Comments on: Eating disorders in children and adolescents

Dear Sir,

Tan *et al*.[1] presented a comprehensive review on eating disorders in children and adolescents. While eating disorders are the commonest causes of significant weight loss and restrictive dietary habits in paediatric patients, malignant disorders of the central nervous system should always be considered as differential diagnoses. The two cases described below are illustrative.

Case 1: An 11-year-old female presented with poor appetite and progressive weight loss of 10 kg over a period of 6 months. She was seen by a paediatrician and a psychiatrist and was treated as anorexia nervosa, but no improvement was found. Attempt to start nasogastric tube feeding resulted in repeated vomiting. When the central nervous system imaging revealed a suprasellar tumour, she came to Singapore for further management. On admission, her body weight was 15 kg (12 kg below the third centile), body height was 125 cm (3 cm below the third centile) and body mass index was 9.6 kg/m^2. Biopsy confirmed the diagnosis of suprasellar germinoma. Further investigations also detected panhypopituitarism with central diabetes insipidus. She responded to chemotherapy and cranial irradiation. At the end of the 6-month treatment, her body weight increased to 28 kg. She remained in complete remission at 14 years of follow-up. The case has been reported in part previously.[2]

Case 2: A 14-month-old male had been followed up for feeding difficulties and failure to thrive for 4 months. He was admitted to the hospital because of intermittent jerky eye movements. His body weight was 8 kg (0.5 kg below the third centile) and body length was 80.5 cm (75th centile). Magnetic resonance imaging identified a suprasellar–hypothalamic tumour that was subsequently confirmed to be pilocytic astrocytoma [Figure 1]. After chemotherapy, he gradually regained his appetite. A year later, his growth parameters were at 50th–75th centile for his age.

Diencephalic syndrome denotes the association of failure to thrive in infants and children with the presence of a neoplastic disease in the central part of the brain (diencephalon), the area around the third ventricle superior to the brainstem. A recent review depicts the typical cases as occurring in young infants with severe emaciation with no loss of appetite but some behavioural problems.[3] Case 2 falls into this category. However, subsequent atypical cases affecting older children with anorexic symptoms were reported. The latter cases are particularly confusing with anorexia nervosa or restrictive eating disorders as illustrated in Case 1. In diencephalic syndrome, neurological symptoms generally occur late. Hence, misdiagnosis by attribution error to an eating disorder is common. Once a diagnosis of eating disorder is anchored, the occurrence of new symptoms such as mood changes, behavioural issues and even vomiting may be readily ascribed to the eating problem.[4] Hence, clinicians managing children with eating disorders should always be alerted to the possibility of the potentially fatal diencephalic syndrome as a differential diagnosis.

Financial support and sponsorship

Nil.

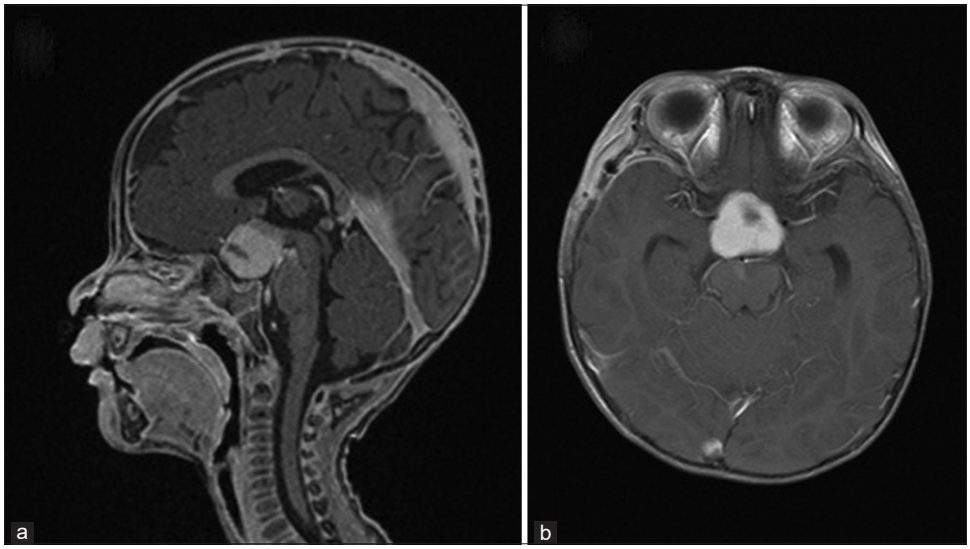

Figure 1: Magnetic resonance imaging in a 14-month-old male showing a gadolinium-enhanced tumour in the suprasellar and hypothalamic regions in (a) sagittal and (b) transverse views.

Conflicts of interest

There are no conflicts of interest.

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Received: 04 Oct 2022 **Accepted:** 11 Oct 2022 **Published:** 18 Nov 2022

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Quick Response Code:

Website: https://journals.lww.com/SMJ

DOI: 10.4103/SINGAPOREMEDJ.SMJ-2022-172

How to cite this article: Lee AC, Tan N, Tang KK, Ng I. Comments on: Eating disorders in children and adolescents. Singapore Med J 2022;63:632.