Trans-Specific Considerations to Eating Disorder Medical Admission Criteria

Standard eating disorder medical admission criteria apply to trans and gender diverse people. However, gender-affirming hormone therapy and co-occurring conditions may affect the interpretation of some findings.

These considerations should be applied where relevant alongside comprehensive assessment, clinical judgement, and local protocols, and should not be used to discount evidence of medical instability.

Indicator	**Medical admission indicator[1]**	**Considerations for trans and gender diverse people**
Weight and BMI	BMI <13 kg/m² or rapid/substantial weight loss	GAHT can alter body composition, complicating weight trajectories and treatment targets. Gender diverse adolescents with eating disorders may have comparable vital-sign instability despite a higher median BMI than cisgender peers.[2,3]
Systolic BP	<80 mmHg	Spironolactone may contribute to hypotension, particularly with restriction or dehydration.[2,4]
Postural BP	>20 mmHg systolic decrease on standing	Spironolactone, dehydration, malnutrition, and dysautonomia may each contribute.[2]
Heart rate	Resting <40 or >120 bpm	POTS may coexist with malnutrition-related postural tachycardia. Limited evidence suggests that testosterone may improve POTS symptoms.[5]
12-lead ECG	New QTc >460 ms or ST/T-wave abnormalities	Feminising GAHT may lengthen QTc by approximately 19–20 ms, whereas testosterone may shorten it.[6,7]
Potassium	<3.0 mmol/L	Spironolactone may partially obscure purging-related hypokalaemia or cause hyperkalaemia.[2]
Phosphate	<0.7 mmol/L	Oestrogen therapy may cause hypophosphataemia during refeeding in rare instances.[8]
eGFR	<60 mL/min/1.73 m² or 25% decrease within one week	GAHT-related changes in muscle mass can affect creatinine-based eGFR.[10]

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