The two groups of children did not differ in terms of gender, insurance type, or program length of stay, but children in the AED group were about 2 years younger than their EOA counterparts (a mean age of 9.7 years vs. 11.4 years, respectively).

All eight children from minority background groups were in the atypical eating disorder group; the children in the AED group were more likely to come from single-parent households than those in the early onset anorexia group.

The two groups did not differ in terms of body mass index and most medical factors, but those in the EOA group were frequently in PANDAS OCD. Collapse, exercise, excessively, and have a family history of eating disorders, compared with the children in the AED group.

In addition, 88.9% of the children in the EOA group had weight loss compared with starting the treatment program, compared with about 50% of those in the AED group. Of the children who had weight loss, the mean loss was 19.7 pounds in the EOA group and 5.3 pounds in the AED group.

On the flip side, children in the AED group were more likely than their EOA counterparts to be depressed, their parents as having a history of picky eating, poor appetite, sensitivity to textures, slow eating, and difficulty swallowing.

Dr. Mehlenbeck said that the treatment implications differ for these two groups of children. “We would treat AED kids more behaviorally, similar to kids with anxiety and behavior disorders,” she said. “Treatment for kids with EOA would be similar to interventions for anorexia.”

Identifying children with food refusal problems early ‘may help quite a bit,’ she added. “Collaboration would be a key way for kids to need to be treated with a team format. So even if they’re an outpatient, pediatricians should be working with a mental health care provider in feeding or eating disorders, and a dietitian.”

Two Subtypes of Food Refusal in Preteens Found

PTSD Found in 16% of Teens A Year After Organ Transplant

BY TIMOTHY P. KIRN
Sacramento Bureau

LOS ANGELES — Adolescents who have experienced a significant, life-threatening illness can develop posttraumatic stress disorder, according to a study of 104 transplant patients.

The study found that 1 year after a transplant procedure, 16% of the patients met all criteria for a posttraumatic stress disorder (PTSD) diagnosis, and 14% met two of the three criteria, said Margaret L. Stuber, M.D., at the annual meeting of the Society for Adolescent Medicine.

Other studies have documented PTSD responses to childhood cancer, diabetes, and burns, said Dr. Stuber, professor of psychiatry at the University of California, Los Angeles.

The purpose of the current study was to try to tease out what specific factors lead to PTSD. Hence, the study included and compared kidney, heart, and liver transplant patients—that is, patients with very different courses and prognoses.

The study found the patients had similar risk factors for developing PTSD, regardless of the type of transplant the patients had had. The factors associated with an adolescent developing PTSD were multiple hospitalizations and the experience of an acute illness (rather than a chronic one), meaning it is uncertainty, anxiety, and what Dr. Stuber called “disruption of expectations” that triggers the PTSD reaction.

Demographics did not seem to play a significant role in determining risk for PTSD, he noted. Other studies have found that PTSD can have a negative impact on a patient’s compliance with his or her medical regimen. One report describing six non-compliant patients with PTSD indicated that treating them for PTSD improved their adherence to medical therapy.

Overall, the work in this field also suggests general anxiety level is an important predictor of the risk that an adolescent will develop PTSD. Dr. Stuber thus recommended focusing on general anxiety level as a risk factor for PTSD. “If it is essential we find out what the patient’s subjective experience is,” he said. “I would screen for anxiety”.

Symptoms of PTSD include recurrent and distressing recollections of the traumatic event, avoidance, and increased arousal. Avoidance may entail efforts to stay away from reminiscers of the event but can also manifest as an inability to recall important aspects of the event, diminished interest, and feelings of detachment from others, and a restricted range of affect. Features of increased arousal can be sleep problems, irritability, a lack of concentration, hypervigilance, and an exaggerated startle response.