HAUTE AUTORITÉ DE SANTÉ

FFAB
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BULIMIA NERVOSA AND BINGE EATING DISORDER

Somatic complications and their management

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- 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.

SOMATIC COMPLICATIONS AND THEIR MANAGEMENT

Complications	Causes	Recommendations
Metabolic: -hypokalaemia with cardiac and renal risks -hyponatraemia -dehydration -metabolic alkalosis -hyperkalaemia in the event of aldosterone antagonist diuretic use	Vomiting	Inform patients about the potentially serious consequences of vomiting (including dental, see end of table). Inform patients that it is necessary to take any oral medications well away from vomiting episodes (in particular, contraception, potassium, psychotropic drugs, antibiotics, etc.). Help patients to stop vomiting. Monitor potassium levels. ■ In the event of hypokalaemia: ◗ correct the hypokalaemia following current recommendations, ◗ prescribe oral potassium supplements to be adapted to the frequency of vomiting and taken away from vomiting episodes. In the event of frequent vomiting without demonstrated hypokalaemia, discuss potassium supplementation on a case-by-case basis as part of a shared decision with the patient (potassium supplements to be taken during more acute vomiting periods).
	Laxative misuse and use of enemas	Identify any laxative use, particularly in the event of unexplained fluid and electrolyte imbalances (hypokalaemia). Inform patients that taking laxatives does not help them lose weight because it does not significantly reduce calorie absorption and that the chronic use of these substances has harmful effects.

Complications	Causes	Recommendations
		In the event of the use of stimulant laxatives or enemas, inform patients about the adverse effects and help them stop using them. They must be discontinued gradually in the event of prolonged use.
	Use of diuretics	Identify any diuretic use, particularly in the event of unexplained fluid and electrolyte imbalances (hyponatraemia, hypokalaemia, dehydration, hyperkalaemia). Explain the risks of diuretic misuse and that they are ineffective for weight loss. Help patients gradually stop taking diuretics in the event of prolonged use.
Micronutrient deficiencies (vitamins and trace elements): vitamin B1, vitamin D, folates	Malnutrition	In situations with a risk of deficiency (in particular, vitamin B1 deficiency in the event of vomiting and vitamin B12 or folate deficiency in the event of a long-term vegetarian diet), look out for the presence of clinical symptoms of specific deficiencies. If these exist, perform laboratory tests and, if necessary, initiate appropriate supplementation.
Metabolic and cardiovascular risks: type 2 diabetes (T2D), dyslipidaemia, sleep apnoea syndrome	Overweight	Weigh patients regularly[1]. Manage overweight and obesity situations secondary to binge eating disorder and screen for associated complications, including type 2 diabetes.
Gastrointestinal: - enlarged salivary glands, eructation, nausea, dyspepsia, sore throat - redness and ulceration of the throat, epigastric pain, feeling of gastric fullness - oesophagitis, gastritis - gastroesophageal reflux (GORD), increased risk of oesophageal cancer - functional bowel disorders, abdominal pain, bloating, constipation - rectal prolapse and haemorrhoids **More rarely:** Mallory-Weiss syndrome (laceration of the walls of the oesophagus at the junction with the stomach), achalasia, Barrett's oesophagus, diarrhoea **In exceptional cases:** oesophageal rupture with mediastinitis (Boerhaave syndrome), acute dilation of the stomach or even gastric rupture, diarrhoea	Vomiting	In the event of gastroesophageal reflux (GORD) and/or frequent vomiting: ■ prescribe lifestyle and dietary measures, ■ prescribe proton pump inhibitors (PPIs), taking into consideration the individual benefit-risk balance and in consultation with the patient, ■ regularly reassess the benefits of maintaining the prescription
	Laxative misuse and use of enemas	In the event of severe constipation secondary to laxative misuse (either related to the toxic effects of simulant laxatives on the intestine, or reactive following the sudden discontinuation of laxatives), it is possible to prescribe first-line osmotic laxatives for a limited period in addition to lifestyle and dietary measures.
	Malnutrition	Watch out for, do not overlook and treat upper and lower gastrointestinal symptoms. These very common symptoms are a source of significant distress for patients and can be an obstacle to a return to balanced, appropriate eating habits. Inform patients that the majority of gastrointestinal disturbances are the consequences of their eating disorder and that treating the eating disorder will improve most of them. In the event of gastroesophageal reflux (GORD), prescribe lifestyle, dietary measures and PPIs.

[1] Overweight and obesity in adults: first-line medical management. HAS – September 2011.

Complications	Causes	Recommendations
Bone: osteopenia, osteoporosis	Malnutrition	Perform a bone mineralisation assessment by bone densitometry in: ■ female patients suffering from bulimia or binge eating disorder and with amenorrhea for at least 6 months in the absence of pregnancy, ■ patients suffering from bulimia or binge eating disorder with a history of anorexia nervosa, ■ patients with another risk factor for osteoporosis. During follow-up, perform another bone densitometry scan if risk factors persist or if any new risk factors later develop if this could theoretically lead to change in the patient's treatment. Monitor for and correct vitamin D deficiencies. Put in place lifestyle and dietary therapeutic measures in accordance with current guidelines for the management of osteoporosis.
Gynaeco-obstetric: - contraception, risky sexual behaviour - impact on fertility, pregnancy and the post-partum period	Vomiting, malnutrition	**Contraception** Explain to patients that oral contraceptives must be taken well away from vomiting episodes and that when there is amenorrhea this does not protect against a risk of pregnancy. In the event of very frequent vomiting in women taking oral contraception, suggest other contraceptive methods (intrauterine device, implant, contraceptive patch, condoms, etc.). **Risky sexual behaviour** In patients with eating disorders, particularly in the event of associated borderline personality disorder, look out for risky sexual behaviours, inform patients about the associated risks and methods of prevention and refer for gynaecological follow-up. **Wanting to become pregnant** Any woman with an eating disorder who wants to become pregnant should be informed about the consequences of eating disorders on fertility (risk of infertility) and the risks during pregnancy (miscarriages, premature delivery) and to the foetus (smallness for dates and perinatal mortality). Women must be given advice to increase the chances of becoming pregnant and limit the risks, in particular by maintaining an adequate nutritional intake and weight. In the event of a request for assisted reproduction technology in a patient with a known eating disorder and being treated, coordinated obstetric care along with follow-up of the eating disorder is recommended. **In women with a known eating disorder during pregnancy or the post-partum period** The perinatal period is a time of major physical and psychological changes and is therefore a highly vulnerable period for women with eating disorders. Regular, close, tailored monitoring of women with eating disorders is therefore important during the perinatal period. Systematically look out for depression during pregnancy and the post-partum period since the risk is increased. Refer patients with eating disorders for specialised multidisciplinary follow-up in coordination with obstetric care. Assess vitamin deficiencies and supplement if necessary (risks to the foetus). Continue multidisciplinary care for eating disorders after delivery, paying particular attention to the mother-baby relationship (diet and interactions). **Following gestational diabetes in women with an eating disorder**

Complications	Causes	Recommendations
		Following gestational diabetes, it is recommended that women be encouraged to continue their lifestyle changes (diet, physical activity for 30 to 60 minutes per day at least 5 days per week, cessation of smoking) since this helps reduce the development of type 2 diabetes.
Dental: extensive erosion damage, multiple dental caries, thermal sensitivity (to cold in particular) or to acids, periodontal disease, receding gums	Vomiting, rumination syndrome, gastroesophageal reflux, excessive tooth-brushing, nocturnal reflux, poorly balanced diet with high sugar intake and multiplication of sources (fizzy drinks, snacking) and disorganised eating rhythms	Provide specific dental hygiene advice to patients who vomit (do not brush teeth immediately after vomiting, rinse mouth with still water after a vomiting episode, avoid acidic foods [fruit, fruit juice, fizzy drinks, marinated products, yoghurts, alcohol], end meals with alkaline foods [milk or cheese]). It is recommended that patients who vomit undergo regular dental assessments with a dentist informed about their condition. It is recommended that teams managing eating disorders work closely with dental services to facilitate access to dental care. ▶ **For more information, see the guide on "Detection and management of dental problems by dentists".**

PATIENTS WITH TYPE 1 DIABETES

In the event of eating disorders in a diabetic patient:

- inform patients about the increased risk of acute and chronic glucose imbalance and its consequences: this risk of acute and chronic glucose imbalance and its consequences warrants very regular monitoring, increased vigilance and specific treatment of the eating disorder,
- put in place coordinated multidisciplinary care, involving a diabetes specialist and eating disorder specialists, focusing on somatic and psychiatric aspects,
- regularly screen for degenerative diabetes complications, which develop earlier and are more severe in patients with eating disorders (micro-angiopathy and, more specifically, diabetic retinopathy),
- watch out for insulin misuse (deliberate reduction of insulin doses with the aim of controlling weight).

BULIMIA TREATMENT: ROLE OF ENTERAL NUTRITION

- Weaning of bulimic crisis via enteral nasogastric tube feeding should be reserved for patients with severe disorders only,
- This method should only be used in a specialist hospital setting.

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