A Case of ARFID presenting with catatonia and responsive to ECT

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Background

- CL psychiatrists are frequently asked to evaluate patients with decreased oral intake.
- Careful discernment for conditions with life threatening sequelae such as catatonia and disordered eating is required. Rarely have the two been described in the same patient.
- We present a case of severe ARFID, avoidant restrictive food intake disorder which was complicated by catatonia and was eventually responsive to ECT with full remission of both the catatonia and the disordered eating symptoms.

Case

24 yo female who presented with weakness, decreased appetite, difficulty swallowing, and weight loss. Voiced overvalued ideas of a variety of food intolerances as "allergies"

- BMI at admission was 11.2
- No distortion of body image or intentional weight loss
- No previous psychiatric history
- Extensive medical work up was unrevealing.

<u>Hospital course</u>

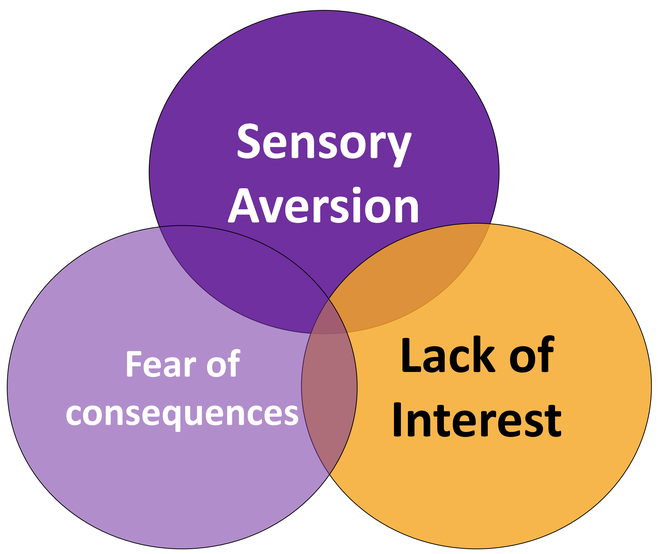
- She developed symptoms of catatonia including stupor, mutism, staring, catalepsy, echopraxia/echolalia, negativism, waxy flexibility, and withdrawal.
- Lorazepam initiation with only moderate response.
- No weight gain in spite of parenteral feedings.
- 16 rounds of ECT over 1 month resulted in full resolution of her catatonic syndrome and ARFID symptoms

<u>Follow up</u>

- At the time of discharge, she had a BMI of 16.1
- 14 month follow up with continued resolution of symptoms, no psychotropic meds and a BMI of 19

Discussion

- Catatonia, an etiologically diverse neuropsychiatric syndrome, warrants urgent psychiatric evaluation and treatment due to its potential life-threatening sequelae. (1,2)
- Withdrawal, or the avoidance of oral intake, is a nonspecific finding in catatonia that also occurs in a number of other psychiatric conditions.
- Patients with catatonia and eating disorders have a high burden of disease morbidity and mortality and require careful attention from the consultant in making the diagnosis and intervening swiftly.
- In our case, while disordered eating and malnutrition was readily apparent, recognition of the catatonic syndrome was delayed. Her stupor, mutism, and withdrawal were initially interpreted as hypoactive delirium secondary to profound malnourishment/refeeding syndrome.
- Our case contributes to the limited body of literature supporting co-existing eating disorders and catatonia. It is further unique in that the ECT not only lysed the catatonic syndrome, but apparently cured her ARFID. She demonstrated no further food avoidance, dysphagia or food intolerance following treatment.



RESOURCES