

## Early-onset anorexia nervosa in prepubertal male twin: A case report

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### Abstract

#### BACKGROUND

Early-onset anorexia nervosa (EOAN), defined by onset before 14 years of age, represents a severe and complex subtype of anorexia nervosa (AN). It is characterized by persistent restriction of energy intake, significantly low body weight relative to age and height, intense fear of weight gain, and disturbed body image. Given that AN carries the highest mortality rate among psychiatric disorders, early recognition and prompt initiation of treatment are crucial, particularly in prepubertal children.

#### CASE SUMMARY

We describe a rare case of a 10-year-old prepubertal male twin admitted for inpatient psychiatric treatment following a 7-month history of progressive dietary restriction, marked weight loss, fear of weight gain, repetitive self-injurious abdominal behaviors, and disturbed body image. Comprehensive psychiatric assessment, psychological testing, and clinical observation led to a diagnosis of AN. Treatment included structured nutritional rehabilitation, restriction of physical activity, psychotherapy with active family involvement, and pharmacotherapy with sertraline (titrated to 100 mg/day) and olanzapine (titrated to 5 mg/day). During a 4-week hospitalization, the patient showed a reduction in obsessive preoccupations related to body shape and food restriction, with early signs of weight restoration.

#### CONCLUSION

This case highlights that AN can present with severe psychopathology in pre-

pubertal children and poses a serious challenge to medical professionals, underscoring the importance of early recognition and intensive, multidisciplinary inpatient treatment, including psychosocial interventions with active family involvement, to achieve meaningful clinical improvement.

**Key Words:** Early-onset anorexia nervosa; Eating disorders in children; Prepubertal anorexia nervosa; Child and adolescent psychiatry; Case report

**Core Tip:** Early-onset anorexia nervosa (EOAN), defined as onset before 14 years of age, is a rare but clinically significant condition that may present in prepubertal boys and remains underrecognized. This case report describes EOAN in a 10-year-old male twin with rapid weight loss and self-injurious behaviors, emphasizing that anorexia nervosa can manifest with significant psychopathology before adolescence. The case highlights the critical importance of early recognition and prompt implementation of intensive, multidisciplinary, family-centered treatment to mitigate long-term physical and developmental consequences.

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## INTRODUCTION

Anorexia nervosa (AN) is a severe, multifactorial eating disorder associated with the highest mortality rates among mental illnesses[1]. According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), AN is characterized by persistent restriction of energy intake relative to physiological requirements, resulting in significantly low body weight in the context of age, sex, developmental trajectory, and physical health. The disorder is further defined by an intense fear of weight gain or by persistent behaviors that interfere with weight restoration despite markedly low body weight[2]. AN most commonly emerges during adolescence, with peak incidence traditionally reported in this developmental period[3]. The disorder predominantly affects adolescent females aged 15-19 years, while its prevalence in males remains substantially lower[4]. The lifetime prevalence of AN is estimated to be up to 3.6% in women and 0.3% in men, with affected males exhibiting a six times higher mortality rate compared with the general population[5,6]. EOAN represents a distinct subclassification of AN, defined by onset of symptoms before 14 years of age and characterized by specific demographic, neuropsychological, and clinical features. EOAN (ORPHA 525738) is recognized as a rare disorder [1]. Given the high mortality associated with AN and the potential for severe developmental consequences in children, early recognition and prompt initiation of treatment are particularly critical in prepubertal children, in whom diagnosis may be delayed due to atypical presentation and lower clinical suspicion. Psychiatric comorbidities are common in pediatric eating disorders (ED) and may complicate treatment, often requiring integrated therapeutic approaches. Emerging evidence suggests that pharmacological agents, including selective serotonin reuptake inhibitors and atypical antipsychotics, may be used as adjunctive treatment in selected cases, particularly when significant anxiety, obsessive-compulsive features, or affective symptoms are present. However, the use of pharmacological interventions in children with ED remains complex due to limited evidence, age-related differences in neurodevelopment, and concerns regarding safety and tolerability, with variable effects on core ED psychopathology[7]. Here, we present the case of a 10-year-old prepubertal male twin admitted for inpatient psychiatric treatment following a seven-month history of progressive dietary restriction, marked weight loss, fear of weight gain, disturbed body image, and repetitive self-injurious abdominal behaviors.

## CASE PRESENTATION

### Chief complaints

A 10-year-old boy presented to the child and adolescent psychiatry unit with a seven-month history of progressive dietary restriction, marked weight loss, fear of weight gain, disturbed body image, and repetitive self-injurious abdominal behaviors.

### History of present illness

Following critical comments from relatives regarding his physical appearance, the patient began restricting the intake of sugary and carbohydrate-rich foods. Dietary restriction gradually extended to other food groups and ultimately progressed to near-complete food refusal, resulting in marked physical weakness. Concurrently, he developed excessive body-checking behaviors, including frequent mirror observation, and engaged in repetitive self-injurious behavior by striking his abdomen. These behaviors appeared to be driven primarily by body-related preoccupations and a distorted

perception of abdominal fat, rather than by suicidal intent, suggesting a combination of compulsive body-focused behavior and maladaptive emotional regulation. According to his parents, he became increasingly irritable and angry. Over a four-month period, the patient experienced a weight loss of approximately 9 kg, corresponding to a loss of 23.7% of his initial body weight.

### **History of past illness**

One month prior to the current admission, the patient had been hospitalized at another institution in a child and adolescent psychiatry unit for similar symptoms, where he completed a three-week inpatient treatment course. During that hospitalization, he was treated with sertraline 50 mg/day and olanzapine 1.25 mg/day. He also underwent a psychological assessment using projective techniques (House-Tree-Person, family drawing), which suggested possible anxiety, reduced energy levels, egocentric tendencies, and competitive dynamics with his twin brother. During that admission, his appetite improved and obsessive behaviors diminished; however, shortly after discharge, his symptoms relapsed, with recurrence of dietary restriction, avoidance of specific foods, discarding of food, and increased body-monitoring behaviors. The patient had no history of chronic medical conditions or head trauma.

### **Personal and family history**

The patient was born at 37 weeks' gestation from a dizygotic twin pregnancy *via* elective cesarean section, with a birth weight of 2555 g. His twin brother had a slightly lower birth weight of 2175 g but no significant perinatal complications, suggesting no major differences in early biological risk factors between them. Early developmental milestones were achieved within expected timeframes, and no feeding difficulties were reported in early childhood. Prior to illness onset, the patient's weight was 38 kg (between the 75<sup>th</sup> and 90<sup>th</sup> percentile), and overall growth parameters were reported by the parents to be within expected ranges, with no prior concerns regarding weight or height development. At the time of symptom onset, the twin brother's weight was 34 kg (between the 25<sup>th</sup> and 75<sup>th</sup> percentile) and his height was 141 cm (50<sup>th</sup> percentile), both appropriate for age. He maintained normal growth and developmental trajectories without evidence of eating-related symptoms, highlighting a divergence in clinical presentation despite a shared familial environment. At the age of 7 years, the patient was evaluated by a neurologist due to motor tics and was treated with tiapride, with a reported positive clinical response. No other formal psychiatric or psychological evaluations were conducted prior to the onset of the current symptoms. The patient demonstrated age-appropriate school functioning, with no significant academic or behavioral difficulties. According to parental report, there was no history of bullying or persistent peer-related stressors. He was described as more emotionally sensitive and particularly vulnerable to external evaluation, especially in response to comments regarding his physical appearance. From an early age, he also exhibited separation anxiety from his mother and multiple anxiety-related fears. He lives in a two-parent household with his mother, father, and twin brother. The patient maintains a positive relationship with his brother, exhibits imitative behavior, and shows occasional competitive tendencies. No family dynamics involving explicit comparison between the siblings were reported.

### **Physical examination**

The patient appeared asthenic. His body weight was 29 kg (between the 10<sup>th</sup> and 25<sup>th</sup> percentile), and his height was 141 cm (50<sup>th</sup> percentile), with a body mass index (BMI) of 14.6 kg/m<sup>2</sup>. Vital signs were within normal limits, including a body temperature of 36.6 °C, blood pressure of 100/60 mmHg, and a heart rate of 78 beats per minute. Abdominal examination revealed no tenderness, organomegaly, or abnormal bowel sounds. Pubertal development corresponded to Tanner stage I, consistent with prepubertal status.

Mental state examination: The patient appeared neatly dressed and appropriately groomed, with an appearance consistent with his chronological age. He was alert and fully oriented to person, time, and place. He was cooperative and readily engaged in verbal interaction, providing basic anamnestic information about himself, his family, and his environment. Speech was normal in rate, tone, and volume, with occasional disruption due to tearfulness. Cognitive functioning appeared age-appropriate. Eye contact was adequately maintained throughout the interview. His mood was markedly depressed, with a tearful affect and prominent anxiety. Thought processes were coherent, concrete, and of moderate pace. Psychomotor activity was mildly reduced. No abnormalities of thought content or perceptual disturbances were observed. Judgment was limited, particularly in relation to eating behaviors.

### **Laboratory examinations**

Complete blood count revealed leukopenia with neutropenia, which were interpreted as likely secondary to malnutrition and did not require specific intervention (Table 1). Biochemical blood analysis showed a slight elevation in phosphorus (1.47 mmol/L) and magnesium (0.85 mmol/L) levels (Table 2). Urinalysis, performed as part of routine medical evaluation to exclude underlying metabolic or renal abnormalities, was unremarkable (Table 3).

### **Imaging examinations**

No imaging studies were performed, as there were no clinical indications for radiological evaluation.

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## **FINAL DIAGNOSIS**

Based on the patient's reported symptoms, medical history, and clinical examination findings, a diagnosis of anorexia nervosa (F50.0) was established according to the International Classification of Diseases, Tenth Revision.

**Table 1 Complete blood count**

Parameter (unit)	Measured value	Reference range
White blood cells (10 <sup>9</sup> /L)	3.50	4.00-9.00
Lymphocytes (10 <sup>9</sup> /L)	1.54	0.76-3.4
Neutrophils (10 <sup>9</sup> /L)	1.68	2-7
Monocytes (10 <sup>9</sup> /L)	0.21	0.12-0.9
Eosinophils (10 <sup>9</sup> /L)	0.05	0-0.45
Basophils (10 <sup>9</sup> /L)	0.02	0-0.09
Red blood cells (10 <sup>12</sup> /L)	4.26	4-5.8
Hemoglobin (g/L)	120	120-160
Hematocrit (%)	36.8	36-50
Platelets (10 <sup>9</sup> /L)	185	180-350
Plateletcrit (%)	0.24	0.17-0.35

**Table 2 Biochemical blood analysis**

Parameter (unit)	Measured value	Reference range
Albumin (g/L)	48	38-54
Glucose (mmol/L)	4.5	3.3-5.6
Calcium (mmol/L)	2.35	2.2-2.7
Protein (g/L)	71	60-78
Creatinine (μmol/L)	54	29-56
Phosphorus (mmol/L)	1.47	0.81-1.45
Sodium (mmol/L)	140	136-145
Potassium (mmol/L)	4.4	3.5-5.1
Urea (mmol/L)	6.0	2.5-6.0
Magnesium (mmol/L)	0.85	0.70-0.80
ALT (U/L)	16	< 45
AST (U/L)	20	11-34
TSH (mU/L)	1.67	0.35-4.94
FT4 (pmol/L)	14.3	9.01-19.05
FT3 (pmol/L)	2.85	2.43-6.01

## TREATMENT

Pharmacological treatment was initiated with sertraline at a dose of 75 mg/day for the management of depressive symptoms, anxiety, and obsessive behaviors and was gradually titrated to 100 mg/day. Olanzapine was subsequently introduced at 2.5 mg/day and increased to 5 mg/day to address body image-related disturbances and support appetite improvement. Nonpharmacological management included structured nutritional rehabilitation, during which the patient was required to meet prescribed daily caloric intake targets through consumption of full main meal portions and multiple scheduled snacks. Nutritional rehabilitation followed a structured refeeding protocol with gradual caloric increase and regular monitoring of electrolytes and vital signs to minimize the risk of refeeding syndrome. Additional components comprised restriction of physical activity, individual psychological counseling, art therapy, and family-based therapy.

## OUTCOME AND FOLLOW-UP

During admission, the patient continued to exhibit obsessive preoccupations with body shape and food restriction,

Table 3 Urinalysis

Parameter (unit)	Measured value	Reference range
Bilirubin (μmol/L)	Negative	Negative
Urobilinogen (μmol/L)	Negative	Negative
Ketones (mmol/L)	Negative	Negative
Protein (g/L)	Negative	Negative
Nitrites	Negative	Negative
Glucose (mmol/L)	Negative	Negative
pH	6.0	5.0-7.5
Specific gravity	1.031	1.005-1.035
Leukocytes (/μL)	Negative	Negative
Color	Yellow	Light yellow
Clarity	Clear	Clear

accompanied by repetitive behaviors focused on the abdomen, including rubbing and occasional self-hitting. During the first week of hospitalization, he demonstrated marked resistance to food intake and required significant encouragement to complete meals. During the second week, gradual improvement in meal compliance was observed, with reduced negotiation around food and increased willingness to consume structured portions. By the third and fourth weeks, the patient was able to consume full meals with minimal resistance, accompanied by a progressive reduction in anxiety and obsessive preoccupations. His mood also improved, with increased emotional stability and decreased irritability. Although obsessive thoughts about food and body shape decreased in intensity, residual cognitive distortions remained at discharge. After four weeks of inpatient treatment, the patient was discharged home with a weight gain of 1.2 kg and was referred for continued outpatient follow-up with a child and adolescent psychiatrist. At discharge, his BMI had increased to 15.2 kg/m<sup>2</sup> and his weight-for-age corresponded to approximately the 25<sup>th</sup>-75<sup>th</sup> percentile. A structured outpatient follow-up plan was established, including regular psychiatric monitoring, continued family-based therapy, and nutritional supervision to reduce the risk of relapse.

## DISCUSSION

EOAN, defined as onset before the age of 14 years, represents a rare clinical presentation and remains insufficiently characterized, particularly in males. Epidemiological data indicate that while the overall incidence of AN has remained relatively stable over recent decades, the incidence among children younger than 15 years has increased, with rare cases documented as early as 8 years of age[1,8]. It remains unclear whether this trend reflects improved early detection or a genuine shift toward earlier manifestation of AN. A recent meta-analysis identified a peak age of onset at 15.5 years, reporting that 18% of patients are diagnosed by the age of 14 years and 55% by the age of 18 years, underscoring the clinical significance of very early presentations[9]. In Europe and North America, a younger age at onset has similarly been observed, accompanied by rising hospital admission rates among children under 15 years. Since the onset of the coronavirus disease 2019 pandemic, a 40% increase in early-onset ED has been reported in Europe, suggesting a further shift toward younger ages at presentation[10]. Nevertheless, EOAN remains uncommon, with reported incidence rates ranging from 1.1 to 7.5 per 100000[1].

AN predominantly affects females; however, sex differences appear less pronounced in younger age groups[11]. EOAN is characterized by a relatively higher proportion of affected males compared with typical adolescent-onset AN, although females remain predominantly affected in both forms[1]. While the overall male-to-female ratio in AN is approximately 1:10, ratios as narrow as 1:3 have been reported in early-onset cases[11]. Accordingly, the present case of a 10-year-old prepubertal boy aligns with existing literature suggesting that AN in males may present earlier in life and may be underrecognized[11,12].

Research on risk factors for AN has frequently used twin samples to clarify the relative contributions of genetic susceptibility, inherited traits, and environmental influences on ED development. Evidence from family, twin, and adoption studies supports a multifactorial model of ED etiology, in which vulnerability arises from the interaction between genetic predisposition and environmental exposures. Twin studies estimate the heritability of AN to range between 48% and 74%, while nonshared environmental factors are thought to account for approximately 17%-46% of the variance in risk for the disorder. Studies of twins discordant for AN are particularly informative, as they highlight how individuals with a shared genetic background may develop markedly different clinical outcomes. Such discordance has been associated with nonshared environmental influences, including individual life experiences, differences in peer relationships, exposure to weight-related comments, and variations in psychological coping mechanisms[13]. In the present case, the absence of eating-disorder symptoms in the patient's twin brother further supports the role of these

individual-specific environmental and psychological factors. Additionally, the reported imitative tendencies and competitive dynamics between the twins may have contributed to heightened sensitivity to external evaluation and body image concerns, potentially acting as amplifying factors in the development of disordered eating behaviors. Although both children shared a similar family environment, subtle differences in peer interactions, individual coping styles, and responses to parental or social feedback may have contributed to the discordant clinical presentation.

EOAN differs from typical adolescent- or adult-onset AN in several clinically relevant aspects. It more frequently presents with rapid weight loss - defined as a reduction exceeding 20% of total body weight within six months - or with growth failure rather than chronically low body mass index. EOAN is also associated with a higher risk of growth retardation and delayed pubertal development, as nutritional restriction may disrupt critical developmental periods[1]. In the present case, a significant weight loss exceeding 23% of the patient's initial body weight prompted inpatient evaluation and treatment. Collectively, these features underscore the need for clinicians to maintain a high index of suspicion for ED in young boys presenting with unexplained weight loss, food restriction, growth deviation, or body-focused repetitive behaviors. Notably, the patient's repetitive abdominal behaviors represent an unusual but clinically relevant manifestation. These behaviors may be conceptualized within a spectrum that includes compulsive body-checking, anxiety-driven self-soothing behaviors, or body-focused repetitive behaviors rather than classical self-injury. Body checking is a well-described behavioral component of ED psychopathology and has also been linked to obsessive-compulsive features, reflecting repetitive, anxiety-driven attempts to evaluate or control perceived body shape. Given their temporal association with weight-related preoccupations and emotional distress, it is plausible that these actions served a maladaptive regulatory function, aimed at reducing anxiety or modifying perceived body shape, rather than reflecting suicidal intent or primary self-harm pathology. This distinction is particularly important in pediatric populations, where symptom expression may differ from that observed in adolescents or adults[14,15].

Current recommendations emphasize early, individualized, multidisciplinary treatment for EOAN, including nutritional rehabilitation, medical monitoring, age-adapted psychological interventions, and active family involvement. Because child-specific evidence remains limited, most treatment approaches and Clinical Practice Guidelines are adapted from adolescent and adult AN protocols. Recent evidence suggests that second-generation antipsychotics and antidepressants may provide modest benefits in selected patients; however, their efficacy in targeting core ED psychopathology remains inconsistent. For example, olanzapine has been associated with some degree of weight gain in certain populations, although its effects on cognitive distortions and behavioral symptoms remain variable. Consequently, pharmacotherapy is not considered a primary treatment modality but may be used as an adjunct to address comorbid symptoms such as anxiety, affective dysregulation, and obsessive-compulsive features. In the present case, the use of sertraline and olanzapine was guided by the prominence of anxiety symptoms, obsessive preoccupations, and emotional dysregulation, and was implemented as part of a comprehensive multidisciplinary treatment approach rather than as a direct intervention for restrictive eating behavior[7]. Although the final doses may appear relatively high in relation to the patient's body weight, both medications were initiated at low doses and gradually titrated based on clinical response and tolerability. Medication doses were adjusted under close clinical monitoring, with good tolerability and no observed adverse effects. However, potential risks associated with pharmacological treatment in this population, including metabolic side effects and the limited evidence base, necessitate careful clinical judgment and close monitoring[16]. The importance of early intervention is underscored by the significant risks EOAN poses to physical development, including reduced bone mineral density and altered body composition. In adult men, AN has been associated with an increased fracture risk later in life[17]. Given the patient's prepubertal status, early nutritional rehabilitation and restriction of physical activity were clinically indicated to reduce the risk of long-term skeletal and metabolic complications.

Psychiatric comorbidity is frequently reported in children and adolescents with AN, with up to 97% presenting with at least one comorbid psychiatric condition[18]. In the present case, no formal comorbid psychiatric diagnoses were established during hospitalization; however, prominent anxiety symptoms and body-focused repetitive behaviors were observed in the context of weight-related preoccupations and disturbed body image. Depressive and anxiety symptoms were considered to be both secondary to malnutrition and reflective of underlying psychological vulnerability. Heightened psychological stress may contribute to these clinical manifestations by disrupting stress-response regulation, leading to alterations in appetite and energy balance. In this context, anxious and obsessive neurocognitive traits may promote restrictive and avoidant eating behaviors as maladaptive strategies for anxiety reduction, underscoring the clinical relevance of subthreshold psychopathology in EOAN[13].

A key strength of this case report is the detailed clinical characterization of a rare presentation of EOAN in a prepubertal male patient, distinguished by very early onset and the twin context. However, several limitations should be acknowledged. As a single case report, the findings are not generalizable. The absence of standardized psychometric measures limits quantitative assessment of symptom severity and treatment response. Furthermore, the relatively short duration of inpatient observation precludes conclusions regarding long-term outcomes, relapse risk, or sustained weight restoration.

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## CONCLUSION

Reports describing EOAN in prepubertal boys remain scarce. This case highlights the heterogeneity of early presentations and emphasizes the importance of considering ED in prepubertal males with restrictive eating, especially when accompanied by anxiety or atypical body-focused repetitive behaviors. The comprehensive assessment - including developmental history, psychiatric and somatic evaluation, laboratory investigations, and close monitoring of treatment response within a multidisciplinary inpatient setting - provides clinically relevant insight into this underrepresented

population. Given the patient's young age and developmental stage, psychosocial interventions with active family involvement were essential, underscoring the central role of caregivers in treatment engagement and recovery in EOAN. Pharmacological treatment may be considered as adjunctive therapy in selected cases to address comorbid symptoms, provided that it is carefully monitored. The discordant presentation in dizygotic twins highlights the potential contribution of nonshared environmental and psychological factors to disorder expression, even in individuals with similar familial backgrounds. Early recognition and timely, individualized intervention are critical to reducing the risk of long-term physical and psychological complications. Further research is needed to improve diagnostic approaches and treatment strategies for EOAN in underrepresented populations.

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## FOOTNOTES

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