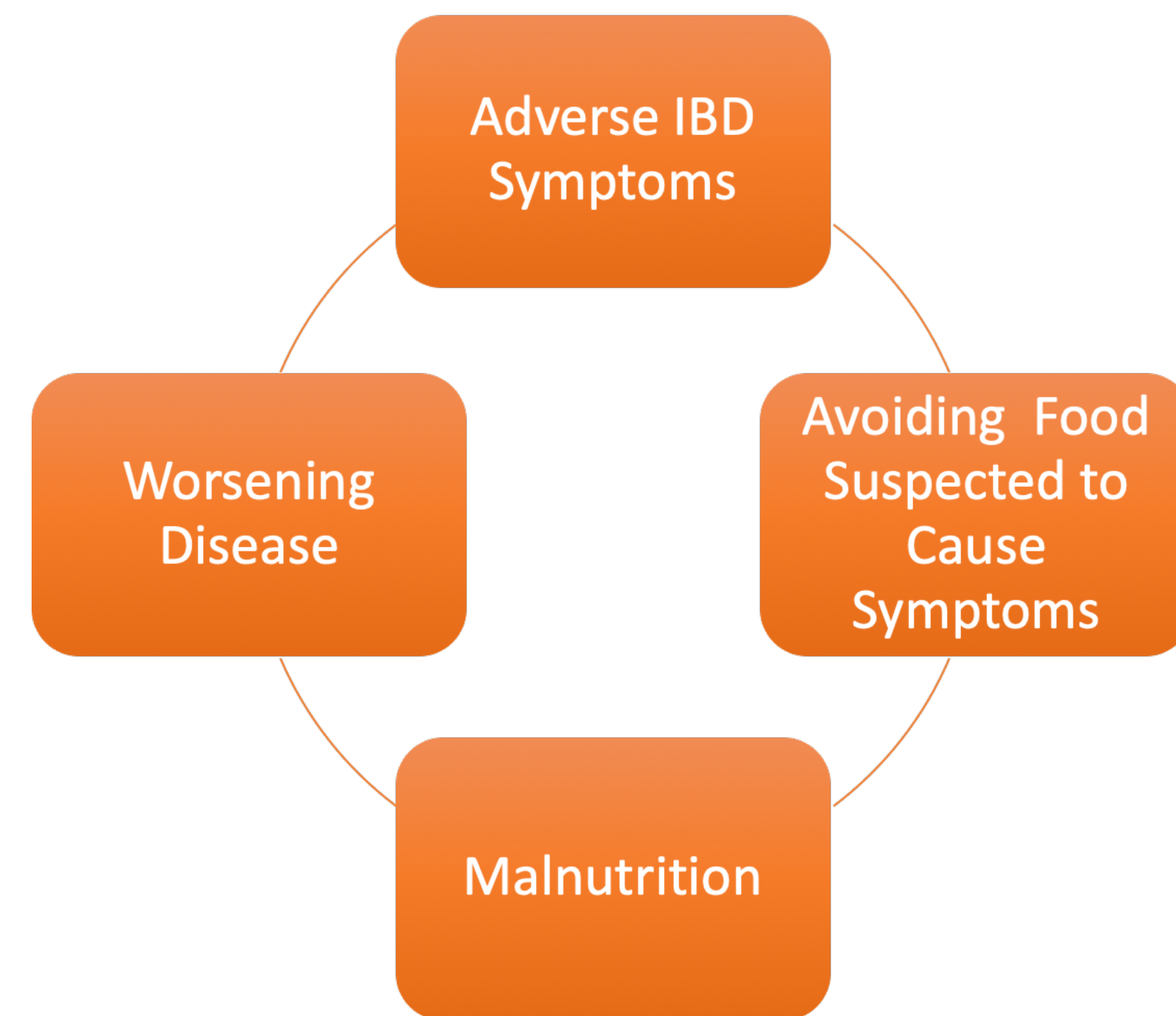


## Background

- **Avoidant/restrictive food intake disorder (ARFID):** restricting or avoiding food intake based on a disinterest in food, disliking its characteristics, or negative experiences associated with food; ARFID is a newer diagnosis included in the DSM-5
- Recent studies have shown a significantly higher rate of ARFID in patients with inflammatory bowel disease (IBD),<sup>1</sup> though these studies have lacked racial and ethnic diversity.



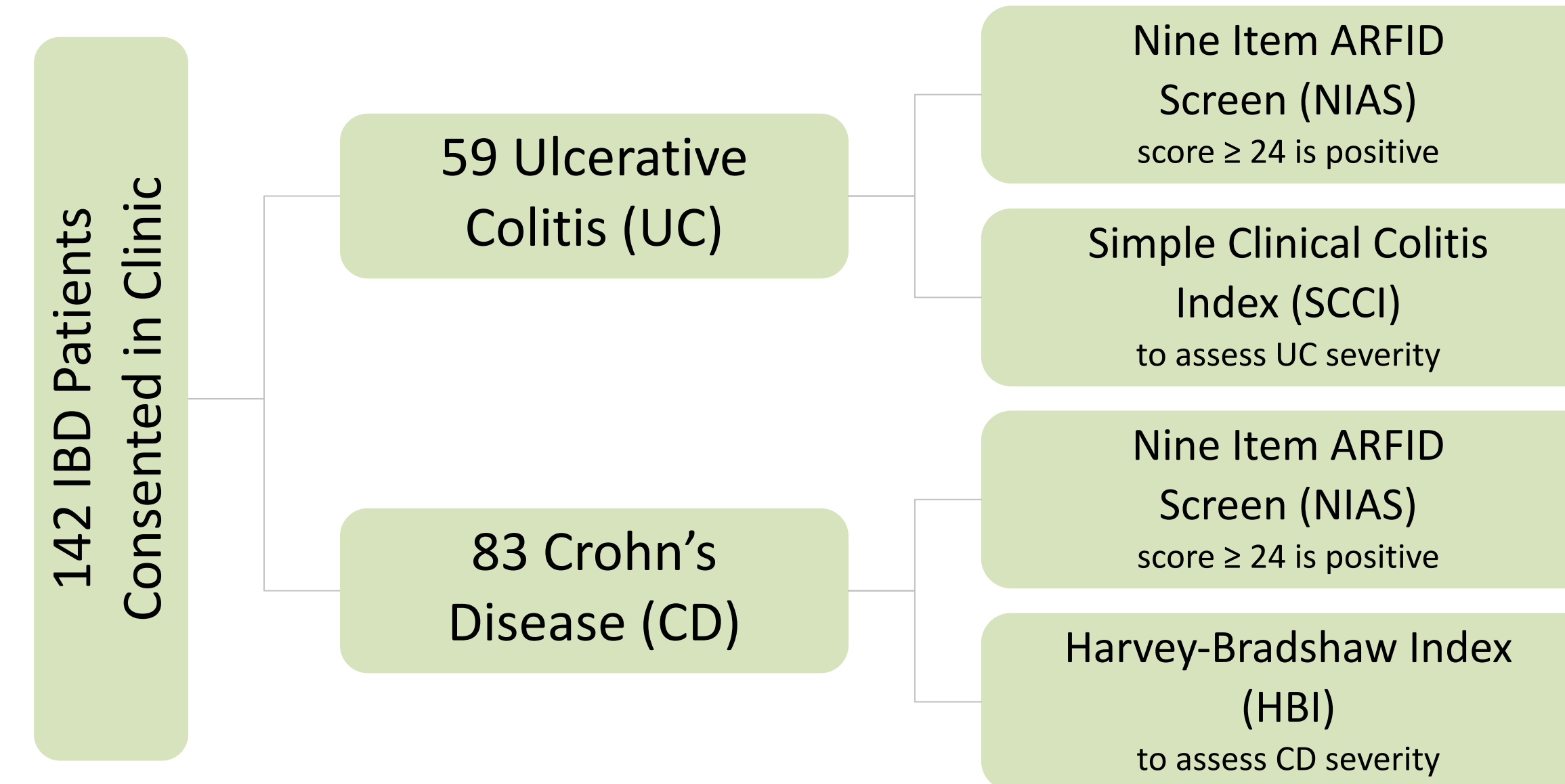
## Study Aim/Hypothesis

**Study Aim:** To determine the risk of ARFID in patients with IBD, focusing on Underrepresented Minority (URM) patients

**Hypothesis:** Patients with more severe IBD will be at higher risk for ARFID than those who have less severe IBD

**Secondary Hypothesis:** URM patients will have higher rates of ARFID

## Methods and Materials



**Table 1.** Demographics.

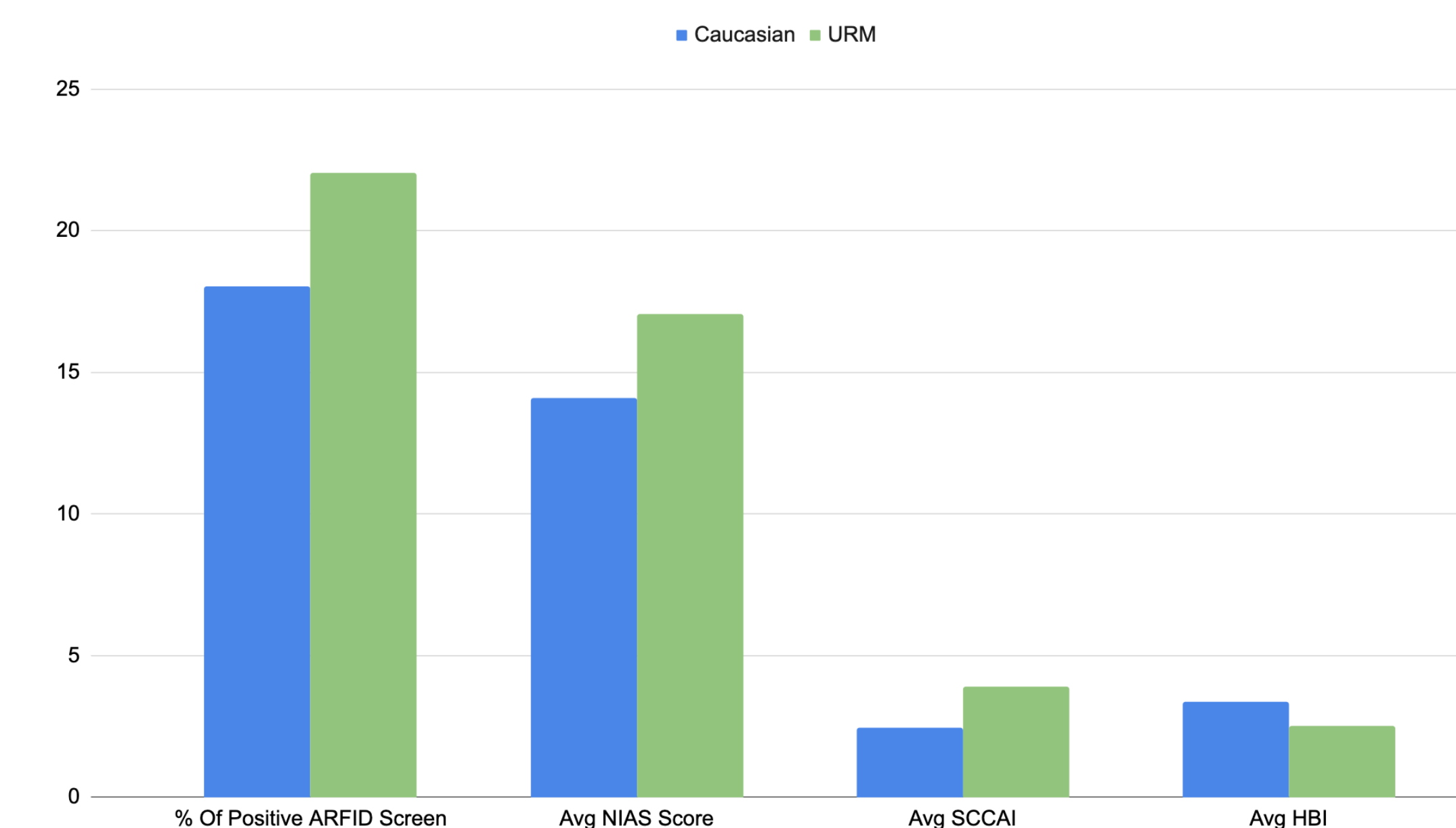
	NIAS respondents
Total	142
Average Age (+/- SD)	44.52 (+/- 15.88)
Female	71 (50%)
Caucasian	86 (60.5%)
Hispanic/Latino	27 (19%)
Black/African American	22 (15.5%)
Asian	5 (4%)
American Indian/Alaskan Native	2 (1%)
CD Patients	83 (58%)
UC Patients	59 (42%)

## Results

**Table 2.** Comparison between patients who screened positive for ARFID, and those who screened negative.

	ARFID (+) (n=28)	ARFID (-) (n=114)	p-Value
Age	41.46	45.27	0.42
Female (%)	64%	46%	-
Average HBI score	5.411	2.303	0.006
Average SCCAI score	4.36	2.85	0.04
Number of UC patients surveyed	11 (12.5%)	48 (87.5%)	-
Number of CD patients surveyed	17 (21%)	66 (79%)	-

Comparison Between Caucasian and URM Respondents



**Figure 1.** Comparison between caucasian patients and patients from URM

## Discussion

Prior studies have noted higher rates of ARFID among Caucasian patients with IBD (when compared to patients without IBD).<sup>1</sup> This study demonstrates that both Caucasian and URM patients with IBD have higher risk for ARFID compared to the general population. Patients with more active CD also had higher NIAS scores than UC patients. There was a trend toward higher average NIAS scores in URM patients compared to Caucasian patients.

Further steps to identify reasons for this trend, such as possible cultural differences in diet addressed during office visits, should be explored.

## Conclusions

Patients with IBD, specifically CD, were at an increased risk of screening positive for ARFID. Patients who screened positive had increased disease severity.

URM Patients tended to have higher NIAS scores, and tended to screen positive more often than caucasian patients.

Next steps will include identification of ways to address ARFID in IBD patients through better screening, and appropriate intervention.

## Contact

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## References

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