ARFID in acute settings

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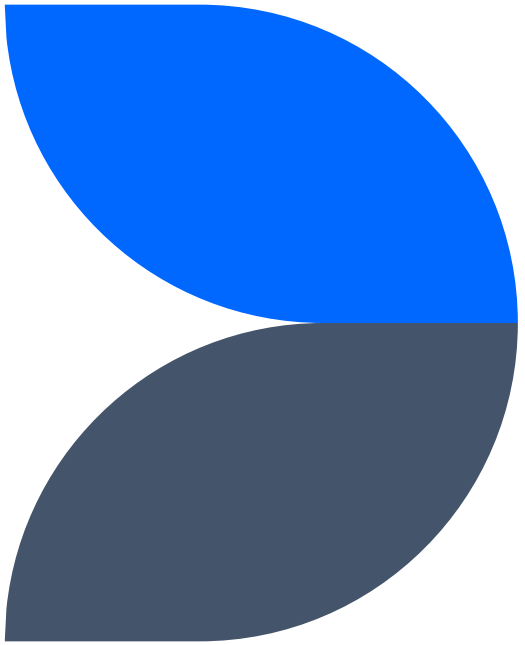
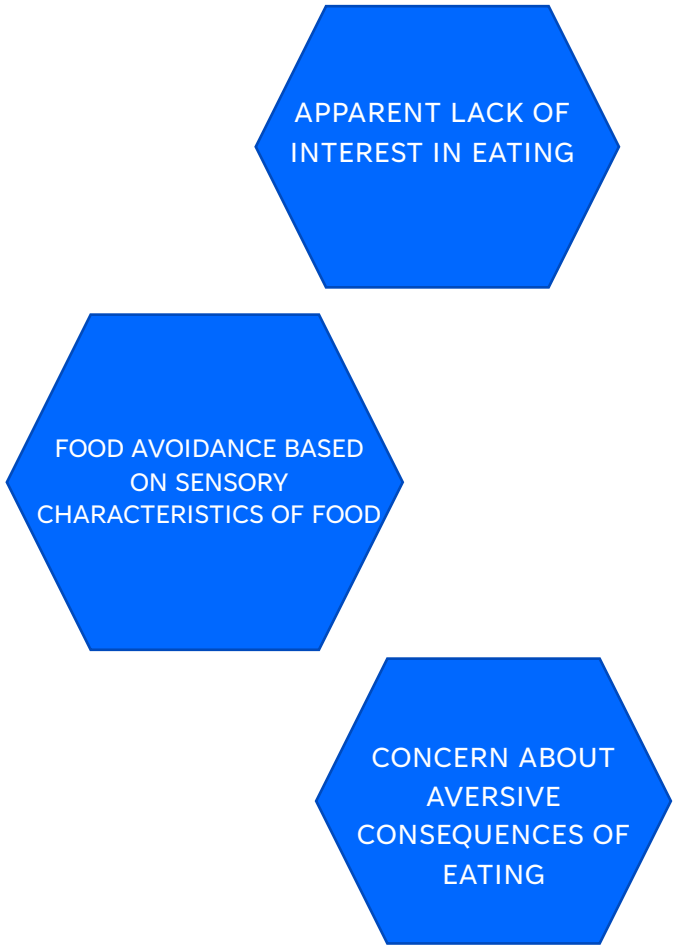
Diagnosis



What is ARFID – Avoidant Restrictive food intake disorder ?



1. Significant weight loss (or failure to gain weight or faltering growth in children)
2. Significant nutritional deficiency
3. Dependence on oral/enteral feeding
4. Marked interference with psychosocial functioning

DSM V, 2013

What ARFID is not – exclusion from DSM-v

- Problems with weight that are related to body and shape concerns
- Feeding problems that are related to scarcity of foods or any religion that has specific rules around food
- Related to any medical or psychiatric condition (i.e. depression that might leads to reduce food intake and consequently weight loss)

Diagnosis

- You cannot be diagnosed with ARFID and AN at the same time
- Autism and ARFID have high prevalence but not all autistic individuals will have ARFID
- You can have sensory difficulties in Anorexia and in Autism and this doesn’t mean they have ARFID
- Emphasising the heterogeneous nature of the condition meaning that no two cases are likely to be the same and therefore standardised anything is not likely to work

Differential Diagnosis

- Paediatric feeding disorder (PFD)
- Anorexia Nervosa
- Dysphagia – with associated medical diagnoses
- Food Avoidance Emotional Disorder
- Paediatric Bulimia
- Selective Eating
- Hemetophobia

Acute settings

Acute settings

- Often patients without a diagnosis and new to CAMHS/EDT
- Often acute weight loss or chronic underweight that stopped eating/drinking
- Food refusal and also often drink refusal
- Usually physically compromised

Assessment

Nutritional/physical health assessment

- Feeding history in the last few months/ days (also include what was working/not working at home)
- Physical health – as per MEED
- Blood test – can indicate deficiencies but normal results need to be looked at with precaution (need to use with a detailed nutritional analysis for long term deficiency)

• Consider: U and E, LFT, thyroid, Calcium, Magnesium, phosphate, zinc, B12, folate, Iron, Vit D, glucose - following nutritional analysis and physical signs such as deteriorating vision, dry and itchy skin, poor growth, bruising easily etc you may want to consider vitamin A and/ or C but be aware you may need to contact the lab to ensure you have the correct procedure

Most patients should have screening blood work including complete metabolic panel, magnesium, phosphorus, complete blood count with differential, thyroid stimulating hormone, erythrocyte sedimentation rate, and c-reactive protein, as well as a urinalysis. It is worth considering screening for coeliac disease with a total immunoglobulin A (IgA) and tissue transglutaminase IgA, as there is a high rate of co-occurrence of celiac disease and AN (16). Patients with bradycardia or hemodynamic instability should have an electrocardiogram.

Brigham, K.S. at all. Evaluation and Treatment of Avoidant/Restrictive Food Intake Disorder (ARFID) in Adolescents. 2019. Curr Pediatri Rep.

Assessment

- Important to give attention to parents/families who may have been struggling to get help and support from medical professionals and wider family and friends unit. So they are likely to be highly frustrated at not having been heard. And then being terrified for their child who is now in hospital.
- Communication with parents and approach need to be mind mindful of that at point of admission, during and after. Parents may be drained and exhausted

Decision tree from MEED

all eating disorders at any BMI. The evidence for refeeding in ARFID and atypical anorexia nervosa is currently lacking, however. Figure 3 provides a decision tree on how to approach the management of a severe eating disorder, which can begin in primary care. Figure 4 provides guidance on the refeeding process and in Table 6, the process of refeeding and its challenges are listed, together with management advice.

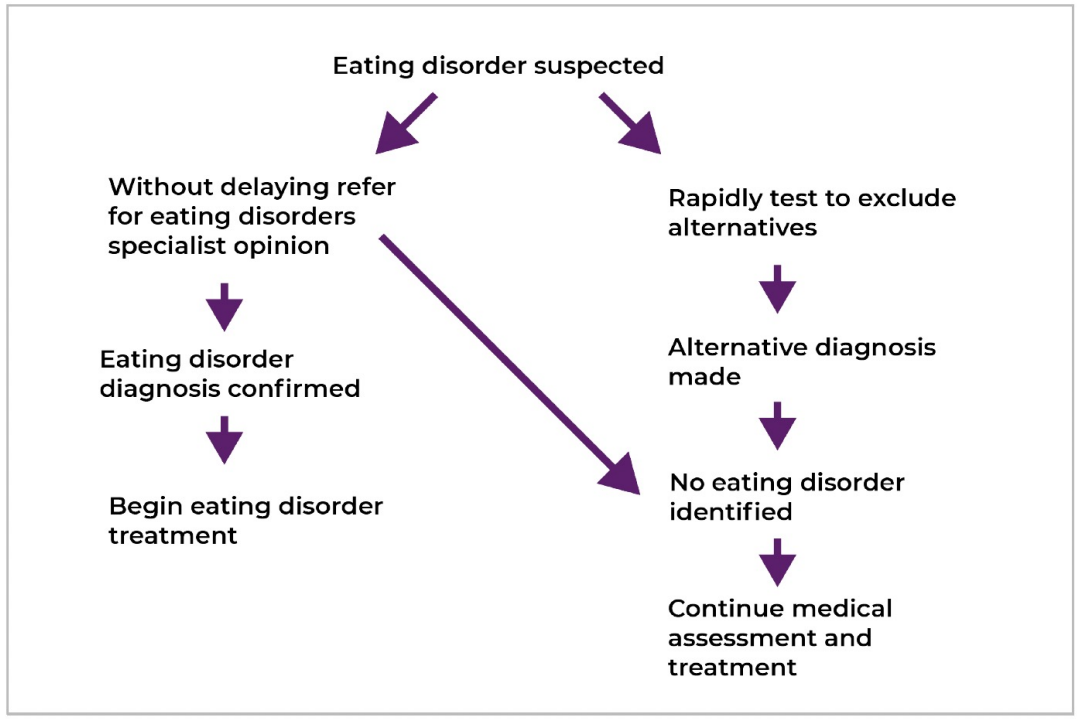


Figure 3: Decision tree for non-specialists in eating disorders (including in primary care)

Risk assessment from MEED

It is important to note that risk parameters for adults cannot be applied to children and young people without adjustment for age and gender.

This is a guide to risk assessment and cannot replace proper clinical evaluation. However, a patient with one or more red ratings or two or more amber ratings should probably be considered high risk.

Table 1: Risk assessment framework for assessing impending risk to life

	Red: High impending risk to life	Amber: Alert to high concern for impending risk to life	Green: Low impending risk to life
Medical history and examination			
Weight loss	Recent loss of weight of ≥1kg/week for 2 weeks (consecutive) in an undernourished patient[34] Rapid weight loss at any weight, e.g. in obesity or ARFID	Recent loss of weight of 500–999g/week for 2 consecutive weeks in an undernourished patient[126]	Recent weight loss of <500g/week or fluctuating weight
BMI and weight	• Under 18 years: m%BMI[35] <70% • Over 18: BMI <13	• Under 18: m%BMI 70–80% • Over 18: BMI 13–14.9	• Under 18: m%BMI >80%[36] • Over 18: BMI >15
HR (awake)	<40	40–50	>50
Cardio-vascular health[37 38]	Standing systolic BP below 0.4th centile for age or less than 90 if 18+, associated with recurrent syncope and postural drop in systolic BP of >20mmHg or increase in HR of over 30bpm (35bpm in <16 years)	Standing systolic BP <0.4th centile or <90 if 18+ associated with occasional syncope; postural drop in systolic BP of >15mmHg or increase in HR of up to 30bpm (35bpm in <16 years)	• Normal standing systolic BP for age and gender with reference to centile charts • Normal orthostatic cardiovascular changes • Normal heart rhythm

[34] Patients losing weight at higher BMI should be assessed for other signs of medical instability and weight loss strategies to determine risk.
[35] Also known as weight for height percentage.
[36] Note these do not denote a healthy weight but rather a weight above which other parameters in this risk framework may better reflect risk.
[37] https://pubmed.ncbi.nlm.nih.gov/24067349/
[38] https://www.nhlbi.nih.gov/files/docs/guidelines/child_tbl.pdf

https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr233-medical-emergencies-in-eating-disorders-(meed)-guidance.pdf?sfvrsn=2d327483_52

From page 31

Challenges in units

- Environment – too overwhelming (noise, too many people, changes all the time, different staff, different rules, different timings, being away from home, not having ‘alone time’). Also to consider how an unsettle ward can impact them (very sensitive to people’s emotions)
- Lack of understanding by staff – often seen as displaying challenging behaviours (i.e. if not accepting a specific food) – special consideration if Autism is present
- Learning behaviours – coping/ mimicking
- Meal times – consider providing a quiet place / use of ear defenders / staff or parents support / changes on the menu / possibility of bringing their own food (brand specific)
- Duration of admission
- Need more time with dietitian as preferences might change a few times
- JOINT WORK is essential!!!!

What to do

- Focus on physical stabilization
- Try as much as possible to give control on choices, even if they are small
- Allow preferred foods, even if it is the same food
- Allow food from home (when possible)
- Assess for sensory difficulties
- Support the creation of an ideal eating environment for the patient and reduce their anxiety
- Allow and support self-regulation stimming
- Accessible communication
- Staff training and awareness
- **Sensory Restrictive Eating Disorder Guidance to be out soon!!!**

Examples

1) Do they prefer to eat with other people?

2) Do they like you to talk to them and offer encouragement? Or do they prefer to eat in silence?

3) Do they prefer to watch their favourite TV show, use a tablet device or listen to music whilst eating?

4) Does it help to wear noise cancelling headphones?

5) Does it help to eat alongside reading, puzzles or other distractions such as tablets and radio?

6) Does their chair have to face the door? Or a specific direction?

7) Can other people touch/prepare their food? Such as others removing lids from food pots.

8) Does it help to eat standing, or sitting on a physiotherapy ball for meals?

Additional questions for children and young people (CYP):

9) Does it help when the person with them models eating (eats the same food with them)? Or do they prefer to eat alone?

10) Do they prefer it when someone sits next to them? In front of them

Examples

- Reasonable adjustment (all if applicable)
- I would like to bring in and use my own plate / bowl / cutlery/ straw from home
- I would like my milk served separately from my cereal portion
- I would like my beans served separately from my toast
- I would like my butter served separately from my bread/toast so I can add this myself
- I would like my sandwich filling to be served separately
- I would like my fruit cut up rather than served whole
- I would like any ‘hot food’ to be served cold
- I would like drinks to be served cold from the fridge
- I would like my jacket potato and filling to be served separately
- I would like my baked beans to be ( ) brand

Oral supplementation – vitamins and minerals

- Capsules
- Tablets
- Powder
- Gummies
- Liquids
- Patch
- Sprinkle
- Spray

- ➢ It is important to notice that very often iron is not present in multivitamins/minerals – need to supplement separately
- ➢ If old enough, let them chose which option they can tolerate better
- ➢ Trying to hide in food can be tricky, as likely to be rejected
- ➢ Remember that if the label changes they might stop accepting the supplement

Chronic poor diet can lead to physical compromise and clinical manifestations of weight loss (or faltering growth) and marked nutritional deficiencies. The nutritional deficiencies are often specific to one or more nutrients and need correcting individually rather than with a generic multi-vitamin/mineral

Oral supplementation

- Often used if weight gain is needed. However, it is important to explore food first (high calorie dense foods)

- Things to consider when choosing an oral supplement:
  - ✓ Flavour
  - ✓ Texture
  - ✓ Nutrition analysis (i.e 2.0 kcal/ fibre)
  - ✓ Quantity

- Strategies: freezing (reduces smell), plain flavour to blend with preferred food (i.e. chocolate), diluting with water/milk if it is too thick, try different brands

- It can be difficult to reduce intake / remove – it is predictable, less sensory input needed, fast to drink

Nasogastric Tube Feeding - NGT

- No prevalence data on ARFID
- Often used in paediatric wards and inpatient units
- Pros: predictable, very low sensory input needed, no interaction with food, helpful to support weight restoration, physical health stability, well tolerated in most cases
- Cons: dependency, who is going to administrate if in community setting, can take a long time to wean it off
- MDT decision based on risk

Percutaneous Endoscopic Gastrostomy - PEG

- No prevalence data on ARFID
- Not often used but numbers are increasing
- More invasive
- Will probably require other teams to be involved (i.e community dietitian / nurse / paediatrician, gastro)
- Wider MDT decision

ARFID and AN

SIMILARITIES	DIFFERENCES
Restrictive eating	Body and shape concern AN - “feeling fat” ARFID - preoccupied with the number – i.e. not wanting the weight to change/ to go up (fixation/rigidity but not because they “feel fat”)
Anxiety at meal times	Anxiety at meal times ARFID – not knowing what to expect AN – fear of calories/volume of meals
Onset	Difficulties at a very young age ARFID usually before 10 AN usually teenagers
Rigidity – OCD??	Sensory issues ARFID most of the times is present AN can be present but usually not (unless those on the spectrum)
Meal times as most difficult moment of the day	Type of food eaten AN will avoid carbs, fats and will have fear foods ARFID no pattern but usually they will eat biscuits, chocolate or a food that for AN is considered fear food
Impact on family and social situations / isolation	Obsession around food ARFID + ASD – numbers, specific things, rigidity AN – obsession about calories (fear of gaining weight) + rituals/rigidity mostly due to starvation

BDA position paper

Feature	ARFID	Anorexia Nervosa
Chronicity	Often chronic/long term	Often more acute
Variety in diet	Selective (severe less than 10 foods, extreme less than 5 foods)	Often varied, although certain food groups may be omitted
Food brand preference	Often very brand specific	Not brand specific
Food Colour	Often prefers one colour such as beige	Not generally an issue
Food Texture	Often prefers limited textures, such as dry or crunchy	Not generally an issue
Multivitamin and mineral supplement	Risk of toxicity (e.g. vitamin A, iron, calcium) due to oversupply through supplements	Toxicity unlikely
Food groups and nutrients	Excessive intake of some nutrients where the diet relies on a few food items (e.g., milk, carbohydrates, sodium)	Some foods may be omitted (e.g. fats, carbohydrates, dairy)
Growth and development	Can be overweight/underweight or healthy weight. Stunting could be an issue	Underweight at diagnosis, not generally a long-term issue
Vitamin and mineral supplement	Needs specific supplementation often alongside or instead of general multivitamin and mineral. Can be difficult to find acceptable preparation due to taste	General multivitamin and mineral supplement usually acceptable
Nutritional Supplements	Often not acceptable due to taste preferences	Can be used for 'top up' or food refusal
Protein deficiency	Likely with extreme restriction if based around carbohydrate foods	Unlikely
High sugar intake	Likely with high intake of sugary foods such as biscuits. This can be particularly detrimental to oral health.	Unlikely
Constipation related to lack of fibre in diet	Likely due to reliance on highly processed foods and low intake of fruit and vegetables.	Unlikely long-term issue

https://www.bda.uk.com/specialist-groups-and-branches/mental-health-specialist-group/child-adolescent-mental-health-services-sub-group/arfid-position-statement.html

Resources

Resources

- British Dietetic Association, ARFID Position Statement 2022. Internet: https://www.bda.uk.com/specialist- groups-and-branches/mental-health-specialist-group/child-adolescent-mental-health-services-sub- group/arfid-position-statement.html (accessed 24 January 2024)
- ARFID Avoidant Restrictive Food Intake Disorder: A Guide for Parents and Carers by Rachel Bryant-Waugh · Food Refusal and Avoidant Eating in Children, including those with Autism Spectrum Conditions: A Practical Guide for Parents and Professionals by Gillian Harris and Elizabeth Shea
- Avoidant Restrictive Food Intake Disorder in Childhood and Adolescence by Rachel Bryant-Waugh
- Cognitive-Behavioral Therapy for Avoidant/Restrictive Food Intake Disorder by Kamryn T. Eddy Jennifer J. Thomas
- Helping your child with Extreme Picky Eating by Katja Rowell and Jenny McGlothlin
- Interoception The Eighth Sensory System – Practical Solutions for Improving Self-Regulation, Self-Awareness and Social Understanding by Kelly Mahler
- The Fun with Food Programme – Therapeutic Intervention for Children with Aversion to Oral Feeding
- Can’t eat, won’t eat - Dietary Difficulties and Autistic Spectrum Disorders by Brenda Legg
- Family-Based Treatment for Avoidant/Restrictive Food Intake Disorder by James Lock

Resources

- https://dev.bebodypositive.org.uk/
- https://www.cntw.nhs.uk/?s=arfid
- https://abuhb.nhs.wales/hospitals/a-z-of-services/paediatric-clinical-psychology-service/our-specialist-services/paediatric-arfid-service/

- https://www.arfidawarenessuk.org – THERE IS A PARENT'S FACEBOOK GROUP that is very helpful
- https://www.beateatingdisorders.org.uk/types/arfid
- https://www.cambscommunityservices.nhs.uk/Bedfordshire/services/occupational-therapy/sensory-processing-awareness-training - also access "Planning wheel" and "How to use the planning wheel) (just after the link)
- https://www.cambscommunityservices.nhs.uk/cambridgeshire-children's-occupational-therapy/sensory-differences---online-learning
- https://sensoryplaytoolkit.weebly.com/
- Helpful Instagram on Food chaining - @feedingpickyeaters
- Helpful Instagram of lived experience - @myarfidlife
- https://www.peacepathway.org/ (more on AN and Autism)

Thank you

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