Case Report: C-L Setting-Based Treatment of Adult ARFID with Exposure and Response Prevention Therapy and Medication Management

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Background

- As a new diagnosis in DSM-5, Avoidant-Restrictive Food Intake Disorder (ARFID) has been mostly associated with pediatric and adolescent patients
- Recent studies show prevalence in adult patients as well
- Patients with ARFID pose unique challenges to inpatient consultation-liaison (C-L) teams due to medical complications that can arise with no clear psychiatric management guidelines
- We present a complex case of a patient with several psychiatric comorbidities who developed new symptoms consistent with ARFID, responding well to short-term exposure and response prevention (ERP) therapy and medication management

Objectives

- To examine a C-L case of an adult patient with symptoms likely consistent with ARFID
- To explore the use of ERP and medication management in the C-L setting
- To review criteria for ARFID in adult patients

Case

- K.O. is a 43-year-old male, domiciled with his mother, with past medical history of obesity, diabetes, prolonged admission for incarcerated hernia after small bowel obstruction, resection, and hernia reduction, past psychiatric history of obsessive compulsive disorder (OCD), possible autism spectrum disorder (ASD), and post traumatic stress disorder (PTSD), presenting with inability to tolerate oral secretions, nausea, and poor oral intake
- Psychiatric History:
  - Patient intermittently followed with an outpatient psychiatrist since 8th grade
  - Remote history of hospitalization in early teens
  - Collateral gained from psychiatrist: had not seen patient in 5 years but reported OCD was severe, there was concern for ASD though no formal diagnosis
- Trauma History:
  - Childhood history of physical abuse by his father, emotional abuse by grandmother
- Substance History: none
- Family History:
  - Maternal and Paternal side unspecified individuals with history of Alcohol Use Disorder
  - Maternal grandfather reported to have Schizophrenia versus "Severe OCD"
  - Father died from an overdose of unknown nature or intent
- Social History:
  - Mother cares for patient fully at home as he cannot walk to the bathroom; she reported patient has not showered or bathed properly since 2008
  - Finished high school, never worked, no special education, was home schooled
  - No significant relationships but has online friends

Hospital Course

10/26/2021: Admitted to General Medicine
- Presented to the hospital with inability to tolerate oral intake after discharge on 08/02
- Reported 4 weeks of worsening phlegm accumulation in throat attributed to difficulty clearing throat since intubation during last admission; reported that the texture of phlegm mixed with food was intolerable; reported globus sensation and vomiting up to 10 times per day when trying to swallow
- Medical workup revealed weight loss, hypokalemia, hypophosphatemia and acute kidney injury, all of which improved with repletion and hydration
- Supportive care included scopolamine patch and glycopyrrolate for secretion management, famotidine for possible reflux contribution, and zofran for nausea
- CT abdomen pelvis, ENT evaluation, SLP evaluation, and esophagogastroduodenoscopy were unrevealing
- Used mouth suction frequently in the hospital, was observed throughout first week with inability to tolerate sips of water without spitting it up

11/03/2021: Initial C-L Consult Placed
- Additional C-L History: reported sensitivity to texture of saliva and phlegm; denied intrusive thoughts, compulsive behaviors, weight concerns, body image issues
- C-L recommended: 2.5mg oral dissolving tablet of olanzapine (zydis)
- Consideration of ARFID suggested to team; psychoeducation provided

11/04/2021: C-L Consult Follow Up Visit
- C-L guided one ERP session, during which the patient held Ensure supplement in his mouth for increasingly long periods of time before swallowing
- Patient reported tolerating 2.5mg zydis

11/05/2021: C-L Consult Follow Up Visit
- Patient progressed to tolerating liquid diet of soup broth and Ensure shakes
- Patient noted that his childhood experience with his father forcing him to eat could be playing a role in his challenges
- Tearful on exam; denied texture issues with food or liquid
- Recommended to increase to zydis 5mg

11/08/2021: C-L Consult Follow Up Visit
- Patient with significantly improved solid intake
- Demonstrated more engagement in terms of taking initiative in his care, with brighter affect and more future oriented thought content
- Able to hold soup in his mouth for 20 seconds
- Met all caloric counts by 11/9 and was discharged to rehab

Discussion

DSM Criteria for ARFID:[3]
- Avoiding or restricting food intake
  - can be based upon lack of interest in food, the sensory characteristics of food, or a conditioned negative response associated with food intake following an adverse experience
- The eating behavior leads to a persistent failure to meet nutritional and/or energy needs, manifested by at least 1 of the following:
  - Clinically significant weight loss
  - Nutritional deficiency
  - Supplementary enteral feeding or oral nutritional supplements are required to provide adequate intake
  - Impaired psychosocial functioning
- Does not occur solely in the course of anorexia nervosa or bulimia nervosa; body weight and shape are not distorted
- Disturbance is not due to a general medical condition or another mental disorder
- Not due to lack of available food or a cultural practice

This case:
- 1st known report of a C-L setting combined intervention of ERP therapy and pharmacotherapy in an adult patient with new ARFID
- This patient is at high risk for ARFID due to his comorbidities of OCD and ASD[1]
- Limited research on ARFID includes some evidence for pharmacotherapy and outpatient cognitive-behavioral-therapy, but there are no FDA-approved medications, and no inpatient therapy guidelines[1]
- Considerations in choosing olanzapine included targeting cognitive rigidity and anxious distress along obsessional symptom spectrum, and its significant anticholinergic properties that could decrease secretions
- ERP has been used for OCD[4] with great effect; this case suggests it can be used for ARFID and implicates a potential underlying link between these disorders
- This case also highlights the liaison role of C-L in providing psychoeducation for the primary team on diagnosis and treatment options that may otherwise fail to be considered, leading to unnecessary psychiatric admission or invasive medical procedures

Conclusion

- ARFID is a new diagnosis, recognized not only by psychiatry but by other medical fields as well
- Unfortunately, there are no specific guidelines for treatment of ARFID in inpatient CL settings
- The successful multimodal treatment approach (ERP and olanzapine) in this case indicates that further thorough research should be considered

References

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