HAUTE AUTORITÉ DE SANTÉ

FFAB
Fédération Française Anorexie Boulimie
French Federation Anorexia Bulimia
(anciennement AFDAS-TCA)

BULIMIA NERVOSA AND BINGE EATING DISORDER

Initial assessment and initiation of treatment

June 2019

- Bulimia nervosa is characterized by episodes of binge eating (consumption of a large amount of food in a short period of time, accompanied by a feeling of being out of control) followed by inappropriate compensatory behaviours, such as: self-induced vomiting, misuse of laxatives, diuretics, or other medicines; fasting; excessive exercise. In addition, self-esteem is unduly influenced by physical appearance in these individuals. Bulimia sufferers usually have a normal body mass index (BMI) due to their compensatory behaviours.

- Binge eating disorder is characterised by recurrent episodes of binge eating, but without the inappropriate compensatory behaviour seen in bulimia nervosa. For this reason, binge eating disorder generally leads to high BMI (overweight or obesity). Binge eating causes significant distress.

INITIAL ASSESSMENT

- When a diagnosis of bulimia or binge eating disorder is considered, conduct an initial general clinical assessment, incorporating somatic – including dental –, nutritional and psychiatric aspects, if necessary, by health professionals from different specialist fields.
- Objective: to identify physical, nutritional, psychological (including suicidal) risks and social impacts.
- Approach the issue of eating disorders carefully, with empathy and kindness, with several consultations if necessary, bearing in mind how difficult it is for patients to talk about these types of problems (see toolkit guide on “How to talk about the issue”).

Investigate for the presence of the various components involved in bulimia or binge eating crisis

- Conditions:
  - occurrence: where, context, triggers (emotions, foods), when, how
  - amount and type of foods and drinks (polydipsia, alcohol abuse)
  - weight control strategies (purging behaviour, etc.)
- Frequency
- Associated guilt and shame
- Impact on body image: frequent dissatisfaction with weight, regardless of BMI
- Impact on sleep and mood (suicidal thoughts, particularly after a binge)
- Impact on social life and sexuality
- Professional and financial impact

Investigation of medical history

- Overweight/obesity and/or rapid weight changes, bariatric (weight loss) surgery
- Assault, mistreatment
- Individual and/or family history of psychiatric and addictive disorders (see Psychiatric assessment below)
- Individual and/or family history of eating disorders

Initial physical/somatic assessment

This must be as comprehensive as possible and include a complete dental exam and a gynaecological assessment.

- Assessment of height and weight: weight, height, calculation of BMI, recording on charts, determination of nutritional status (underweight, overweight, obesity)
- Assessment of impact of nutritional status in the event of underweight or obesity, if applicable
- Cardiovascular assessment: palpitations, chest pain, dyspnoea, blood pressure, pulse, ECG.
- Gastroenterological assessment: upper gastrointestinal tract disorders, abdominal pain, transit problems (diarrhoea/constipation), signs of gastrointestinal bleeding
- Dermatological assessment: scarring, Russell's sign, symptoms of malnutrition-related deficiencies (hair loss, brittle nails, angular cheilitis)
- Ophthalmological exam: subconjunctival haemorrhage (related to induced vomiting)
- Muscle assessment: fatigability, cramps, twitching
- ENT exam: salivary gland enlargement (related to vomiting), angular cheilitis
- Oral and dental exam: condition of teeth and mucous membranes for early detection and prevention of complications; to be repeated every 6 months in the event of vomiting
- Endocrine and gynaecological assessment: investigation of menstrual disturbances; for younger patients; investigation for presence of delayed puberty, gynaecological assessment with examination
- Initial laboratory workup (FBC, platelets, clotting, blood electrolytes, creatinine, alkaline reserve, fasting glucose). In the event of overweight or obesity, also conduct a metabolic assessment [1, 2]

Psychiatric assessment

- History of suicidal thoughts, suicide attempts
- Current suicidal thoughts[3], plan or intention to commit suicide
- Self-harm
- Impulsive behaviour
- Mood symptoms and disorders (depression and bipolar disorder)

[1] Overweight and obesity in adults: first-line medical management. HAS 2011: https://www.has-sante.fr/portail/jcms/c_964938/fr/sur-poids-et-obesite-de-l-adulte-prise-en-charge-medicale-de-premier-recours

[2] Overweight and obesity in children and adolescents. HAS 2011: https://www.has-sante.fr/portail/upload/docs/application/pdf/2011-10/reco2clics_obesite_enfant_adolescent.pdf

[3] Suicidal episodes: recognition and management: https://www.has-sante.fr/portail/jcms/c_271964/fr/la-crise-suicidaire-reconnaitre-et-prendre-en-charge;

Proposals concerning individual screening in children aged from 7 to 18 years, aimed at general practitioners, paediatricians and school doctors: https://www.has-sante.fr/portail/jcms/c_451142/fr/propositions-portant-sur-le-depistage-individuel-chez-l-enfant-de-7-a-18-ans-destinees-aux-medecins-generalistes-pediatres-et-medecins-scolaires

- Anxiety symptoms and disorders
- Obsessive compulsive symptoms and disorders
- Personality disorders (in particular, borderline personality disorder, especially in the case of self-harm or very severe forms of bulimia or binge eating disorder)
- Addictions, substance abuse
- Attention deficit hyperactivity disorder (ADHD)
- History of abuse (psychological, physical and sexual)
- Assessment of social impact of disorders (family, relationships, professional, or in young people in education/training)

SIGNS TO LOOK FOR ON THE INITIAL PHYSICAL ASSESSMENT
SPECIFIC COMPLICATIONS OF BINGING AND VOMITING EPISODES

Clinical signs	Paraclinical signs	Pathophysiological mechanisms
General presentation Calluses on the knuckles Enlarged salivary glands Dehydration Muscle weakness Poor dental status (decay, erosion, receding gums) Petechiae on the face, conjunctival haemorrhage	**Blood electrolytes** Hypokalaemia Hypochloraemia alkalosis (vomiting) Hypochloraemia acidosis (laxatives) Hyperamylasaemia	Vomiting (blood electrolyte disturbances can be exacerbated by laxative and/or diuretic use)
Cardiac and haemodynamic status Hypotension, palpitations	**ECG** Signs of hypokalaemia	Vomiting, laxatives, diuretics
Gastrointestinal system Enlarged parotid glands Sore throat Redness and ulceration of the throat Oesophagitis Gastritis Abdominal pain Transit disturbances Gastroesophageal reflux, oesophageal ulcer **More rarely:** Mallory-Weiss syndrome, oesophageal achalasia **In exceptional cases:** oesophageal rupture with mediastinitis (Boerhaave syndrome), acute dilation of the stomach or even gastric rupture, diarrhoea	Hyperamylasaemia (investigation not routinely indicated) with normal lipase levels	Vomiting
Kidney function	Functional kidney failure Tubulo-interstitial nephritis with type 1 tubular acidosis in the event of prolonged hypokalaemia End-stage kidney failure	Dehydration Chronic hypokalaemia (vomiting, diuretics)
Gynaecology Amenorrhea Oligomenorrhea, prolongation of menstrual cycle Ovulation disturbances Polycystic ovarian syndrome (associated syndrome)		Malnutrition disrupting the gonadotropic axis (vomiting)
Oral and dental sphere Dental enamel erosion, tooth decay		Vomiting

INITIATION OF TREATMENT

- Name the eating disorders, tactfully and without stigmatising.
- Provide information about the risks associated with the disorder (chronic nature, potentially serious short and long-term effects), which require long-term multidisciplinary treatment.
- Provide information about the possibilities of recovery with appropriate management.
- Explain the objectives of treatments:
  - to treat emotional disturbances and the associated psychological dimensions
  - to restore appropriate eating behaviour
  - to reduce episodes
  - broader therapeutic aims: somatic, psychological, social and relationship complications.
- Establish a therapeutic alliance: create a good quality relationship between the practitioner, the patient, and the family, including in adults. Motivational interviews are recommended in the event of difficulties committing to treatment.
- After detection, depending on the patient's abilities and needs, the practitioner may handle treatment or refer the patient to another health professional for specific management tailored to the patient's age.

ADDITIONAL INFORMATION FOR HEALTH PROFESSIONALS OR PARENTS AND FAMILIES

- Patient and family information documents and best practice guidelines for health professionals:
  - Bulimia Nervosa and Binge Eating Disorder guidelines. 2019 https://www.has-sante.fr/

- Free Anorexia-Bulimia information helpline in France on 0810 037 037: enables health professionals, patients and their families to contact health professionals or patient's associations for support or specific information

- National directory of eating disorder services: FFAB website (former AFDAS-TCA): www.ffab.fr

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This document presents the main points of the best practice guidelines on "Bulimia nervosa and binge eating disorder – Detection and general management information"
Clinical practice guidelines method – June 2019.
These recommendations and the scientific rationale can be consulted in full on www.has-sante.fr