A CASE REPORT OF AN EARLY ONSET OF ANOREXIA NERVOSA

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ABSTRACT

The early onset cases of anorexia nervosa, which occur in children between the ages of 8 and 14, pose a serious challenge to eating disorders professionals. The interdisciplinary approach to this eating disorder is a prerequisite for timely development of therapeutic strategy and individual approach to the complex needs of the child and family. This case report presents an early onset of anorexia nervosa in a 12-year-old outpatient girl. The history of the case is described, with the stages of awareness of the problem; seeking professional help; nutritional rehabilitation; psychiatric and psychological help that the child and the family receive. A plan for managing the clinical consequences of weight loss, risk assessment tools, as well as the possibilities of a family-oriented approach in providing psychological support are presented. The roles of the various specialists involved in the case and their collaborative work in progress are discussed.

Keywords: *anorexia nervosa, early onset, interdisciplinary approach*

INTRODUCTION

Anorexia nervosa (AN) is probably the most severe eating disorder. *The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-V) defines AN as limited intake of calories, leading to severe underweight, severe fear of gaining weight or obesity, and dysmorphophobia. Two forms of AN are described: a restrictive form (AN-R), characterized by severe food restriction, and a bulimic form (AN-B), in which patients limit calories but have episodes of overeating with subsequent cleansing behavior, self-induced vomiting, intake of laxatives, diuretics, and excessive physical activity (1). There are two critical periods for the onset of AN: at 13–14 years of age and around 18–20 years (2). The earlier onset of the disease (under the age of 13) is associated with more serious health consequences and risk for life (3). Patients with AN usually have comorbid mental health problems. The most common are anxiety disorders (in 46.6% of all hospitalized), OCD (8.2%), and self-harm behaviors—including, but not limited to suicide, 7.1% and 20%, respectively (4). The health consequences of AN can be very serious and even life-threatening. Mortality is twice as high as any other mental illness and is the most common cause of death among women aged 15–24 (5,6). In view of the real risk to life, medical care for this disease should be comprehensive and include both psychiatric and cognitive-behavioral and somatic therapy (7). An obligatory component of the treatment is the adequate nutritional support.

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CASE REPORT

We present a clinical case of a girl (H.) with an early onset of AN. The observations, research, and assessment of the case are based on a six-month period. Work on the case began with the already severe clinical picture of AN, after refusing to conduct hospital treatment in a child and adolescent psychiatric clinic accredited for the treatment of eating disorders. When the parents sought counseling, H.'s calendar age was 12 years. The parents say that H. has been involved in athletics since she was 10 years old. Behavioral changes have been noticed for about a year—increased time for exercise and a change in some of the eating habits that were not yet disturbing according to the parents' opinion during this period. At the end of the summer, after psychotrauma related to rejection by peers and days of forced isolation without the opportunity to receive support, H. gradually limited the amount of food and skipped main meals. In the beginning, parents associated the limitations with the prolonged depressed mood. Subsequently, H. radically refused to eat with her family, introduced her own diet, with extreme and obvious calorie restriction combined with intense physical activity outside the regulated hours for athletics training. Due to visible weight loss at the beginning of the school year, the parents stopped the training. Eating was becoming more restrictive with the elimination of staple foods from the menu. H. denied having any problems. Within a month, H.'s condition became more complicated, the dietary restrictions deepened—she ate only small amounts of vegetables, started to refuse food completely, her pulse became bradycardic. She was hospitalized in a child and adolescent psychiatric clinic, but due to the lack of assistance from H. and the inability to adapt to the regimen of the ward, after a 24-hour stay in the clinic, she was discharged.

DISCUSSION

The treatment and the follow-up of the case continued in an outpatient setting after the formation of a multidisciplinary team from general practitioner, psychiatrist, nutritionist, pediatrician, and psychologist. *The Junior Marsipan Risk Assessment Tool* (8) was used for case management monitoring. *The Marsipan Score* after leaving the clinic showed high risk and posed a serious challenge to the multidisciplinary team. Continuous monitoring of the condition required intensive communication with the family. The psychiatrist prescribed drug treatment with an antidepressant from the group of so-called selective serotonin reuptake inhibitors and an atypical antipsychotic, with a single dose adjustment. Within two months, a therapeutic effect was achieved with a significant reduction in anxiety, tension, suspicion and elimination of intrusive unpleasant thoughts, the fear of gaining weight persists despite the reduced intensity compared to the beginning. At the time of the consultation with a nutritionist (on the 2nd month of abnormal eating behavior), H. severely limited the range of foods she consumed. Examination revealed severe malnutrition and lanugo on the shoulders, forearms, and back ad sacrum. Particularly impressive was the atrophy of the muscles of the limbs and face. Body fat measured by the method of bioelectrical impedance analysis was a particular concern (TANITA BC-420MA)—only 3% with an age norm of 16–29.9% (this corresponds to 1 kg of body fat; anthropometric status was taken with a bioimpedance meter from professional class TANITA BC-420MA, in compliance with all ESPEN recommendations for accuracy and reliability). BMI was 12.74 kg/m2. Laboratory tests of blood and urine showed no abnormalities in blood counts, electrolytes, liver enzymes, carbohydrate, and protein metabolism. The only exception was CK (creatine kinase), which showed elevated values (CK—248 U/L at a rate of 26–140 U/L). The increase in CK was expected and was due to the breakdown of the patient's own muscle tissue and prolonged dietary restriction. Due to the reduced functional capacity of the digestive system, it was desirable that the diet included 5–6 intakes of relatively small portions of food. The amount of low-calorie foods and beverages (such as raw fruits, vegetables, skim milk, cottage cheese, etc.) should not be large (approximately ¼ of the portion size). Since at this stage the thought of gaining weight caused great fear and anxiety in H., at the first meeting with the nutritionist we agreed to try to keep the current weight. To this end, she and her family received advice and recommendations to focus on some foods of high biological value, which at the same time were not very high in calories (not high in energy). In the following months, H.'s weight ranged between 34.2

and 36.9 kg. The lowest weight (34.2) was in January 2022. After this period, H. began to gain slowly weight and in about 45 days recovered nearly 5.8 kg. (40 kg, BMI = 14.7 kg/m2). Consultations with the team psychologist were of the highest frequency and intensity. The aim of psychological counseling for H. was to adapt and recover from trauma, to develop trust, and subsequently gain insight about the disease. One of the most significant successes in the counseling process was the changes in emotional regulation in H. The application of techniques from art therapy and cognitive-behavioral therapy, such as cognitive restructuring, had a beneficial effect. As a result of the intervention of the multidisciplinary team and the follow-up of the case through *the Junior Marsipan Risk Assessment Tool*, the risk was changed from high to moderate. At this stage, the most influential risk factors were H.'s behavioral control and the presence of family distress/anxiety. Work on the case should continue until the risk is kept low for at least six months.

CONCLUSION

The treatment of AN remains a major challenge due to the immediate danger to life, severe complications, and the risk of chronicity. A multidisciplinary approach by experienced professionals, including clinicians and experts in clinical nutrition and malnutrition, psychiatrists, clinical psychologists, pediatricians, general practitioners, and active partnerships with parents, is a prerequisite for successfully addressing a severe case of AN.

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