Psychiatric Presentation of a Child With Crohn's Disease

To the Editor: Several cases of pediatric onset of Crohn's disease have presented with psychiatric symptoms, such as depression, anxiety, and abnormal eating behaviors.[1,2] These patients usually experience delay in diagnosis of the inflammatory bowel disease.[3] We describe a patient with weight loss and restrictive eating patterns who was admitted to the psychiatric ward and ultimately found to have Crohn's disease.

Case report. An 11-year-old boy presented to the emergency department in February 2009 for evaluation of a 6-month history of weight loss of 20 lb (25% of the patient's body weight). The patient reported diffuse abdominal pain associated with meals, early satiety, restrictive eating patterns, fatigue, and anxiety. On initial examination, the patient's weight was below the 10th percentile and his height was in the 25th percentile for age. Abdominal examination revealed no distention, tenderness, or guarding. He displayed anxiety at mealtimes, psychomotor agitation, and dysphoric mood without irritability and without suicidal ideation. He was admitted to the child psychiatric ward for further evaluation and management of presumed diagnosis of anorexia nervosa, restrictive type (based on *DSM-IV-TR* criteria).

The patient was previously diagnosed with *DSM-IV-TR* generalized anxiety disorder and had been under psychiatric care for several years. He was managed with psychotherapy and had been managed with several pharmacologic agents, including olanzapine and bupropion. He had developed a mild microcytic anemia over the months prior to presentation but had no other chronic medical disorders.

Sertraline 12.5 mg daily and clonazepam 0.25 mg at bedtime were initiated to manage the anxiety, and supervised mealtimes were implemented to observe and encourage caloric intake. The patient displayed less dysphoria and anxiety over several days, but reported persistent abdominal pain and anxiety at mealtime and continued losing weight despite taking in 3 meals daily (under staff supervision).

Laboratory evaluation revealed a microcytic anemia and an elevated erythrocyte sedimentation rate of 48 mm/h. The gastroenterology service was consulted, and colonoscopy demonstrated external skin tags, an anal fissure, exudates, and erythema at the terminal ileum. Colon and small bowel biopsy findings were consistent with Crohn's disease. Treatment with ciprofloxacin 500 mg and lansoprazole 30 mg was initiated. The patient was discharged to follow-up with his outpatient psychiatrist and with a comprehensive care plan for management of new-onset inflammatory bowel disease.

Inflammatory bowel diseases commonly cause postprandial abdominal pain. This recurrent pain may lead to fear of eating, food avoidance (restrictive eating patterns), and consequent weight loss. Restrictive eating patterns are also characteristic of anorexia nervosa. Physicians observing restrictive eating patterns in patients may not always look for the other characteristics of anorexia nervosa (such as fear of weight gain and body image disturbance) before making a presumptive diagnosis of anorexia nervosa.[4] This patient's prior diagnosis of generalized anxiety disorder (based on *DSM-IV-TR* criteria) most likely led the team to initially suspect a second psychiatric disorder as an explanation for the weight loss.[3] This reasoning delayed further diagnostic evaluation, resulting in delayed treatment of Crohn's disease.

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