



Facultad de Estudios Superiores

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Avoidant restrictive eating disorder and panic attacks in an adult man: A case report

Trastorno evitativo restrictivo de la ingesta alimentaria y ataques de pánico en un hombre adulto: Reporte de caso.

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Abstract.

Avoidant or Restrictive Food Intake Disorder (ARFID) is an eating disorder (ED) not common in adults. In this article we present a clinical case of ARFID in a 37-year-old male patient treated in an ED center in Medellin, Colombia; displaying anxious symptoms that began a year earlier and concomitant weight loss, following a traumatic event causing an overall impairment with that patient. Several medical evaluations/examinations looking for organic causes, were excluded. Interventions were implemented by a psychiatry, a psychotherapist using cognitive-behavior therapy (CBT), and a nutritionist, all in face-to-face modality, which were carried out weekly for the first three months, then biweekly and subsequently quarterly. each lasting approximately 40-60 minutes. After the set

of pharmacological interventions and psychotherapy, a great improvement in the functionality of the patient was observed. Improvement was found with respect to eating in public, food variation and panic attacks. In the absence of guidelines, it is important to use standardized and replicable treatments in this population.

Keywords: Avoidant Restrictive Food Intake Disorder, Feeding and eating disorders, Panic disorder, Psychotherapy, Selective serotonin reuptake inhibitors, Case Reports.

Resumen. El trastorno evitativo restrictivo de la ingesta (TERIA) es un trastorno alimentario (TCA) raro en adultos. Se presenta el caso de un hombre de 37 años con TERIA y trastorno de pánico atendido en un centro para TCA en Medellín, Colombia, quien presentó un año de síntomas ansiosos y pérdida de peso después de evento traumático, generando disfuncionalidad. Fue evaluada y excluida orgánicidad. Se realizaron intervenciones por parte de psiquiatría, psicoterapia con enfoque cognitivo conductual y nutrición, todas en modalidad presencial, las cuales se realizaron semanalmente los primeros tres meses, luego quincenalmente y posteriormente trimestralmente. Cada una con una duración de 40-60 minutos aproximadamente por sesión. Posterior al conjunto de intervenciones farmacológicas y psicoterapia, se observó una gran mejoría la funcionalidad del paciente, se encontró mejoría con respecto a comer en público, variación en los alimentos y ataques de pánico. Ante la ausencia de guías de manejo de TERIA en adultos es relevante realizar tratamientos estandarizados que puedan ser replicados.

Palabras claves: trastorno por evitación/restricción de la ingesta de alimentos, Trastornos de Alimentación y de la Ingestión de Alimentos, trastorno de pánico, psicoterapia, antidepresivos, reporte de casos.

Introduction

Avoidant-restrictive food intake disorder (ARFID) is an eating disorder (ED) characterized by difficulties regarding the ingestion without affecting the overall body image or an underlying fear of gaining weight; nutritional compromise is important with failures in anthropometric parameters (Katzman et al., 2019). It appeared as an independent entity in the DSM-5 and can now be diagnosed at any age, unlike previous editions that considered it a childhood diagnosis (Zimmerman & Fisher, 2017).

Since its recognition in the DSM-5, investigations have provided data of this condition, however, its prevalence varies according to the context, being able to affect 1.5 to 23% of children and adolescents from centers specialized in gastroenterology and eating disorders (Seetharaman & Fields, 2020). There are no large epidemiological studies in the general

population and the information available in adults is mainly limited to case reports (De Toro et al., 2021; Thomas et al., 2017). Evidence on treatment in adults is based on studies of the pediatric population or in case reports (Steen & Wade, 2018). Although there is not much evidence of the use of medication for this condition, there are reports of the utility of olanzapine, mirtazapine, buspirone and d-cycloserine in ARFID (Bourne et al., 2020).

It is important to point out that comorbidities are common in ARFID, in a systematic review reported in the Mexican Journal of eating disorders, it was found that the comorbidities most frequently related to this disorder were anxiety disorders (38.4%), followed by autism spectrum disorders (13.8%), depressive disorders (12.3%), attention deficit hyperactivity disorder (7.6%), among others, but panic disorder was one of the least prevalent (1.54%) (Medina Tepal et al., 2023).

Below, we present the case of an adult male patient with ARFID and panic disorder, who consulted an outpatient management center specialized in eating disorders in Medellín (Colombia). Evolution was evaluated with the Eating Assessment Tool-10 (EAT-10), a 40-point self-applied instrument (the higher the score, the more serious), which measures dysphagia symptoms, validated into Spanish with validity and reliability (Peláez et al., 2012) and which could be used in the evaluation of ARFID (Bryant-Waugh et al., 2019). The internal consistency (Cronbach alpha) of the instrument is 0.960 and the test-retest intra-item correlation coefficients ranges from 0.72 to 0.91, it is suggested that an EAT-10 score of 3 or higher is abnormal (Belafsky et al., 2008). The objective is to detail the diagnostic process, the foundations of the psychotherapy provided and the successful treatment experience, being relevant in the absence of specific guidelines in adults at that moment, and its comorbidity with panic disorder that, as we mentioned before, is quite uncommon.

Patient identification

A 37-year-old man, engineer, divorced, father of one son, with a medical history of generalized anxiety disorder and panic like symptoms.

Motive of the consultation

He consulted a center specializing in eating disorders, for 12 months due to sudden episodes of dysphagia, dyspnea associated with ingestion, nausea, diaphoresis, paleness, tachycardia, paresthesia, feeling of imminent death, fatigue, anticipatory anxiety (he bought a pulse-oximeter to monitor ventilation, had a suitcase ready in case he required hospitalization), avoidance behaviors (progressive abandonment of food, liquid diet, not eating with other people, being afraid of their judgement), weight loss of 14 kg in a year and multiple work disabilities with one to three episodes per day.

Medical history

He already had a history of panic disorder that resolved with selective serotonin reuptake inhibitors (SSRI) and benzodiazepines (fluoxetine 20 mg daily and clonazepam 0.5 mg twice daily), managed

by a psychiatrist three years before the diagnosis of ARFID.

Evaluation and diagnosis

At the time of the initial evaluation, he weighed 60 kg, his height was 1.62 m, and his body mass index was 22.9 kg/m², with no abnormalities found via the physical examination. He subsequently presented an episode of dehydration that required emergency management. He had been medically evaluated by both the internal medicine, gastroenterology, as well as the otorhinolaryngology arriving at achalasia as suspected diagnosis with studies with normal results (Table 1). The patient's trigger was having witnessed another person choking on meat. It was concluded that the diagnosis was ARFID and panic disorder made by a psychiatrist using DSM 5 criteria, after ruling out organic disease with multiple paraclinical and diagnostic images such as: simple blood tests, endoscopic manometry, capsule endoscopy, stress test, abdominal tomography, chest X-ray, among others; these diagnosis were made in two sessions after all the laboratory tests were completed. Specific interdisciplinary treatment was started by psychiatry, psychology, and nutrition with an expertise in eating disorders described in Tables 2 and 3.

Treatment

Since the diagnosis was made, it was decided to start fluoxetine 20 mg per day and clonazepam 10 drops per day. Subsequently, the dose of clonazepam was increased as follows: 5 drops in the morning, 3 drops at noon and 5 drops at night, and the dose of fluoxetine was also increased to 40 mg per day. After three months, clonazepam was suspended without relapse, continuing with fluoxetine. The psychological approach used was based on cognitive-behavioral therapy implementing different techniques such as: psychoeducation, relaxation training, exposure and mindful eating, cognitive restructuring, problem solving and relapse prevention.

Results

Clinical improvement was observed regarding the amount of intake, food variation, exposure to eating in public, hyperarousal, and remission of panic attacks.

Table 1. Tests performed on the patient.

| Differential diagnosis | Symptoms | Diagnostic tests |
|-------------------------|---|--|
| Constitutional syndrome | Asthenia, anorexia, and objective weight loss, we sought to rule out various etiologies including malignancy, autoimmune diseases, and infectious diseases such as human immunodeficiency virus (HIV) | Potassium: 4.24; sodium: 141; calcium: 9.3; chlorine: 105; urinalysis: normal; glutamic oxaloacetic transaminase: 29, glutamic pyruvic transaminase: 62, gamma-glutamyl transferase: 31; total cholesterol: 222; high density cholesterol: 38; low-density cholesterol: 140; triglycerides: 222. Creatinine: 0.95; total bilirubin: 0.41; direct bilirubin: 0.17; blood urea nitrogen: 14.6, creatine phosphokinase: 62; uric acid: 6.9; lactate dehydrogenase: 135; lipase: 25; amylase: 62; ferritin: 290.10; vitamin B12: 886.3; thyroid-stimulating hormone: 1.34; free thyroxine: 0.86; antibodies (including antinuclear and extractable nuclear) and normal immunoglobulins. HIV test: negative; serology: non-reactive. Contrast-enhanced abdominal CT scan: aortic atheromatosis, no abdominal masses or adenopathy, pelvic phleboliths, mild osteochondrosis. Posteroanterior and left lateral chest X-rays: calcified nodule of no pathological significance in the middle lobe. |
| Chronic diseases | Due to weight loss and fatigue, it was necessary to rule out Diabetes Mellitus | Glucose: 87; glycated hemoglobin: 5.4. |
| Achalasia | Due to the progressive dysphagia presented, associated with weight loss, weakness, and retrosternal pain. | Esophageal manometry: normal upper esophageal sphincter, normal esophageal body motility, and mildly hypotonic lower esophageal sphincter. |
| Coronary heart disease | Since during the anxiety symptoms he presented chest pain and subjective dyspnea. | Stress test: negative for myocardial ischemia, 12-mets energy consumption, adequate pressor and chronotropic response, no symptoms or arrhythmias, was suspended due to fatigue, performed for functional evaluation and exercise prescription, maximum 95%, double baseline product 8600, double peak product 24360. |

Table 2. Summary of the treatment implemented.

| Type of treatment | Description of the treatment |
|-------------------|---|
| Psychotherapy | Weekly 60-minute psychotherapy sessions were held. Each session: began with the review of the weekly food record, a specific topic was worked on, and homework was given to consolidate what had been learned. |
| Nutrition | He evaluated the patient every two weeks, took care of nutritional parameters, regularized intake, identified feared foods, and food exposure. |
| Psychiatry | He had one admission consultation and three follow-up consultations where the pharmacological treatment was managed. Fluoxetine 40 mg per day orally (with gradual ascent) and clonazepam 1.5 mg per day orally were ordered. At the end of the study, the persistence of anxious symptoms was evaluated. |

Table 3. Summary of psychotherapy implemented.

| Type of treatment | Activities | Treatment goal | Number of sessions |
|--|--|---|--------------------|
| Evaluation | Complete clinical history, medical history, review of symptoms, previous treatments, physical examination, diagnosis through DSM5 criteria, other mental disorders were ruled out at that time. A scale was used to assess dysphagia symptoms. | Formulation of clinical case and definition of treatment strategies | 2 |
| Psychoeducation | Delivery of information on anxiety, panic, hyperarousal, avoidance behaviors and anticipatory anxiety, as well as the swallowing process | Recognition of the symptomatic nature and physiology of anxiety and swallowing, decreasing the associated emotional intensity and generating greater emotional regulation | 1 |
| Relaxation training | Basic principles of mindfulness, breathing and relaxation exercises were left as homework 3 times a day with series of 10 repetitions (standing, sitting, and lying down) | Decreased autonomic hyperarousal associated with anxiety | 1 |
| Exposure and mindful eating | Gradual exposure to different foods, initially ranking them, and mindful eating skills were taught. Subsequently, work was done on sharing meals with family members and then starting to eat in public places | To work on the main associated cognitive distortions (catastrophizing, personalization, polarization) | 3 |
| Cognitive restructuring | Confrontation of dysfunctional beliefs about the possibility of choking on food when compared with the actual occurrence of said event | To work on main associated cognitive distortions (catastrophizing, arbitrary inference) | 2 |
| Problem solving and relapse prevention | Coping ahead and analysis of solutions, identification of imminent relapse through warning signs | Management of possible contingencies and reduce the risk of relapses | 1 |

The greatest difficulty remained food exposure and eating in public, improving with behavioral shaping; there were no adverse effects or adherence problems. At admission the score of the Eating Assessment Tool-10 was 29 points and at the end of the treatment it was 2 points. Regarding his improvement, the patient reported: *"...I have been able to resume my life, simple things like going to the movies and having dinner on the street, I am recovering what was lost, I don't think of food as a threat anymore, I don't feel like I'm about to choke when swallowing, and without all those physical symptoms that I used to have, all the anxiety that my body was releasing..."*.

Discussion and Conclusions

TERIA has been subclassified into three types: people with little interest in eating and low appetite; sensory

aversion to types of food and a group with fear of adverse consequences following ingestion (Cañas et al., 2021; Dinkler & Bryant-Waugh, 2021). The latter one has been associated with having witnessed threatening events related to food consumption, as occurred in our case. Not all authors agree with this classification (Bryant-Waugh, 2019), but in our clinical experience we have been able to find patients with this type of clinical presentation, such as the one that we describe here.

Another striking finding is the age of the patient, since it usually occurs more frequently within pediatric populations, but in adults the evidence on ARFID is scant (Boerner et al., 2021). In Japan, a study evaluated 1029 patients with eating symptoms and 9.2% were diagnosed with ARFID. In this sample, the diagnosis occurred only in women and compared to anorexia nervosa (AN), there was a shorter duration of

symptoms, their severity, and overall hospitalizations. It is necessary to assess whether the demographic and clinical characteristics, other than age, are similar in children and adults (Nakai et al., 2016). Our patient, despite having started his psychopathology in adulthood and being male, also presented gastrointestinal and anxiety symptoms.

Interdisciplinary evaluation is essential to rule out medical and psychiatric conditions and understand the exact psychopathology. Diagnostic aids are necessary even in the presence of a normal nutritional state in order not to ignore complications (Bryant-Waugh, 2019). In our case, the patient was evaluated clinically and with diagnostic aids, although this delayed the start of treatment it increased the diagnostic reliability since the confusion with gastrointestinal disorders is frequent (Schöffel et al., 2021).

On this case the diagnosis was made using the DSM-5 criteria and the "Eating Assessment Tool-10" for evaluating initial severity and evolution, the reason to choose these methods was related with the experience of the clinical team using them frequently. Although these tools have been shown to be useful, there are already other scales designed specifically for this disorder such as the Eating Disorders in Youth-Questionnaire (EDY-Q), Pica ARFID and Rumination Disorder Interview (PARDI) and the Nine Item ARFID Screen (NIAS) (Brigham et al., 2018).

In pediatric treatment, strategies used in our patient have been described: regular feeding, weighing the patient, food hierarchy, among others. Regarding the reported frequency of treatment, between 20 and 30 sessions of pediatric cognitive behavioral therapy (CBT) have been described, including the involvement of the family in the process (Becker et al., 2020). But the evidence of its efficacy in adults is scarce (Thomas et al., 2018). The therapy used on this case was based on CBT, and benzodiazepines and SSRIs were chosen as treatment for the anxiety symptoms presented in this patient.

Something striking in this report is the joint appearance of ARFID with panic attacks, since it has not been frequently described yet. Milligan et al. reported an 18-year-old woman with ARFID, panic disorder, and body dysmorphic disorder with a marked degree of malnutrition that required hospitalization

and later hospital-day, without further descriptions of subsequent management but in our case the treatment was implemented in an outpatient setting (Milligan & Middleman, 2022). Another study evaluated a CBT protocol designed specifically for ARFID in 20 children and adolescents, (two of them with panic symptoms), including: psychoeducation, formulation, maintainer approach, and relapse prevention, like our protocol but ours was implemented in an adult male with a good response (Thomas et al., 2020).

It should be noted that when treating our patient in 2017, no empirically supported psychotherapies had been published for the management of ARFID, and less so in the adult population, and CBT for this diagnosis (CBT-AR) was only published until 2019, therefore, evaluating and formulating this patient was essential for the successful response (Thomas et al., 2018). One important limitation is the fact that this is a one case report so it would be important to replicate this treatment protocol in other patients with similar features to the one described in this report.

In conclusion, we believe that it is important to identify adults with ARFID early in the clinical course, since subjects who previously had this diagnosis could not be classified as such before the DSM5 era. In addition, recognition of ARFID by other medical specialties is required, ruling out organic causes without delaying diagnosis or treatment, thus improving the quality of life of patients.

Ethic responsibilities

Protection of people and animals

The authors declare that no experiments were carried out on humans or animals for this research.

Data confidentiality

The authors declare that they have followed the protocols of their work center regarding the publication of patient data.

Right to privacy and informed consent

The patient's authorization was obtained through informed consent and the confidentiality of the data was guaranteed. The endorsement of the Ethics

Committee of the Faculty of Medicine of the University of Antioquia was obtained through the approval record number 031 of 2022.

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