework of these statements to the structures and resources available within their own healthcare systems.

At the same time, our study's small specialist panel necessarily limits the breadth of perspectives, with potential implications for generalisability in settings without dedicated ED expertise. Moreover, the absence of consumer or caregiver participation prevents us from fully capturing patient-centred viewpoints, an area that future investigations might address, especially for long-term adherence and relapse prevention.

Notably, the plan to convene an online meeting for finalising any unresolved statements stands to reinforce, rather than diminish, the quality of this consensus. By using quantitative data from the anonymous rounds as a foundation, the group was able to clarify subtle discrepancies in real time without reintroducing a full rating cycle. This process ensures that nuanced clinical scenarios are accounted for, ultimately strengthening the overall recommendations. Looking ahead, further research should examine

TABLE 5 | Consensus statements on Sections 10–12.

Section 10. ETHICAL and legal considerations in the treatment of EDS	
S10.1	Healthcare teams must acknowledge patients' right to refuse certain nutritional interventions, while recognising that severe EDs can impair judgement and insight into the medical risks of non-consent; balancing autonomy with a duty of care (beneficence) necessitates meticulous assessments of decision-making capacity. (RCPSYCH n.d. ; Westermair et al. 2024 ; Kendall 2014 ; Takimoto 2022)
S10.2	In instances where fear of weight gain dominates and patients resist potentially life-saving nutrition, early shared decision-making, involving the patient, mental health professionals, and possibly family, can reduce coercion by emphasising the supportive intent and clarifying risks if treatment is declined. When capacity is doubtful due to the distorted cognitions inherent in EDs, beneficence may rightly take precedence (RCPSYCH n.d. ; Westermair et al. 2024 ; Kendall 2014 ; Takimoto 2022).
S10.3	In adolescent or paediatric cases, parental consent or authorisation should be invoked for nutritional interventions when the child's resistance poses imminent health risks. However, care teams must also ensure that the young person's views are heard and weighed proportionally to their emerging autonomy and maturity (Westermair et al. 2024 ; Kendall 2014 ; Norrington et al. 2012).
S10.4	Involuntary feeding, such as NGT insertion under restraint, is ethically defensible only when imminent risk to life exists and the patient's refusal is deemed invalid due to lack of capacity or severe cognitive distortion. Documentation should include rationale, therapeutic intent, and proportionality of the intervention (Westermair et al. 2024 ; Takimoto 2022 ; Norrington et al. 2012).
S10.5	Respecting least restrictive alternatives and regular multidisciplinary reviews can mitigate the ethical concerns around coercion in severe AN. Restrictive measures should be time-limited, embedded in ongoing dialogue with the patient (as well as families or caregivers for children and adolescents), and paired with psychological support to preserve dignity and therapeutic alliance (Kendall 2014 ; Takimoto 2022 ; Norrington et al. 2012).
S10.6	Ethics consultations can offer a structured platform for conflicts arising from perceived coercion, clarifying how compulsory measures align with professional codes of conduct, local legislation, and the best interest principle in minors or severely compromised adults (RCPSYCH n.d. ; Crone et al. 2023 ; Westermair et al. 2024).
Section 11. Interdisciplinary collaboration in the treatment of hospitalised patients with EDs.	
S11.1	In many inpatient programs, Registered Dietitians (RDs) are integrated as consistent members of the care team, attending regular ward rounds alongside physicians, psychiatrists, nurses, and therapists. Their expertise in meal planning, nutritional status monitoring, and refeeding strategies ensures a comprehensive and cohesive treatment approach (RCPSYCH n.d. ; Gosa et al. 2020 ; Dahmen et al. 2024 ; Bray et al. 2023).
S11.2	Close dietitian-psychiatrist collaboration is essential for addressing the psychological barriers to adequate nutritional intake. Through shared assessment tools, behavioural contracting, and family-inclusive consultations, RDs and mental health professionals can align MNT with the patient's overall therapeutic goals (RCPSYCH n.d. ; Gosa et al. 2020 ; Bray et al. 2023 ; Pehlivan et al. 2022).
S11.3	Nurses, speech-language pathologists, and occupational therapists frequently partner with dietitians to manage complex feeding behaviours, especially in paediatric or developmental feeding disorders, using coordinated swallowing assessments, mealtime observations, and tailored interventions to ensure safe and effective nutritional rehabilitation (RCPSYCH n.d. ; Gosa et al. 2020 ; Pehlivan et al. 2022).
S11.4	Family members or caregivers can serve as active co-therapists, particularly in adolescent cases, by reinforcing meal plans at home, ensuring consistency in portion sizes and meal timing, and providing emotional support at mealtimes (RCPSYCH n.d. ; Dahmen et al. 2024 ; Pehlivan et al. 2022 ; Maestro et al. 2022).
S11.5	A family-centred approach to nutritional care, which may include parent training sessions on portioning, safe refeeding rates, and motivational strategies, enhances patient engagement and reduces relapse rates by extending the hospital's supportive environment into the home (RCPSYCH n.d. ; Pehlivan et al. 2022 ; Maestro et al. 2022).
S11.6	When transitioning from inpatient to home-based care, dietitians collaborate closely with caregivers and, where applicable, with community-based dietitians or multidisciplinary teams to establish a sustainable maintenance meal plan. They also provide guidance on recognising early warning signs of relapse. This coordinated approach ensures continuity between hospital-based interventions and the family's daily

(Continues)

TABLE 5 | (Continued)

	routines, supporting long-term recovery (RCPSYCH n.d. ; Dahmen et al. 2024 ; Pehlivan et al. 2022 ; Maestro et al. 2022).
Section 12. Long-term outcomes in ED recovery.	
S12.1	Achieving and maintaining a medically appropriate weight range (e.g., stable BMI or growth trajectory for adolescents) with adequate macronutrient and micronutrient intake is a core long-term goal that supports physical health, hormonal balance and prevention of relapse (RCPSYCH n.d. ; Testa et al. 2022 ; Saccomani et al. 1998 ; Steinglass et al. 2024 ; Long et al. 2012).
S12.2	Patients benefit from flexible but structured meal patterns, incorporating a wide variety of foods to reduce rigidity around eating and avoid nutritional gaps: this is crucial in sustaining recovery and minimising relapse to restrictive or binge-purge behaviours (RCPSYCH n.d. ; National Guideline Alliance [UK] 2017 ; Steinglass et al. 2024 ; Bergh et al. 2013 ; Fichter et al. 1998).
S12.3	Residual deficiencies of micronutrients (e.g. iron, vitamin D, essential fatty acids) should be ruled out at discharge and, if detected, should be addressed through long-term structured nutrition plans. Proactive supplementation and periodic labs can mitigate risks of complications and re-hospitalisation (RCPSYCH n.d. ; Steinglass et al. 2024 ; Alañón Pardo et al. 2017).
S12.4	To prevent relapse, ongoing outpatient support (dietetic follow-ups, therapy sessions, and possible peer-support groups) can maintain positive eating behaviours, encourage self-monitoring of hunger/fullness cues, and reinforce mindful meal planning (National Guideline Alliance [UK] 2017 ; Academy for Eating Disorders n.d. ; Testa et al. 2022 ; Saccomani et al. 1998 ; Bergh et al. 2013).
S12.5	Relapse prevention plans often include establishing a ‘safety net’ of contacts (family members, healthcare providers) and emphasising strategies for stress management and emotional regulation to reduce impulsive or disordered eating responses (RCPSYCH n.d. ; Academy for Eating Disorders n.d. ; Long et al. 2012 ; Bergh et al. 2013).
S12.6	Gradually increasing autonomy in food choices, guided by a collaborative approach between dietitians, mental health professionals, and the patient, ensures the translation of nutritional knowledge into flexible, lasting habits (da Silva et al. 2020 ; Lopes et al. 2023 ; Yang et al. 2023 ; Alañón Pardo et al. 2017 ; O’Brien et al. 2018 ; RCPSYCH n.d. ; National Guideline Alliance [UK] 2017 ; Academy for Eating Disorders n.d. ; Steinglass et al. 2024 ; Fichter et al. 1998).

Note: Final consensus statements on 3.10 ethical and legal considerations, 3.11 interdisciplinary collaboration and 3.12 long-term outcomes in the treatment and recovery of hospitalised patients with EDs. Statements reflect the final wording endorsed after the Delphi process, with supporting references included. Acceptance rates and statistical details are available in the Supporting Information [S1](#).

how effectively these consensus-based protocols translate into patient outcomes (such as reduced refeeding complications or improved rates of sustained recovery) and whether including non-specialist clinicians or caregivers in subsequent panels might broaden their applicability in more diverse clinical environments.

5 | Conclusion

This Delphi study provides a specialised consensus framework for inpatient management of patients with EDs, integrating MNT with psychosocial interventions. The final statements offer practical, expert-validated guidance on refeeding protocols, supplementation, interdisciplinary collaboration, and long-term relapse prevention. While further research may refine or expand these recommendations, they represent an important step toward standardised, evidence-informed care for hospitalised patients with EDs.

Ethics Statement

This consensus involved healthcare professionals participating as experts in a modified Delphi process and did not include patient data or

interventions. Ethical approval was not required, as the study did not involve human subjects. Voting during the Delphi rounds was conducted anonymously to ensure unbiased input, while participants' identities are disclosed in the publication as members of the expert panel.

Consent

All participants provided informed consent to take part in the process and to the publication of the results.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are presented within the manuscript and its supplementary materials. No additional datasets were generated or analysed.

References

- Abed, J., H. Judeh, E. Abed, M. Kim, H. Arabelo, and R. Gurunathan. 2014. “Fixing a Heart”: The Game of Electrolytes in Anorexia Nervosa.” *Nutrition Journal* 13, no. 1: 90. <https://doi.org/10.1186/1475-2891-13-90>.
- Academy for Eating Disorders. “Eating Disorders: A Guide to Medical Care.” Accessed March 17, 2025. <https://www.aedweb.org/resources/publications/medical-care-standards>.

- Alañón Pardo, M. D. M., M. Ferrit Martín, M. Á Calleja Hernández, and F. Morillas Márquez. 2017. "Adherence of Psychopharmacological Prescriptions to Clinical Practice Guidelines in Patients With Eating Behavior Disorders." *European Journal of Clinical Pharmacology* 73, no. 10: 1305–1313. <https://doi.org/10.1007/s00228-017-2287-2>.
- Alberti, M., C. Galvani, M. El Ghoch, et al. 2013. "Assessment of Physical Activity in Anorexia Nervosa and Treatment Outcome." *Medicine & Science in Sports & Exercise* 45, no. 9: 1643–1648. <https://doi.org/10.1249/MSS.0b013e31828e8f07>.
- American Dietetic Association. 2001. "Position of the American Dietetic Association: Nutrition Intervention in the Treatment of Anorexia Nervosa, Bulimia Nervosa, and Eating Disorders Not Otherwise Specified (EDNOS)." *Journal of the American Dietetic Association* 101, no. 7: 810–819. [https://doi.org/10.1016/s0002-8223\(01\)00201-2](https://doi.org/10.1016/s0002-8223(01)00201-2).
- Amianto, F., T. Oliaro, F. Righettoni, C. Davico, D. Marcotulli, and B. Vitiello. 2024. "Psychological Effects of Nasogastric Tube (NGT) in Patients With Anorexia Nervosa: A Systematic Review." *Nutrients* 16, no. 14: 2316. <https://doi.org/10.3390/nu16142316>.
- Ang, S. Y., M. L. Lim, X. P. Ng, M. Lam, M. M. Chan, and V. Lopez. 2019. "Patients and Home Carers' Experience and Perceptions of Different Modalities of Enteral Feeding." *Journal of Clinical Nursing* 28, no. 17–18: 3149–3157. <https://doi.org/10.1111/jocn.14863>.
- Bahat, G., M. Akmansu, L. Gungor, et al. 2023. "Optimal Use of Oral Nutritional Supplements (ONS) in Medical Nutrition Therapy: ONS Consensus Report From KEPAN." *European Journal of Clinical Nutrition* 77, no. 7: 705–709. <https://doi.org/10.1038/s41430-022-01229-9>.
- Bendall, C., and N. F. Taylor. 2023. "The Effect of Oral Refeeding Compared With Nasogastric Refeeding on the Quality of Care for Patients Hospitalised With an Eating Disorder: A Systematic Review." *Nutrition & Dietetics* 80, no. 1: 44–54. <https://doi.org/10.1111/1747-0080.12770>.
- Bergh, C., M. Callmar, S. Danemar, et al. 2013. "Effective Treatment of Eating Disorders: Results at Multiple Sites." *Behavioral Neuroscience* 127, no. 6: 878–889. <https://doi.org/10.1037/a0034921>.
- Białek-Dratwa, A., D. Szymańska, M. Grajek, K. Krupa-Kotara, E. Szczepańska, and O. Kowalski. 2022. "ARFID-Strategies for Dietary Management in Children." *Nutrients* 14, no. 9: 1739. <https://doi.org/10.3390/nu14091739>.
- Braude, M. R., D. Con, D. Clayton-Chubb, R. Nandurkar, L. E. Chua, and E. D. Newnham. 2020. "Acute Medical Stabilisation of Adults With Anorexia Nervosa: Experience of a Defined Interdisciplinary Model of Care." *Internal Medicine Journal* 50, no. 1: 77–85. <https://doi.org/10.1111/imj.14329>.
- Bray, M., G. Heruc, S. Byrne, and O. R. L. Wright. 2023. "Collaborative Dietetic and Psychological Care in Interprofessional Enhanced Cognitive Behaviour Therapy for Adults With Anorexia Nervosa: A Novel Treatment Approach." *Journal of Eating Disorders* 11, no. 1: 31. <https://doi.org/10.1186/s40337-023-00743-w>.
- Brodie, E., N. van Veenendaal, E. Platz, et al. 2024. "The Incidence of Refeeding Syndrome and the Nutrition Management of Severely Malnourished Inpatients With Eating Disorders: An Observational Study." *International Journal of Eating Disorders* 57, no. 3: 661–670. <https://doi.org/10.1002/eat.24151>.
- Cairns, J., and R. L. Milne. 2006. "Eating Disorder Nutrition Counseling: Strategies and Education Needs of English-Speaking Dietitians in Canada." *Journal of the American Dietetic Association* 106, no. 7: 1087–1094. <https://doi.org/10.1016/j.jada.2006.04.025>.
- Castro Alija, M. J., M. Valero Pérez, S. Belmonte Cortés, and M. de Diego Díaz Plaza. 2022. "[Alimentary and Nutritional Education in Eating Disorders]." *Nutrición Hospitalaria* 39, no. Spec No2: 27–32. <https://doi.org/10.20960/nh.04175>.
- Clark Bryan, D., K. Rowlands, P. Macdonald, et al. 2024. "Transition Support for Patients Admitted to Intensive Treatment for Anorexia Nervosa: Qualitative Study of Patient and Carer Experiences of a Hybrid Online Guided Self-Help Intervention (ECHOMANTRA)." *BJPsych Open* 10, no. 3: e81. <https://doi.org/10.1192/bjo.2023.642>.
- Crone, C., L. J. Fochtmann, E. Attia, et al. 2023. "The American Psychiatric Association Practice Guideline for the Treatment of Patients With Eating Disorders." *American Journal of Psychiatry* 180, no. 2: 167–171. <https://doi.org/10.1176/appi.ajp.23180001>.
- Crook, M. A. 2014. "Refeeding Syndrome: Problems With Definition and Management." *Nutr Burbank Los Angeles City California* 30, no. 11–12: 1448–1455. <https://doi.org/10.1016/j.nut.2014.03.026>.
- Cuntz, U., T. Körner, and U. Voderholzer. 2022. "Rapid Renutrition Improves Health Status in Severely Malnourished Inpatients With AN—Score-Based Evaluation of a High Caloric Refeeding Protocol in Severely Malnourished Inpatients With Anorexia Nervosa in an Intermediate Care Unit." *European Eating Disorders Review: The Journal of the Eating Disorders Association* 30, no. 2: 178–189. <https://doi.org/10.1002/erv.2877>.
- Dahmen, B., I. Zielinski-Gussen, M. Föcker, et al. 2024. "Anorexia Nervosa-Specific Home Treatment in Children and Adolescents and Their Families (The HoT Study): A Study Protocol of a Randomized, Controlled, Multicenter, Open-Label, Parallel Group Superiority Trial." *Trials* 25, no. 1: 760. <https://doi.org/10.1186/s13063-024-08566-z>.
- da Silva, J. S. V., D. S. Seres, K. Sabino, et al. 2020. "ASPEN Consensus Recommendations for Refeeding Syndrome." *Nutrition in Clinical Practice* 35, no. 2: 178–195. <https://doi.org/10.1002/ncp.10474>.
- Davén, J., O. Hellzen, L. Kristiansen, and M. Häggström. 2025. "Nurses' Professional Roles: Supervision and Support During Meals in Caring for Adult Inpatients With Anorexia Nervosa—A Qualitative Study." *Nordic Journal of Nursing Research* 45: 20571585241297957. <https://doi.org/10.1177/20571585241297957>.
- Denison-Day, J., K. M. Appleton, C. Newell, and S. Muir. 2018. "Improving Motivation to Change Amongst Individuals With Eating Disorders: A Systematic Review." *International Journal of Eating Disorders* 51, no. 9: 1033–1050. <https://doi.org/10.1002/eat.22945>.
- Diamanti, A., M. S. Basso, M. Castro, et al. 2008. "Clinical Efficacy and Safety of Parenteral Nutrition in Adolescent Girls With Anorexia Nervosa." *Journal of Adolescent Health* 42, no. 2: 111–118. <https://doi.org/10.1016/j.jadohealth.2007.09.024>.
- Dumitriu, A. M., C. Cobilinschi, B. Dumitriu, et al. 2025. "Advancing Nutritional Care Through Bioelectrical Impedance Analysis in Critical Patients." *Nutrients* 17, no. 3: 380. <https://doi.org/10.3390/nu17030380>.
- Falcoski, P., S. J. Fuller, U. Philpot, et al. 2024. "Eating and Feeding Management of Eating Disorders and the Role of the Dietitian. More Than Just a Meal Plan: The Wider Role of the Dietitian in Eating Disorder Treatment." *Cutting Edge Psychiatry in Practice*, no. 1: 241–248.
- Fichter, M. M., N. Quadflieg, and A. Gnutzmann. 1998. "Binge Eating Disorder: Treatment Outcome Over a 6-Year Course." *Journal of Psychosomatic Research* 44, no. 3–4: 385–405. [https://doi.org/10.1016/s0022-3999\(97\)00263-8](https://doi.org/10.1016/s0022-3999(97)00263-8).
- Fonseca, N. K. O., V. D. Curtarelli, J. Bertolotti, et al. 2024. "Avoidant Restrictive Food Intake Disorder: Recent Advances in Neurobiology and Treatment." *Journal of Eating Disorders* 12, no. 1: 74. <https://doi.org/10.1186/s40337-024-01021-z>.
- Forsberg, S., and J. Lock. 2015. "Family-Based Treatment of Child and Adolescent Eating Disorders." *Child and Adolescent Psychiatric Clinics of North America* 24, no. 3: 617–629. <https://doi.org/10.1016/j.chc.2015.02.012>.
- Galbally, M., H. Himmerich, S. Senaratne, et al. 2022. "Management of Anorexia Nervosa in Pregnancy: A Systematic and State-of-the-Art Review." *Lancet Psychiatry* 9, no. 5: 402–412. [https://doi.org/10.1016/S2215-0366\(22\)00031-1](https://doi.org/10.1016/S2215-0366(22)00031-1).

- Gallagher, D., A. Parker, H. Samavat, and R. Zelig. 2022. "Prophylactic Supplementation of Phosphate, Magnesium, and Potassium for the Prevention of Refeeding Syndrome in Hospitalized Individuals With Anorexia Nervosa." *Nutrition in Clinical Practice* 37, no. 2: 328–343. <https://doi.org/10.1002/ncp.10786>.
- Garber, A. K., K. Mauldin, N. Michihata, S. M. Buckelew, M. A. Shafer, and A. B. Moscicki. 2013. "Higher Calorie Diets Increase Rate of Weight Gain and Shorten Hospital Stay in Hospitalized Adolescents With Anorexia Nervosa." *Journal of Adolescent Health* 53, no. 5: 579–584. <https://doi.org/10.1016/j.jadohealth.2013.07.014>.
- Garber, A. K., S. M. Sawyer, N. H. Golden, et al. 2016. "A Systematic Review of Approaches to Refeeding in Patients With Anorexia Nervosa." *International Journal of Eating Disorders* 49, no. 3: 293–310. <https://doi.org/10.1002/eat.22482>.
- Gentile, M. G., P. Pastorelli, R. Ciceri, G. M. Manna, and S. Collime-daglia. 2010. "Specialized Refeeding Treatment for Anorexia Nervosa Patients Suffering From Extreme Undernutrition." *Clinical Nutrition (Edinburgh, Scotland)* 29, no. 5: 627–632. <https://doi.org/10.1016/j.clnu.2010.03.008>.
- Gianini, L. M., D. A. Klein, C. Call, et al. 2016. "Physical Activity and Post-Treatment Weight Trajectory in Anorexia Nervosa." *International Journal of Eating Disorders* 49, no. 5: 482–489. <https://doi.org/10.1002/eat.22495>.
- Golden, N. H., C. Keane-Miller, K. L. Sainani, and C. J. Kapphahn. 2013. "Higher Caloric Intake in Hospitalized Adolescents With Anorexia Nervosa Is Associated With Reduced Length of Stay and No Increased Rate of Refeeding Syndrome." *Journal of Adolescent Health* 53, no. 5: 573–578. <https://doi.org/10.1016/j.jadohealth.2013.05.014>.
- Gómez-Candela, C., S. Palma Milla, A. Miján-de-la-Torre, et al. 2018a. "[Consensus Document About the Nutritional Evaluation and Management of Eating Disorders: Anorexia Nervosa]." *Nutricion Hospitalaria* 35: 11–48. <https://doi.org/10.20960/nh.1561>.
- Gómez Candela, C., S. Palma Milla, A. Miján-de-la-Torre, et al. 2018b. "[Consensus Document About the Nutritional Evaluation and Management of Eating Disorders: Bulimia Nervosa, Binge Eating Disorder, and Others]." *Nutricion Hospitalaria* 35: 49–97. <https://doi.org/10.20960/nh.1562>.
- Gordon, K., G. Jhe, R. Adhikari, et al. 2024. "Treatment Adherence and Nasogastric Tube Use in Hospitalized Youth With Anorexia Nervosa and Premorbid Overweight/Obesity." *Eating Disorders* 33, no. 4: 1–9. <https://doi.org/10.1080/10640266.2024.2379158>.
- Gosa, M. M., P. Dodrill, M. A. Lefton-Greif, and A. Silverman. 2020. "A Multidisciplinary Approach to Pediatric Feeding Disorders: Roles of the Speech-Language Pathologist and Behavioral Psychologist." *American Journal of Speech-Language Pathology* 29, no. 2S: 956–966. https://doi.org/10.1044/2020_AJSLP-19-00069.
- Haas, V., M. Kohn, T. Körner, et al. 2021. "Practice-Based Evidence and Clinical Guidance to Support Accelerated Re-Nutrition of Patients With Anorexia Nervosa." *Journal of the American Academy of Child & Adolescent Psychiatry* 60, no. 5: 555–561. <https://doi.org/10.1016/j.jaac.2020.09.010>.
- Hadigan, C. M., E. J. Anderson, K. K. Miller, et al. 2000. "Assessment of Macronutrient and Micronutrient Intake in Women With Anorexia Nervosa." *International Journal of Eating Disorders* 28, no. 3: 284–292. [https://doi.org/10.1002/1098-108x\(200011\)28:3<284::aid-eat5>3.0.co;2-g](https://doi.org/10.1002/1098-108x(200011)28:3<284::aid-eat5>3.0.co;2-g).
- Harris, B. A., J. F. Boswell, J. M. Holmes, H. Espel-Huynh, and H. Thompson-Brenner. 2023. "A Baseline Comparison of Three Diagnostic Groups Using the Progress Monitoring Tool for Eating Disorders." *European Eating Disorders Review: The Journal of the Eating Disorders Association Journal* 31, no. 5: 643–654. <https://doi.org/10.1002/erv.2992>.
- Harshman, S. G., O. Wons, M. S. Rogers, et al. 2019. "A Diet High in Processed Foods, Total Carbohydrates and Added Sugars, and Low in Vegetables and Protein Is Characteristic of Youth With Avoidant/Restrictive Food Intake Disorder." *Nutrients* 11, no. 9: 2013. <https://doi.org/10.3390/nu11092013>.
- Hay, P., D. Chinn, D. Forbes, et al. 2014. "Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for the Treatment of Eating Disorders." *Australian and New Zealand Journal of Psychiatry* 48, no. 11: 977–1008. <https://doi.org/10.1177/0004867414555814>.
- Hermens, D. F., G. Simcock, M. Dutton, et al. 2020. "Anorexia Nervosa, Zinc Deficiency and the Glutamate System: The Ketamine Option." *Progress In Neuro-Psychopharmacology & Biological Psychiatry* 101: 109921. <https://doi.org/10.1016/j.pnpbp.2020.109921>.
- Heruc, G., S. Hart, G. Stiles, et al. 2020. "ANZAED Practice and Training Standards for Dietitians Providing Eating Disorder Treatment." *Journal of Eating Disorders* 8, no. 1: 77. <https://doi.org/10.1186/s40337-020-00334-z>.
- Hofer, M., A. Pozzi, M. Joray, et al. 2014. "Safe Refeeding Management of Anorexia Nervosa Inpatients: An Evidence-Based Protocol." *Nutr Burbank Los Angeles City California* 30, no. 5: 524–530. <https://doi.org/10.1016/j.nut.2013.09.019>.
- Hoo, P., R. Goldschlager, J. Katsoulis, et al. 2023. "Narrative Review of Inpatient Nutritional Management of Anorexia Nervosa With Management Recommendations for Australian Tertiary Health Services." *Internal Medicine Journal* 53, no. 10: 1752–1767. <https://doi.org/10.1111/imj.15958>.
- Hotta, M., M. Araki, A. Urano, and R. Ohwada. 2014. "Home Parenteral Nutrition Therapy in Seven Patients With Anorexia Nervosa: The Role and Indications." *Internal Medicine Journal* 53, no. 23: 2695–2699. <https://doi.org/10.2169/internalmedicine.53.3023>.
- Irish, M., B. Dalton, L. Potts, et al. 2022. "The Clinical Effectiveness and Cost-Effectiveness of a 'Stepping Into Day Treatment' Approach Versus Inpatient Treatment as Usual for Anorexia Nervosa in Adult Specialist Eating Disorder Services (DAISIES Trial): A Study Protocol of a Randomised Controlled Multi-Centre Open-Label Parallel Group Non-Inferiority Trial." *Trials* 23, no. 1: 500. <https://doi.org/10.1186/s13063-022-06386-7>.
- Kaß, A., A. F. Dörsam, M. Weiß, S. Zipfel, and K. E. Giel. 2021. "The Impact of Maternal Eating Disorders on Breastfeeding Practices: A Systematic Review." *Archives of Women's Mental Health* 24, no. 5: 693–708. <https://doi.org/10.1007/s00737-021-01103-w>.
- Kells, M., M. Gregas, B. E. Wolfe, A. K. Garber, and S. Kelly-Weeder. 2022. "Factors Associated With Refeeding Hypophosphatemia in Adolescents and Young Adults Hospitalized With Anorexia Nervosa." *Nutrition in Clinical Practice* 37, no. 2: 470–478. <https://doi.org/10.1002/ncp.10772>.
- Kells, M., and S. Kelly-Weeder. 2016. "Nasogastric Tube Feeding for Individuals With Anorexia Nervosa: An Integrative Review." *Journal of the American Psychiatric Nurses Association* 22, no. 6: 449–468. <https://doi.org/10.1177/1078390316657872>.
- Kendall, S. 2014. "Anorexia Nervosa: The Diagnosis. A Postmodern Ethics Contribution to the Bioethics Debate on Involuntary Treatment for Anorexia Nervosa." *Journal of Bioethical Inquiry* 11, no. 1: 31–40. <https://doi.org/10.1007/s11673-013-9496-x>.
- Lascar, R., A. Letranchant, F. Hirot, and N. Godart. 2021. "[What Factors Explain the Length of Hospitalization for Anorexia Nervosa: A Systematic Review]." *L'Encephale* 47, no. 4: 362–368. <https://doi.org/10.1016/j.encep.2020.11.002>.
- Long, C. G., K.-A. Fitzgerald, and C. R. Hollin. 2012. "Treatment of Chronic Anorexia Nervosa: A 4-Year Follow-Up of Adult Patients Treated in an Acute Inpatient Setting." *Clinical Psychology & Psychotherapy* 19: 1–13. <https://doi.org/10.1002/cpp.738>.
- Lopes, H. C. B., B. C. Mazzolani, P. Koritar, and T. A. Cordás. 2023. "Characterization of Refeeding Protocols for Under 18 Years Old

- Hospitalized Patients With Anorexia Nervosa: A Systematic Review.” *General Hospital Psychiatry* 85: 43–54. <https://doi.org/10.1016/j.genhosppsych.2023.09.007>.
- Loria, K. V., C. Gómez Candela, T. Lourenço Nogueira, et al. 2009. “[Evaluation of the Utility of a Nutrition Education Program With Eating Disorders].” *Nutricion Hospitalaria* 24, no. 5: 558–567. PMID: 19893866.
- Maestro, S., O. Curzio, S. Calderoni, et al. 2022. “Feeding Disorders in Preschoolers: A Short-Term Outcome Study in an Italian Family Care Program.” *Eating and Weight Disorders* 27, no. 4: 1467–1479. <https://doi.org/10.1007/s40519-021-01282-6>.
- Martini, M., P. Longo, C. Di Benedetto, et al. 2024. “Nasogastric Tube Feeding in Anorexia Nervosa: A Propensity Score-Matched Analysis on Clinical Efficacy and Treatment Satisfaction.” *Nutrients* 16, no. 11: 1664. <https://doi.org/10.3390/nu16111664>.
- Marzola, E., J. A. Nasser, S. A. Hashim, P. a. B. Shih, and W. H. Kaye. 2013. “Nutritional Rehabilitation in Anorexia Nervosa: Review of the Literature and Implications for Treatment.” *BMC Psychiatry* 13, no. 1: 290. <https://doi.org/10.1186/1471-244X-13-290>.
- Matthews, K., J. Hill, S. Jeffrey, et al. 2018. “A Higher-Calorie Refeeding Protocol Does Not Increase Adverse Outcomes in Adult Patients With Eating Disorders.” *Journal of the Academy of Nutrition and Dietetics* 118, no. 8: 1450–1463. <https://doi.org/10.1016/j.jand.2018.01.023>.
- Matthews-Rensch, K., A. Young, C. Cutmore, A. Davis, S. Jeffrey, and S. Patterson. 2023. “Acceptability of Using a Nasogastric Refeeding Protocol With Adult Patients With Medically Unstable Eating Disorders.” *Journal of Evaluation in Clinical Practice* 29, no. 1: 49–58. <https://doi.org/10.1111/jep.13718>.
- McMaster, C. M., T. Wade, J. Franklin, and S. Hart. 2020. “Development of Consensus-Based Guidelines for Outpatient Dietetic Treatment of Eating Disorders: A Delphi Study.” *International Journal of Eating Disorders* 53, no. 9: 1480–1495. <https://doi.org/10.1002/eat.23330>.
- McMaster, C. M., T. Wade, J. Franklin, and S. Hart. 2022. “Discrepancies Between Australian Eating Disorder Clinicians and Consumers Regarding Essential Components of Dietetic Treatment.” *Journal of the Academy of Nutrition and Dietetics* 122, no. 8: 1543–1557. <https://doi.org/10.1016/j.jand.2021.12.006>.
- Ministero della Salute. 2021. “Percorso Lilla: Italian Guidelines for the Management of Eating Disorders in Emergency Settings.” https://www.salute.gov.it/imgs/C_17_publicazioni_2961_allegato.pdf.
- Mitchell, J. S., D. F. Hermens, M. R. Bennett, A. T. Can, and J. Lagopoulos. 2023. “Ketamine and Zinc: Treatment of Anorexia Nervosa via Dual NMDA Receptor Modulation.” *CNS Drugs* 37, no. 2: 159–180. <https://doi.org/10.1007/s40263-022-00984-4>.
- Nagata, J. M., P. Bojorquez-Ramirez, A. Nguyen, et al. 2022. “Sex Differences in Refeeding Among Hospitalized Adolescents and Young Adults With Eating Disorders.” *International Journal of Eating Disorders* 55, no. 2: 247–253. <https://doi.org/10.1002/eat.23660>.
- Nagata, J. M., A. Grandis, P. Bojorquez-Ramirez, et al. 2022. “Assessment of Vitamin D Among Male Adolescents and Young Adults Hospitalized With Eating Disorders.” *Journal of Eating Disorders* 10, no. 1: 104. <https://doi.org/10.1186/s40337-022-00627-5>.
- National Guideline Alliance (UK). 2017. *Eating Disorders: Recognition and Treatment*. National Institute for Health and Care Excellence (NICE).
- Norrington, A., R. Stanley, M. Tremlett, and G. Birrell. 2012. “Medical Management of Acute Severe Anorexia Nervosa.” *Archives of Disease in Childhood-Education and Practice Edition* 97, no. 2: 48–54. <https://doi.org/10.1136/adc.2010.199885>.
- O’Brien, A., J. McCormack, K. J. Hoiles, et al. 2018. “Consensus-Based Perspectives of Pediatric Inpatient Eating Disorder Services.” *International Journal of Eating Disorders* 51, no. 5: 401–410. <https://doi.org/10.1002/eat.22857>.
- O’Connor, G., and D. Nicholls. 2013. “Refeeding Hypophosphatemia in Adolescents With Anorexia Nervosa: A Systematic Review.” *Nutrition in Clinical Practice* 28, no. 3: 358–364. <https://doi.org/10.1177/0884533613476892>.
- Pehlivan, M. J., J. Miskovic-Wheatley, A. Le, et al. 2022. “Models of Care for Eating Disorders: Findings From a Rapid Review.” *Journal of Eating Disorders* 10, no. 1: 166. <https://doi.org/10.1186/s40337-022-00671-1>.
- Pettersson, C., A. Svedlund, O. Wallengren, D. Swolin-Eide, G. Paulson Karlsson, and L. Ellegård. 2021. “Dietary Intake and Nutritional Status in Adolescents and Young Adults With Anorexia Nervosa: A 3-Year Follow-Up Study.” *Clinical Nutrition (Edinburgh, Scotland)* 40, no. 10: 5391–5398. <https://doi.org/10.1016/j.clnu.2021.08.014>.
- Puls, H.-C., R. Schmidt, S. Herpertz, et al. 2020. “Adherence as a Predictor of Dropout in Internet-Based Guided Self-Help for Adults With Binge-Eating Disorder and Overweight or Obesity.” *International Journal of Eating Disorders* 53, no. 4: 555–563. <https://doi.org/10.1002/eat.23220>.
- RCPSYCH. Medical Emergencies in Eating Disorders (MEED): Guidance on Recognition and Management (CR233). Accessed March 17, 2025. <https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2022-college-reports/cr233>.
- Redgrave, G. W., J. W. Coughlin, C. C. Schreyer, et al. 2015. “Refeeding and Weight Restoration Outcomes in Anorexia Nervosa: Challenging Current Guidelines.” *International Journal of Eating Disorders* 48, no. 7: 866–873. <https://doi.org/10.1002/eat.22390>.
- Ridout, K. K., J. Kole, K. L. Fitzgerald, S. J. Ridout, A. A. Donaldson, and B. Alverson. 2016. “Daily Laboratory Monitoring Is of Poor Health Care Value in Adolescents Acutely Hospitalized for Eating Disorders.” *Journal of Adolescent Health* 59, no. 1: 104–109. <https://doi.org/10.1016/j.jadohealth.2016.03.015>.
- Rizzo, S. M., J. W. Douglas, and J. C. Lawrence. 2019. “Enteral Nutrition via Nasogastric Tube for Refeeding Patients With Anorexia Nervosa: A Systematic Review.” *Nutrition in Clinical Practice* 34, no. 3: 359–370. <https://doi.org/10.1002/ncp.10187>.
- Rocks, T., F. Pelly, and P. Wilkinson. 2014. “Nutrition Therapy During Initiation of Refeeding in Underweight Children and Adolescent Inpatients With Anorexia Nervosa: A Systematic Review of the Evidence.” *Journal of the Academy of Nutrition and Dietetics* 114, no. 6: 897–907. <https://doi.org/10.1016/j.jand.2013.11.022>.
- Roman, C., R. Aglave, S. Farine, C. Joris, L. Lefebvre, and F. Vermeulen. 2024. “High-Calorie Refeeding in Adolescents With Anorexia Nervosa: A Narrative Review.” *Acta Gastro Enterologica Belgica* 87, no. 2: 287–293. <https://doi.org/10.51821/87.2.12851>.
- Rome, E. S., S. Ammerman, D. S. Rosen, et al. 2003. “Children and Adolescents With Eating Disorders: The State of the Art.” *Pediatrics* 111, no. 1: e98–e108. <https://doi.org/10.1542/peds.111.1.e98>.
- Rosen, E., N. Bakshi, A. Watters, H. R. Rosen, and P. S. Mehler. 2017. “Hepatic Complications of Anorexia Nervosa.” *Digestive Diseases and Sciences* 62, no. 11: 2977–2981. <https://doi.org/10.1007/s10620-017-4766-9>.
- Saccomani, L., M. Savoini, M. Cirrincione, F. Vercellino, and G. Ravera. 1998. “Long-Term Outcome of Children and Adolescents With Anorexia Nervosa: Study of Comorbidity.” *Journal of Psychosomatic Research* 44, no. 5: 565–571. [https://doi.org/10.1016/s0022-3999\(97\)00210-9](https://doi.org/10.1016/s0022-3999(97)00210-9).
- Savino, P. 2018. “Knowledge of Constituent Ingredients in Enteral Nutrition Formulas Can Make a Difference in Patient Response to Enteral Feeding.” *Nutrition in Clinical Practice* 33, no. 1: 90–98. <https://doi.org/10.1177/0884533617724759>.
- Schebendach, J., N. H. Golden, M. S. Jacobson, et al. 1995. “Indirect Calorimetry in the Nutritional Management of Eating Disorders.”

- International Journal of Eating Disorders* 17, no. 1: 59–66. [https://doi.org/10.1002/1098-108x\(199501\)17:1<59::aid-eat2260170108>3.0.co;2-f](https://doi.org/10.1002/1098-108x(199501)17:1<59::aid-eat2260170108>3.0.co;2-f).
- Simpson, C. C., T. L. Towne, A. M. Karam, et al. 2021. “Predictors of Stepping up to Higher Level of Care Among Eating Disorder Patients in a Partial Hospitalization Program.” *Frontiers in Psychology* 12: 667868. <https://doi.org/10.3389/fpsyg.2021.667868>.
- Soto-Célix, M., S. Martínez-Blanco, A. del-Riego-Valledor, and A. Miján-de-la-Torre. 2019. “Is Adductor Pollicis Skinfold an Accurate Tool When Checking Local Muscle Improvement in Malnourished Patients With Anorexia Nervosa?” *Nutrition* 63–64: 87–91. <https://doi.org/10.1016/j.nut.2018.11.026>.
- Staab, R., J. Campagna, J. Ma, and A. Sengar. 2022. “Rapid Refeeding in Anorexia Nervosa: A Dialectic Balance.” *International Journal of Eating Disorders* 55, no. 5: 653–663. <https://doi.org/10.1002/eat.23698>.
- Steinglass, J. E., W. Fei, K. Foerde, et al. 2024. “Change in Food Choice During Acute Treatment and the Effect on Longer-Term Outcome in Patients With Anorexia Nervosa.” *Psychological Medicine* 54, no. 6: 1133–1141. <https://doi.org/10.1017/S0033291723002933>.
- Strumila, R., A. Lengvenyte, E. Olie, et al. 2022. “Selenium Deficiency Is Associated With Disease Severity, Disrupted Reward Processing, and Increased Suicide Risk in Patients With Anorexia Nervosa.” *Psychoneuroendocrinology* 140: 105723. <https://doi.org/10.1016/j.psyneuen.2022.105723>.
- Su, J. C., and C. L. Birmingham. 2002. “Zinc Supplementation in the Treatment of Anorexia Nervosa.” *Eating and Weight Disorders* 7, no. 1: 20–22. <https://doi.org/10.1007/BF03354425>.
- Suzuki, H., A. Asakawa, J. B. Li, et al. 2011. “Zinc as an Appetite Stimulator—The Possible Role of Zinc in the Progression of Diseases Such as Cachexia and Sarcopenia.” *Recent Patents on Food, Nutrition & Agriculture* 3: 226–231. <https://doi.org/10.2174/2212798411103030226>.
- Takimoto, Y. 2022. “Key Components of the Mental Capacity Assessment of Patients With Anorexia Nervosa: A Study of Three Countries.” *Journal of Eating Disorders* 10, no. 1: 110. <https://doi.org/10.1186/s40337-022-00633-7>.
- Tanner, A. B. 2023. “Unique Considerations for the Medical Care of Restrictive Eating Disorders in Children and Young Adolescents.” *Journal of Eating Disorders* 11, no. 1: 33. <https://doi.org/10.1186/s40337-023-00759-2>.
- Testa, G., R. Granero, A. Misiolek, et al. 2022. “Impact of Impulsivity and Therapy Response in Eating Disorders From a Neurophysiological, Personality and Cognitive Perspective.” *Nutrients* 14, no. 23: 5011. <https://doi.org/10.3390/nu14235011>.
- Trovato, C. M., T. Capriati, G. Bolasco, et al. 2022. “Five-Year Inpatient Management of Teenagers With Anorexia Nervosa: Focus on Nutritional Issues.” *Journal of Pediatric Gastroenterology and Nutrition* 74, no. 5: 674–680. <https://doi.org/10.1097/MPG.0000000000003410>.
- Turner, P. 2023. “Implementation of the Medical Emergencies in Eating Disorders in Adults Guidance on Non-Specialist Units.” Supplement, *British Journal of Nursing* 32, no. 13: S8–S12. <https://doi.org/10.12968/bjon.2023.32.13.S8>.
- Vollert, B., I. Beintner, P. Musiat, et al. 2019. “Using Internet-Based Self-Help to Bridge Waiting Time for Face-to-Face Outpatient Treatment for Bulimia Nervosa, Binge Eating Disorder and Related Disorders: Study Protocol of a Randomized Controlled Trial.” *Internet Interventions* 16: 26–34. <https://doi.org/10.1016/j.invent.2018.02.010>.
- Ward, V. B. 2008. “Eating Disorders in Pregnancy.” *BMJ* 336, no. 7635: 93–96. <https://doi.org/10.1136/bmj.39393.689595.be>.
- Westermair, A. L., S. Reiter-Theil, S. Wäscher, and M. Trachsel. 2024. “Ethical Concerns in Caring for Persons With Anorexia Nervosa: Content Analysis of a Series of Documentations From Ethics Consultations.” *BMC Medical Ethics* 25, no. 1: 102. <https://doi.org/10.1186/s12910-024-01101-4>.
- Wild, B., H.-C. Friederich, G. Gross, et al. 2009. “The ANTOP Study: Focal Psychodynamic Psychotherapy, Cognitive-Behavioural Therapy, and Treatment-as-Usual in Outpatients With Anorexia Nervosa—a Randomized Controlled Trial.” *Trials* 10, no. 1: 23. <https://doi.org/10.1186/1745-6215-10-23>.
- Willmott, E., R. Dickinson, C. Hall, et al. 2024. “A Scoping Review of Psychological Interventions and Outcomes for Avoidant and Restrictive Food Intake Disorder (ARFID).” *International Journal of Eating Disorders* 57, no. 1: 27–61. <https://doi.org/10.1002/eat.24073>.
- Yang, Y., J. Conti, C. M. McMaster, M. K. Piya, and P. Hay. 2023. “‘I Need Someone to Help Me Build up My Strength’: A Meta-Synthesis of Lived Experience Perspectives on the Role and Value of a Dietitian in Eating Disorder Treatment.” *Behavioral Sciences (Basel, Switzerland)* 13, no. 11: 944. <https://doi.org/10.3390/bs13110944>.
- Yoshiuchi, K., H. Yamada, S. Takakura, M. Isobe, K. Maruyama, and T. Nagata. 2022. “Assessment and Treatment of Eating Disorders.” Supplement, *Journal of Nutritional Science and Vitaminology* 68, no. Supplement: S46–S48. <https://doi.org/10.3177/jnsv.68.S46>.

Supporting Information

Additional supporting information can be found online in the Supporting Information section.

Supporting Information S1: erv70042-sup-0001-suppl-data.docx.