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BULIMIA NERVOSA & BINGE EATING DISORDER

This is an edited extract from ***'An expert's guide to eating disorders'*** by Dr Eric Johnson-Sabine, FRCPsych, published in **The Spectator**, 21 February 2015

All eating disorders are characterised by abnormal attitudes towards food that lead to a change in eating habits and behaviour. But eating disorders vary significantly in other ways.

We know that the main eating disorders are anorexia nervosa, bulimia nervosa and binge-eating disorder. But just what do we know about Bulimia Nervosa (BN) and Binge Eating Disorders (BED)? And what is the difference between these two?

Recognition in the medical community

Bulimia Nervosa was first described in the UK in 1979. It was not until 1980 that bulimia was given an entry in the Diagnostic Statistical Manual (DSM).

Binge eating behaviours entered the DSM in 1987, as part of the criteria for bulimia. Binge eating disorder (BED) was first recognized separately from bulimia in the DSM-IV, published in 1994.

Difference lies in purge behaviour

Binge eating is common to both BN and BED. People with bulimia nervosa have bouts of binge eating followed by compensatory purging, usually by laxative abuse or vomiting. Weight gain or loss may not therefore be evident.

In binge-eating disorder, individuals overeat in binges but do not purge. Those who binge eat regularly usually put on a great deal of weight.

Secret symptoms

The fact that people with bulimia nervosa can be of normal weight means symptoms often go unrecognised. The episodes of bingeing and vomiting frequently occur in secret.

Overlapping conditions

Eating disorders often overlap and people can start with symptoms of anorexia and later develop bulimic symptoms. Some people have an atypical eating disorder where they have some, but not all, of the typical features of bulimia.

The Bulimia Nervosa diagnosis

Using the intake of food as a means of coping with stress or mood disturbance is a shared characteristic of all the eating disorders. People with bulimia often have a phase of dieting but they cannot maintain it and eventually 'rebound' into binge eating. Binge eating can be provoked by stressful situations. The binge has an immediate anxiety-relieving effect, this, however, is quickly followed by anxiety about potential weight gain. That, in turn, is relieved by purging, through

vomiting or excessive laxative use. The diagnosis is made when these behaviours occur at least once per week.

The Binge Eating Disorder diagnosis

People are diagnosed with binge-eating disorder if they overeat in binges, on average, at least once a week for an extended period of at least three months. The binge occurs in a specific period of time when a large quantity of food is consumed. There are feelings of lack of control and, typically, the person feels guilty afterwards. While the triggers for the behaviour are often the same as for bulimia, the person with BED experiences further discomfort owing to additional perceived humiliation about weight gain. While depressed mood can occur with all eating disorders, it is particularly associated with binge-eating disorder.

Incidence BN vs Anorexia

Bulimia is around five times more common than anorexia and often develops at a slightly later age than anorexia, which usually first develops in the teenage years.

Binge eating seems to affect males and females equally and most commonly first appears in the thirties. Up to 50 per cent of patients undergoing bariatric surgery (gastric operations for weight loss) have binge-eating disorder.

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Complications of BN and BED

In bulimia the main complication is the biochemical abnormity that occurs as a result of purging, especially self-induced vomiting. The blood level of potassium falls and, as potassium is involved in its electrical conduction, this puts the heart at risk. If sufferers have hypokalaemia (low potassium), they can experience palpitations and there is a risk of cardiac arrest. In milder cases, the main complications of vomiting are the enlargement of the salivary glands in the cheeks (hamster cheeks) and tooth decay from stomach acid.

In binge-eating disorder the main complication is obesity with its own health risks.

Investigations

For bulimia, the blood electrolytes should be checked to exclude hypokalaemia.

For binge-eating disorder, a check should be made of medical causes of weight gain. Drugs such as steroids, anti-hypertensives, anti-psychotics and insulin can be associated with weight gain.

Treatment options

Bulimia is usually treated with cognitive behavioural therapy (CBT) and response to treatment is very favourable. More complex cases, especially where there are additional complicating mood or personality factors, require more specialised psychological treatment. In some areas CBT is available

through the GP but specialist psychological treatment is usually only available from specialist eating disorder units.

Binge-eating disorder can also be treated with CBT, often provided on a group basis. The binge eating responds well to psychological treatment but overweight is usually unaffected and will require management separately.

Medication may be used to treat bulimia or binge eating. An SSRI (selective serotonin reuptake inhibitor) can be a useful adjunct to psychological treatment.

What should you do if you are concerned about someone who may have an Eating Disorder?

For sufferers with bulimia there is often relief in disclosing the symptoms to an empathic and experienced professional. A good outcome is often linked with being in a non-judgmental, supportive relationship.

Relatives or carers can contact B-eat, a charity concerned with eating disorders, which can point them to support groups and services in their area. These groups offer general advice and specific support for families. There are also self-help books and websites that have useful information.

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