

Coexistence of Autism and Eating Disorder: a Case Report

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ABSTRACT

Coexistence of autism and eating disorder: a case report

A case of autism who lost 18kg within one and a half months with vomiting episodes following binge eating attacks and refused to eat solid foods within the last ten days is presented in this study. As solid food intake was completely stopped and fluids were vomited out, it was decided to hospitalize the patient who was admitted to the psychiatry clinic with a diagnosis of feeding or eating disorders not elsewhere classified (FED-NEC). Intravenous hydration and 15mg/day olanzapine were initiated. Studies on children with autism spectrum disorders (ASD) showed that these children had atypical eating patterns and rituals compared to a healthy control group.

Keywords: Autism spectrum disorders, binge eating, hospitalization, rejection of eating, vomiting

ÖZ

Otizme eşlik eden yeme bozukluğu: Bir olgu sunumu

Bu çalışmada, aşırı yeme ataklarını takiben bir buçuk ay içinde 18kg kaybeden ve son on gün içinde katı gıdalar yemeyi reddeden bir otizm vakası sunulmuştur. Katı gıda alımı tamamen duran ve sıvı gıdaları kusmaya devam eden olgunun hastaneye yatırılmasına karar verildi. Tanımlanmamış diğer beslenme ve yeme bozukluğu (TD-BYB) tanısı ile psikiyatri kliniğine yatırıldı. İntravenöz hidrasyon ve olanzapin 15mg/gün başlandı. Otizm spektrum bozukluğu (OSB) olan çocuklar üzerinde yapılan çalışmalar, bu çocukların sağlıklı çocuklara kıyasla atipik yeme paternleri ve ritüelleri olduğunu göstermiştir.

Anahtar kelimeler: Otizm spektrum bozukluğu, tıkanırçasına yeme, hospitalizasyon, yeme reddi, kusma

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INTRODUCTION

Autism spectrum disorders (ASD) are a group of common neurodevelopmental disorders characterized by impaired reciprocal social interaction and communication and restrictive, repetitive behavior or interests (1). Eating disorders (ED) are a group of diseases that usually begin in adolescence or early adulthood and occur more commonly in women (2). Eating disorders include anorexia nervosa (AN) and its restrictive and bulimic sub-types, bulimia nervosa (BN) and its purging and non-purging sub-types, binge eating disorder (BED), pica, rumination disorder, avoidant/restrictive food intake disorder, and feeding or eating disorders not elsewhere classified (FED-NEC) (1).

Studies on children with ASD showed that these children had atypical eating patterns and rituals compared to a healthy control group. In addition, these children were sensitive regarding smell and taste, which may lead them to overreacting to new foods emotionally, being picky about food, and refusing to eat certain food (3,4). As a consequence, vitamin and trace element deficiencies and gastrointestinal symptoms were observed and the risk of obesity was increased in these children (5,6). Although eating problems frequently occur in autism, the coexistence of autism and eating disorders is rare. Due to communication problems in patients with ASD, it is quite difficult to differentiate AN, BN, and BED according to Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) diagnostic criteria.

In this study, an autism case who lost 18kg within one and a half months due to vomiting episodes following binge eating attacks and rejecting food intake for the past 10 days is reported.

CASE

A 14-year-old male patient diagnosed with ASD was referred to our department from pediatric gastroenterology due to symptoms of weight loss, vomiting, and rejection of eating. An organic pathology was not detected during endoscopy and his biochemical test results were also normal. His medical and clinical history was received from the family because the patient's speaking skills were inadequate. His parents reported that the patient started to eat high amounts of food in a very short period of time and then made himself vomit by putting his finger into the throat 5-10 minutes after the meal. The patient was said to have lost 18kg in one and a half months, declining from 98kg to 80kg. It was learned that these symptoms started after his sister had left home for college education. He completely stopped eating solid food within the past ten days. The patient was diagnosed with an eating disorder as he had shown binge eating episodes, lost more than 15% of his body weight within a short time and had a stressor factor in the form of his sister leaving home. Since thought content regarding body perception and body weight could not be evaluated, he was diagnosed with FED-NEC. The patient was hospitalized in the psychiatric clinic because of vomiting and rejecting to ingest solid food. Intravenous hydration and 15mg/day olanzapine were initiated. Previously, when attending the outpatient clinic of an external hospital, 1mg risperidone and 20mg fluoxetine had been started due to behavioral problems like agitation, volatility and crying, then risperidone up to 2mg, but the clinical improvement was not satisfactory. Olanzapine was preferred because it had not been tried previously and is superior to other antipsychotics in preventing vomiting attacks and increasing appetite. Since the symptoms were severe, a high dose of olanzapine was initiated at admission. After the third day, intravenous (IV) hydration was

stopped and treatment was maintained with only 15mg/day olanzapine. In hospital, the patient was accompanied by his sister and he was fed only by her. When he had finished his meal and did not try to vomit, he was rewarded with his favorite foods. Half-solid food intake started in addition to fluid nutrition, and provoked vomiting episodes decreased in the first week of admission. In the second week, complete solid food intake started and vomiting attacks almost completely stopped. One month after admission, his nutritional habits completely recovered and he was discharged with 15mg olanzapine/day. The patient had no symptoms at the first month follow-up and olanzapine was tapered to 10mg/day. At present, he is still being followed up with monthly visits to our clinic.

DISCUSSION

Although it is well known that psychiatric behavioral problems may accompany autism, there are few studies on its association with eating disorders. Some researchers examined ASD prevalence in patients diagnosed with eating disorders and mentioned that especially some of the anorectic patients showed an autistic eating pattern and met diagnostic criteria for ASD. In fact, Gillberg (7,8) pointed out that AN and ASD were associated with each other and similar in terms of their cognitive profiles. However, to our knowledge, our study is the first case report about ASD-associated BN or FED-NEC in the literature.

Olanzapine has been chosen as medication for the patient, as it is arguably the most efficacious psychopharmacological agent for AN (9). At the same time, low-dose olanzapine is thought to be beneficial in avoidant and restrictive food intake disorder (ARFID). In addition to enhancing reduced appetite, which is a common clinical feature of ARFID, olanzapine also promotes mood stabilization, reduction of obsessional anxiety, and enhanced cognition (9). Its safety profile in children and adolescents has been well established (10). In this way, for children with autism accompanied by eating disorders, olanzapine can be selected as medication.

When the developmental problems brought about by autism and serious food rejection are added to the eating disorders, which is difficult to treat, the regulation of patient management and treatment becomes more difficult and makes hospitalization necessary.

In some cases, hospitalization of the patients may lead them to be separated from the environment that they are accustomed to and cause disruption of their routines, excessive reaction and crisis, making the situation more challenging for family and health care team. The present case demonstrates that reaction to stressors in children with autism may manifest as atypical eating behaviors. Severe ED may rarely accompany autism, in which case multidisciplinary approaches are required in treatment.

REFERENCES

1. Diagnostic and statistical manual of mental disorders. Fifth ed., Arlington, VA: American Psychiatric Publishing, 2013.
2. Turnbull S, Ward A, Treasure J, Jick H, Derby L. The demand for eating disorder care: An epidemiological study using the general practice research database. *Br J Psychiatry* 1996; 165:705-712. **[CrossRef]**
3. Bandini LG, Anderson SE, Curtin C, Cermak S, Evans, EW, Scampini R, Maslin M, Must A. Food selectivity in children with autism spectrum disorders and typically developing children. *J Pediatr* 2010; 157:259-264. **[CrossRef]**
4. Cermak SA, Curtin C, Bandini LG. Food selectivity and sensory sensitivity in children with autism spectrum disorders. *J Am Diet Assoc* 2010; 110:238-246. **[CrossRef]**
5. Curtin C, Anderson SE, Must A, Bandini L. The prevalence of obesity in children with autism: a secondary data analysis using nationally representative data from the National Survey of Children's Health. *BMC Pediatr* 2010; 10:11. **[CrossRef]**
6. Schreck KA, Williams K, Smith AF. A comparison of eating behaviors between children with and without autism. *J Autism Dev Disord* 2004; 34:433-438. **[CrossRef]**
7. Gillberg C. Autism and anorexia nervosa: related conditions? *Nord J Psychiatry* 1985; 39:307-312. (Swedish) **[CrossRef]**
8. Gillberg C, Cederlund M, Lamberg K, Zeijlon L. Brief report: "the autism epidemic". The registered prevalence of autism in a Swedish urban area. *J Autism Dev Disord* 2006; 36:429-435. **[CrossRef]**
9. Brewerton TD. Antipsychotic agents in the treatment of anorexia nervosa: neuropsychopharmacologic rationale and evidence from controlled trials. *Curr Psychiatry Rep* 2012; 14:398-405. **[CrossRef]**
10. Norris ML, Spettigue W, Buchholz A, Henderson KA, Gomez R, Maras D, Gaboury I, Ni A. Olanzapine use for the adjunctive treatment of adolescents with anorexia nervosa. *J Child Adolesc Psychopharmacol* 2011; 21:213-220. **[CrossRef]**

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