INTRODUCTION
Avoidant/restrictive food intake disorder (ARFID) is defined as an eating or feeding disturbance not attributed to food disparity or cultural practices resulting in:
• Significant weight loss
• Nutritional deficiency
• Dependence on enteral feeding or oral nutritional supplements
• Marked interference with psychosocial function

It was introduced in Diagnostic and Statistical Manual, Fifth Edition (DSM-5) in 2013.

Lack of interest in eating not due to weight or body image concerns
• Discomfort or avoidance of sensory characteristics of foods
• Anxiousness due to adverse experience related to eating (e.g., choking)

Statistical Analysis: SAS 9.4

• Exact binomial 95% confidence bounds (prevalence rate)
• Descriptive demographic analysis

Patients diagnosed with another eating disorder were excluded (e.g., anorexia nervosa, bulimia nervosa, unspecified eating disorder)

OBJECTIVE
To investigate institutional referral patterns and treatment outcomes of patients diagnosed with ARFID.

METHODS
Institutional Review Board approval
• Electronic health record retrospective review

Patients diagnosed with another eating disorder were excluded (e.g., anorexia nervosa, bulimia nervosa).

Statistical Analysis: SAS 9.4
• Descriptive demographic analysis
• Exact binomial 95% confidence bounds (prevalence rate)

RESULTS
Figure 1
AFRID Prevalence per 10,000 Pediatric Patients, by Year.

Prevalence
Year, Number ARFID Dxs

Table 1. Prevalence Rate of ARFID in Selected Studies
Abbreviations: MEDPC, multidisciplinary eating disorder program/clinic; PAG, pediatric and adolescent gynecology program/cell (female only).

<table>
<thead>
<tr>
<th>Study</th>
<th>Setting</th>
<th>N</th>
<th>Age, years</th>
<th>Prevalence, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Otuowo, 2013</td>
<td>Pediatric clinic</td>
<td>275</td>
<td>8-17</td>
<td>14.0</td>
</tr>
<tr>
<td>Fisher, 2014</td>
<td>MEDPC</td>
<td>712</td>
<td>8-14</td>
<td>13.8</td>
</tr>
<tr>
<td>Roman, 2014</td>
<td>MEDPC</td>
<td>369</td>
<td>&lt;18</td>
<td>12.4</td>
</tr>
<tr>
<td>Boudreau, 2014</td>
<td>MEDPC</td>
<td>205</td>
<td>N/A</td>
<td>5.0</td>
</tr>
<tr>
<td>Williams, 2015</td>
<td>MEDPC</td>
<td>422</td>
<td>0.33-16.25</td>
<td>32.0</td>
</tr>
<tr>
<td>Conover, 2018</td>
<td>MEDPC</td>
<td>100</td>
<td>0-10</td>
<td>64.0</td>
</tr>
<tr>
<td>Korn, 2019</td>
<td>MEDPC</td>
<td>369</td>
<td>&lt;18</td>
<td>8.4</td>
</tr>
<tr>
<td>Goldberg, 2020</td>
<td>MEDPC</td>
<td>190</td>
<td>8-18</td>
<td>3.7</td>
</tr>
<tr>
<td>Bertrand, 2021</td>
<td>Pediatric clinic</td>
<td>201</td>
<td>8-18</td>
<td>2.7</td>
</tr>
</tbody>
</table>

Table 2

<table>
<thead>
<tr>
<th>Year, Number ARFID Dxs</th>
<th>Symptoms Improved after Treatment, no. improved/no. treated (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>First Episode: 36/209 (17%) &amp; 29/68 (42.1%)</td>
</tr>
<tr>
<td>2016</td>
<td>Second Episode: 17/10 (17%) &amp; 7/30 (23%)</td>
</tr>
<tr>
<td>2017</td>
<td>First Episode: 14/11 (36%) &amp; 7/16 (43.7%)</td>
</tr>
<tr>
<td>2018</td>
<td>Second Episode: 17/3 (100%)</td>
</tr>
</tbody>
</table>

Symptoms improved after treatment, no. improved/no. treated (%)

Department Referral  | Referred out after intake n (%)  | Treated | First Episode | Second Episode |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health</td>
<td>36 (17)</td>
<td>29/68 (42.1%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutritional Therapy</td>
<td>17 (41)</td>
<td>10/30 (33.3%)</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>14 (21)</td>
<td>11/16 (68.8%)</td>
<td>0/3 (0)</td>
<td></td>
</tr>
</tbody>
</table>

Treatment Outcomes
• Similar for patients receiving behavioral health treatment (69%) and occupational therapy (64%)
• Significantly lower positive outcomes (30%) for patients receiving only nutritional therapy
• Does not dismiss importance of collaborating with RDs during treatment
• ARFID treatment teams with RD show better long-term outcomes versus without
• RDs help guide food selection by families ensuring nutritional balance
• Therapists work from behavioral perspective to include these food options in regular eating repertoire
• Even one consultation with RD at start of treatment for ED is beneficial
• Special dietary needs present due to other medical conditions or dietary preferences

NUTRITIONAL THERAPY
• Not effective treatment alone for ARFID
• May provide notable patient benefits to eating disorder teams

INCORRECT REFERRALS AND DELAYS IN TREATMENT
• Referral to Behavioral Health, Nutritional Therapy, or Occupational Therapy not based on standard criteria
• Lack of pattern is a significant problem
• Inappropriate referrals (n = 16, 29%) lead to immediate referrals to other services after intake (Table 2)
• Struggle with diagnosis and management of symptoms by PCPs
• In-depth training in eating disorders by all PCPs not practical
• Training expense for one specific area not feasible for small health systems
• Short recorded lectures vs investing in rigorous training to improve PCP’s confidence and accuracy of screening
• Use of ARFID screeners
• Improved access to integrated behavioral health professionals

DISCUSSION

REFERENCES

FOR ADDITIONAL INFORMATION
Jia Jian Tin PhD; Sydney Green, BA; Sarah Long, PhD; Dawn Steffes AAS; Andrew Borgert PhD; Serina Johnson DNP, RN, PHN