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AVOIDANT/RESTRICTIVE FOOD INTAKE DISORDER (ARFID) IN CHILDREN: A CASE REPORT AND REVIEW OF THE LITERATURE

Y. Fahfouhi*, N. Seghrouchni, H. Berrani, T. Meskini, S. Ettair

Department of Pediatric Hepato-Gastroenterology and Nutrition, Children's Hospital, Rabat, Morocco.

***Corresponding Author: Y. Fahfouhi**
Department of Pediatric Hepato-Gastroenterology and Nutrition, Children's Hospital, Rabat, Morocco.
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ABSTRAT
Avoidant/Restrictive Food Intake Disorder (ARFID) is a recently recognized eating disorder that can lead to severe nutritional and psychosocial complications in children. Its clinical presentation is heterogeneous, and diagnosis remains challenging due to overlap with other pediatric conditions. We report the case of a 10-year-old girl with a severe form of ARFID requiring enteral nutrition, complicated by relapse, but with favorable outcomes under prolonged pediatric, nutritional, and psychological follow-up. This case illustrates the potential severity of ARFID in pediatric populations and emphasizes the need for early detection, multidisciplinary management, and long-term follow-up to reduce the risk of relapse and improve prognosis.

KEYWORDS: ARFID; Undernutrition; Multidisciplinary approach ; Family-based therapy.

INTRODUCTION

Introduced as a distinct entity in the DSM-5 (2013), ARFID is defined by restricted or avoidant eating that leads to weight loss, nutritional deficiencies, faltering growth, or psychosocial impairment—without weight- or shape-related concerns, in contrast to anorexia nervosa or bulimia nervosa.[1] In children, three typical clinical profiles are observed : heightened sensory sensitivity, a persistent lack of interest in eating, and fear of aversive consequences (e.g., choking, vomiting, abdominal pain).[2,3] Prevalence estimates range from ~0.3–6% in community samples, with higher rates reported in specialized programs (up to ~22%).[3,4] Common comorbidities include anxiety disorders, autism spectrum disorder and other neurodevelopmental difficulties, and gastrointestinal conditions.[2,5] Management is multidisciplinary, centered on nutritional rehabilitation and psychological interventions; family-based and cognitive-behavioral approaches show promising outcomes, with hospitalization and pharmacotherapy used in severe presentations.[1,5]

In this context, we report the case of an 8-year-old girl with a severe form of ARFID that required hospitalization and enteral nutrition.

CASE REPORT

We report the case of a 10-year-old girl, with normal psychomotor development and excellent school performance, who had longstanding selective eating since early childhood. Two months before hospitalization, she developed recurrent epigastric pain followed by a near-total disinterest in food, resulting in weight loss exceeding 10 kg. On admission, her weight was 17 kg at a height of 129 cm, corresponding to a BMI of 10.2 kg/m² and indicating severe malnutrition. Physical examination revealed profound asthenia rendering her unable to walk or perform any activity; the neurological examination was strictly normal.

A comprehensive etiological work-up was performed. Laboratory tests demonstrated iron-deficiency anemia; serum electrolytes, renal function, and liver panel were within normal limits. The extended phosphocalcic profile (calcium, phosphate, magnesium), 25-OH vitamin D, and parathyroid hormone were unremarkable; vitamin B12 and folate levels were normal; thyroid function (TSH, free T4) was normal. Dual-energy X-ray absorptiometry (DXA) showed osteopenia. Gastrointestinal investigations did not reveal an organic etiology : celiac serology was negative (total IgA measured, then IgA anti–tissue transglutaminase according to the recommended algorithm), and upper gastrointestinal endoscopy was normal. The speech and swallowing (orality) assessment was normal. Brain MRI was normal, ruling out a tumoral process. Psychiatric evaluation identified meal-related anxiety without weight or shape concerns.

After exclusion of organic causes, a diagnosis of avoidant/restrictive food intake disorder (ARFID) was established according to DSM-5-TR criteria : an eating disturbance leading to inadequate intake with marked weight loss and nutritional deficiency (iron deficiency); not attributable to food unavailability or cultural practices; absence of weight/shape concerns with exclusion of anorexia nervosa and bulimia nervosa; and clinical severity warranting specific attention beyond comorbidities.

The patient was managed by a multidisciplinary team, benefiting from enteral nutrition via a nasogastric tube, psychotherapeutic support, and anxiolytic medication. Refeeding was conducted under close monitoring of serum phosphate, potassium, and magnesium to prevent refeeding hypophosphatemia. The initial outcome was favorable, with weight gain to 27 kg after two months; a relapse occurred after discontinuation of enteral feeding, necessitating resumption of specialized care. At follow-up, the course was satisfactory : weight 32 kg, exclusive oral intake, selective eating persisting but functional, with preserved school and social integration.

Figure 1: photograph obtained during Hospitalization : weight 17 kg.

Figure 2 : photograph taken after 2 years of follow-up : weight 32 kg.

DISCUSSION

The case presented illustrates a severe form of avoidant/restrictive food intake disorder (ARFID) in a child, a disorder recently defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) that has attracted increasing attention in pediatrics. Epidemiological data suggest a prevalence ranging from 0.3% to 6.4% in the general population, while in specialized clinical cohorts the figures may exceed 20%.[1–4] This disparity reflects both the diversity of clinical presentations and the greater severity of cases referred to specialized centers.

Clinically, our patient showed a mixed profile spanning the three commonly described ARFID dimensions : long-standing sensory selectivity, subsequent lack of interest in eating, and fear of aversive consequences linked to abdominal pain, patterns consistent with pediatric descriptions.[2,7] In her case, severity manifested as substantial weight loss, iron-deficiency anemia, reduced bone mineral density (BMD), and a transient impairment of daily functioning.

Differential diagnoses were explored systematically. Unlike simple food neophobia typically transient and without biological consequences, her course was marked by objective nutritional deficits and psychosocial impact. The absence of weight/shape concerns distinguished this presentation from anorexia nervosa. Somatic evaluation excluded chronic organic disease (negative celiac work-up, normal endoscopy) and neurological pathology; psychiatric assessment documented meal-related anxiety. Given the frequency of psychiatric and neurodevelopmental comorbidities in ARFID, our targeted screening was appropriate; in this patient, anxiety was evident, whereas autistic traits reported in 8%–55% of series were not prominent.[5,7]

Management followed a multidisciplinary model. Nutritional rehabilitation was prioritized; although oral intake is preferred, nasogastric enteral nutrition was required given the degree of malnutrition, with close refeeding monitoring an approach aligned with recommendations for severe presentations.[1,6] Regular psychological care was instituted. In light of emerging evidence, our therapeutic plan incorporated principles of Cognitive Behavioral Therapy for ARFID (CBT-AR) to expand dietary repertoire and reduce anxiety[8], and engaged the family using Family-Based Treatment for ARFID (FBT-ARFID) to support refeeding and maintenance, approaches associated with weight gain in several pediatric series.[9] These elements are consistent with more recent work demonstrating the feasibility and effectiveness of coordinated care including telehealth

components showing improved weight outcomes and symptom reduction in large cohorts.

Prognosis in ARFID is variable. Our patient experienced initial improvement, a relapse when enteral feeding was withdrawn, and subsequent stabilization under follow-up an evolution consistent with the documented relapse risk, particularly when anxiety and rigid eating patterns persist. Nevertheless, the 2-year outcome (32 kg, functional oral intake, preserved school and social participation) supports the view that early, sustained, and coordinated intervention improves trajectories.[2,5]

CONCULSION

In conclusion, this observation reinforces the key lessons from the literature : the importance of early detection and diagnosis, the necessity of coordinated multidisciplinary care, the growing role of cognitive-behavioral and family-based therapies, and the value of long-term follow-up to prevent relapses and optimize growth, development, and quality of life in children with ARFID.

Consent: The patient's parents provided and informed consent for the publication of the case report and the accompanying photographs.

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