

## OPSOMANIA: A CASE OF UNSPECIFIED FEEDING AND EATING DISORDER

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### INTRODUCTION

Opsomania, or mania against a specific type of food, is an excessive and uncontrollable ambition to eat only one kind of food. This situation manifests itself in our psychiatric practice as an overwhelming and irresistible desire, especially for sugary foods or appetizers (Quackenbos 1901). This word originated in Ancient Greece. Fish at that time was of great commercial importance. An enthusiastic desire for fish consumption is accompanied by this situation, referred to as fish mania (Davidson 2018). Sugar mania is common in America and threatens young women's health (Adam 1892). It manifests itself with various diseases, including stomach complaints, indigestion, decreased cognitive functions, smelly breath, etc. (Quackenbos 1901). Here, we aimed to mention a patient who ate only sugary foods after her mother's death and had various medical conditions caused by this diet. Since there is not enough information about opsomania, we believe our case will contribute to the literature.

### CASE REPORT

A 53-year-old female patient was referred to the psychiatric outpatient clinic due to her primary care physician's suspicion of an eating disorder. The patient stated that he had a diet consisting only of cookies and cola after his mother died 14 years ago. She ate three biscuits and drank 1 cup of cola with a 200 cc glass three times a day in her diet. She did not consume any food or drink other than water on this diet. She rarely ate fruit or drank a glass of milk in the evening. Applying this diet was not because of disgust with any food or her weight or body dissatisfaction. On the contrary, she felt an irresistible desire for sweet foods when she was hungry. Our patient did not have bulimic or anorexic symptoms and dietary restrictions. According to her history, the 2-year marriage of the patient ended four years ago due to her spouse's infidelity. Currently, he lives with his sister and brother-in-law. She had been smoking one pack of cigarettes a day for twenty-nine years and not using alcohol or drugs.

According to the patient's medical history, she had an endotracheal stricture five years ago and was opened with an endotracheal stent. No family history of psychiatric disorders was reported. Shortness of breath, fatigue, lack of energy, weakness, headache, and dizziness was started five years ago. However, fatigue and weakness symptoms have worsened for the last two months.

According to the physical examination, she was cachectic and paled with abnormal pulmonary sounds, including stridor and wheezing. She was eager to interview with a distressing effect and a depressive mood. Her speech tone was slightly low with an average speed. No delusion, obsession, or suicidal thoughts were detected. Her intelligence and memory tests were normal. She had a constant weight of 97 lbs (44 kg) and a height of 5.18 ft (158 cm) with a low body mass index (BMI:17.6). The direct thorax roentgenogram revealed a slight increase in the cardiothoracic index (0.6) and moderate bronchiectasis of both lungs with an endotracheal stent. The biochemical tests revealed low serum ferritin and iron levels (2 ng/mL and 19 mcg/dL, respectively) with a high total iron-binding capacity (680 ug/dL), indicating a severe iron deficiency. The complete blood count demonstrated a microcytic iron deficiency anemia with a low red blood cell count (2.87 m/dL), low mean corpuscular volume (MCV:72.3 fL), and low hemoglobin levels (9.3 mg/dL). The beck anxiety scale was 12 (mild anxiety) with the Hamilton Depression Scale of 13 (mild depression).

The patient was taken into the hospital, forming multidisciplinary treatment. The iron depletion was initially corrected with intravenous iron therapy followed by oral iron replacement as maintenance for six months. Her endotracheal stent's aperture was consulted for cardiothoracic surgery, and there was no obstruction. A multivitamin supply was prescribed for her underfeeding and other possible vitamin deficiencies.

Psychoeducation was given on healthy nutrition. It was decided to apply supportive psychotherapy. The patient received 36 sessions of psychotherapy with weekly interviews. During psychotherapy, her first-period experiences and conflicts, the relationship between

consuming sweet foods and beverages after her mother's death, were discussed. After psychotherapy, the patient's awareness increased. She gained 5 kg in 6 months, reached 108 lbs (49 kg), and had a BMI of 19.6. The patient's depressive complaints regressed, and her self-confidence has regained. Written informed consent was taken from the patient to publish this study.

## DISCUSSION

Opsomania is a feeding and eating disorder that is not included explicitly in DSM-5 and can be considered unspecified feeding and eating disorder. It refers to an extreme addiction to only one kind of food. Our 53-year-old female patient presented with eating only sweet foods when she was hungry after her mother's death, not enjoying life, unhappiness, low energy, and low self-esteem. In routine blood tests and physical examination, vitamin deficiencies, anemia, and cachexia were observed due to the diet. Depressive disorder due to another medical condition with major depressive-like episode and opsomania (unspecified feeding or eating disorder) was considered.

The concept of Persistent Complex Bereavement Disorder (PCBD) has recently begun to be among the diagnostic and evaluation criteria. In DSM-5, the differential diagnosis mentions grief-related disorders in the major depressive episode section. It is included in Trauma- and Stressor-Related Disorders in the "Conditions for Further Study" section. In PCBD, missing a loved one due to separation, inability to accept and anger towards the situation, sleep disorders, depressive mood, guilt feelings, somatic complaints, and keeping the deceased's memories alive. As a result of all these, not enjoying life and a significant decrease in functionality can be described as symptoms. According to DSM-5, the diagnosis of PCBD can be made after 12 months of grief (American Psychiatric Association 2013, Li & Prigerson 2016). Our patient had a loss of energy, unhappiness, and fatigue, but it was thought that these were not due to her mother's death. She did not have a longing or guilt about her mother's death. She had accepted her mother's death and distributed her belongings to those in need. She had no sleep disturbances. Therefore, we excluded this diagnosis.

When the patient's low BMI is examined, anorexia nervosa is considered in the differential diagnosis. Anorexia nervosa is usually expected to begin during adolescence, and these people are afraid of gaining weight. There is a conscious restriction in energy intake or a great effort to lose energy. Body perception of the person is impaired (American Psychiatric Association 2013). On the other hand, our patient was not afraid of gaining weight, restricting energy intake, or experiencing an increase in inappropriate physical activity. She did not have any problems with body perception. Weight loss is involuntary due to her diet. For these reasons, we exclude the diagnosis of anorexia nervosa.

Avoidant/restrictive food intake disorder is observed in infants, children, adolescents and can rarely be seen in adults (Hay et al. 2017, Nakai et al. 2016, Norris et al. 2018, Tanaka et al. 2015). It is characterized by a lack of interest in food, anorexia, being affected by the sensory properties of food (taste, smell, shape, etc.), and fear of food intake's negative consequences (i.e., choking or vomiting). Weight loss and nutritional deficiency are seen (American Psychiatric Association 2013). Weight loss and nutritional deficiency in our patient were due to the diet she preferred. No aversion to food, avoidance of negative consequences related to eating, and indifference to food were observed. However, when she was hungry, she only preferred sweet foods. We excluded this diagnosis since diagnostic criteria for avoidant/restrictive food intake disorder were not met.

Major depression is a mental disorder characterized by unhappiness, loss of interest and desire for all activities, weight gain or loss despite not dieting, sleep disturbances, low energy, fatigue, hopelessness, thoughts of guilt, and occasional suicidal thoughts. In depressive disorder due to another medical condition, these depressive complaints are seen as another medical disease (American Psychiatric Association 2013). It is known that depressive complaints may occur due to iron deficiency anemia (Hidese et al. 2018, Lee et al. 2020, Shafi et al. 2018). Also, regression in depressive complaints can be observed with iron replacement (Lee et al. 2020, Maryam et al. 2020). Our patient has been using this diet for 14 years, but her depressive complaints have become unbearable recently. Our patient's iron deficiency probably deepened and led to depressive complaints. Oral iron supplementation continued after intravenous iron supplementation. Our patient was followed up without antidepressants. The depressive complaints of the patient resolved with psychotherapy and iron replacement therapy. Our diagnosis was depressive disorder due to another medical condition with major depressive-like episodes.

Opsomania refers to the inevitable desire for a particular type of food. In our patient, regardless of the fear of gaining weight, body perception, she preferred only sugary foods when she was hungry, although she did not feel distaste for other types of foods. The clinical condition of our patient was compatible with opsomania.

## CONCLUSION

Although opsomania is not included in DSM-5, it can be considered unspecified feeding and eating disorder. Opsomania is more common than it is thought in all societies. It is believed that these people do not apply psychiatry because they do not complain about this situation. However, they apply to different specialties, especially primary care physicians, because of other medical conditions caused by this diet. Therefore, clini-

cians should draw attention to opsomania and state that these patients should receive a multidisciplinary treatment and be evaluated by a psychiatrist. Although there are articles about opsomania in the clinic (Adam 1892, Quackenbos 1901), there is not enough literature on this subject. For the future, we need more information about why opsomania occurs, what complaints these patients present to doctors, and the treatment of this disease.

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### **Contribution of individual authors:**

All authors made equal contribution to this case report in terms of drafting, writing, obtaining the patient's consent, revising the paper and approved the final version of manuscript.

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