BMJ Visual summary logo

Physical health complications in Avoidant Restrictive Food Intake Disorder (ARFID)

A systematic review and meta-analysis

Data

Inclusion criteria: All studies that contained one or more child or young person (CYP, <25 years old) diagnosed with ARFID that reported one of more physical health outcome as a result of ARFID.
Data extracted: Any data on the physical health complications associated with ARFID and any comparison populations (HC: healthy controls; or AN: Anorexia Nervosa)

6,407 abstracts screened

530 full texts screened

132 studies included

Key findings

1.

CYP with ARFID can present across the weight spectrum, highlighting ARFID is not an exclusively low-weight ED. However, the majority of CYP with ARFID are of healthy weight to underweight.

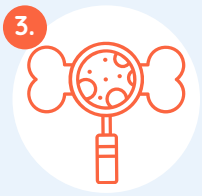
The prevalence of growth delay in ARFID is still relatively unknown with only 5 studies reporting it with a range of 1.4-51%.

2.

The prevalence of bradycardia was reported at between 4-53% and hypotension at ~2% in CYP with ARFID; consistently lower than what was reported in AN.

CYP with ARFID on average have higher heart rates than those with AN despite similar levels of underweight.

3.



CYP with ARFID are at risk of low bone mineral density; to similar levels seen in AN.

Low bone mineral density was found in CYP with ARFID across the weight spectrum. This is likely due to the high levels of nutritional deficiencies contributing to bone demineralisation.

4.

CYP with ARFID experienced less menstrual problems than those with AN, despite similar levels of underweight. The prevalence of amenorrhea in ARFID was reported at around 10%.

Puberty data is very thin, with no evidence found for pubertal delay in ARFID.

5.

Nutritional deficiencies are prevalent in CYP with ARFID across the weight spectrum.

There were also 22 cases of such severe nutritional deficiencies that lead to clinical disorders and irreversible damage (e.g. xeropthalamia, rickets and scurvy).

6.

Electrolyte abnormalities are common in ARFID with up to 75% prevalence reported.

Other medical complications mentioned in CYP with ARFID included: constipation, diarrhoea, syncope, dehydration, hypothermia and cognitive problems.

Take away

Individuals with ARFID are at risk of a number of critical physical health complications at all weights. Therefore, comprehensive medical assessments should be completed for every CYP with ARFID regardless of their weight status.

There are some key differences between ARFID and AN in terms of physical health risk; with one of the most significant being the higher heart rates and lower levels of cardiac disruption in ARFID compared to AN despite similar levels of underweight. This has important implications for using AN as a model or risk for ARFID and the use of the same risk-assessment approaches. Consequently, when working with CYP with ARFID more nuanced approach to risk should be taken instead of relying on weight cut-offs alone.