Bulimia in Adults: Information for Primary Care

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Summary: Bulimia nervosa is an eating disorder characterized by 1) binge eating, 2) purging behaviours such as self-induced vomiting and excess exercise, and 3) dysfunctional thoughts surrounding their weight and body shape. Patients with bulimia nervosa can easily be missed because patients appear normal (or overweight) and may not spontaneously report having symptoms of bulimia. Management of bulimia nervosa generally involves includes psychotherapy (such as CBT) and may include medications (SSRIs such as fluoxetine).

Epidemiology

- Prevalence among young females 1-1.5% (DSM-5)
- 10:1 F:M
- Primary care physicians may encounter more patients with bulimia nervosa than anorexia nervosa because of its higher prevalence (Sim LA et al., 2010)
- Up to 70% recover with treatment (Roscoe C. 2015)

Case

- D. is a 24-yo college student who is living away from home
- She presents to your office, complaining of problems with fatigue and menstrual symptoms
- She has had a stressful year, with a challenging workload, and relationship stresses as well as relationships (including a breakup with her boyfriend)
- Since the breakup, she has felt extremely lonely and inadequate
- She tells you she feels bloated and fat, and would like some help with being “healthier” and getting more exercise, in order to lose weight
- You ask her what strategies she has tried so far in order to lose weight, and she pauses uncomfortably…

Risk Factors

- Consider screening female patients who have the following risk factors

- Weight concerns
- Low self-esteem
- Depression/anxiety symptoms
- Obesity as a child and early pubertal maturation
- Family history of obesity
- History of sexual or physical abuse
- Certain occupations such as athletes, models, dancers

Clinical Presentation

- Due to shame and secretiveness, patients do not often openly report problems with bulimic symptoms, and the lack of obvious physical signs can similarly make it harder to be detected by professionals
- Patients may present to their physicians for other problems, such as:
  - Seeking help for weight loss
  - Physical symptoms
  - Weight gain/loss
  - Amenorrhea
  - Fatigue
  - Infertility
  - Bowel irregularities
  - Palpitations.
  - Mental health
  - Anxiety
  - Depression

Typical Signs/Symptoms

- Classic symptoms from bulimia nervosa include:
  - General – Dizziness, lightheaded, palpitations (due to dehydration, orthostatic hypotension, possibly hypokalemia)
  - Gastrointestinal symptoms - Pharyngeal irritation, abdominal pain (more common among persons who self-induce vomiting), blood in vomitus (from esophageal irritation and more rarely actual tears, which may be fatal), difficulty swallowing, bloating, flatulence, constipation, and obstipation
  - Pulmonary symptoms - Uncommonly aspiration pneumonitis or, more rarely, pneumomediastinum
  - Menstrual irregularities : Amenorrhea, or other problems with periods

Screening Questions

- **2-item screener**

  1. Do you ever eat in secret? (“Yes” is abnormal)
  2. Are you satisfied with your eating patterns? (“No” is abnormal)

  - Scoring: One abnormal response is 16% sensitive, whereas two positive responses is 91% sensitive; either warrants warrants further exploration (Freund, 1999).

- **5-items - The Eating Disorder Screen for Primary Care (ESP)**

  1. Are you satisfied with your eating patterns? (“No” is abnormal)
  2. Do you ever eat in secret? (“Yes” is abnormal)
  3. Does your weight affect the way you feel about yourself? (“Yes” is abnormal)
  4. Have any members of your family suffered with an eating disorder? (“Yes” is abnormal)

5. Do you currently suffer with or have you ever suffered in the past with an eating disorder? (“Yes” is abnormal)

- Scoring: A cutoff of 2 or more abnormal responses has been shown to be 100% sensitive with a specificity of 71%, and warrants further exploration (Cotton, 2003).

Diagnosis

- Essential features:
  - Recurrent episodes of binge eating
  - Recurrent inappropriate compensatory behaviours
  - Self-evaluation that is overly influenced by body shape and weight
  - Weight is typically within normal weight or overweight range

DSM-5 Criteria

1. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
   1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances
   2. A sense of lack of control over eating during the episode (feeling that one cannot stop eating or control what or how much one is eating)
2. Recurrent inappropriate compensatory behaviours in order to prevent weight gain, such as self-induced vomiting; misuse of laxative, diuretics, or other medications; fasting; or excessive exercise
3. The binge eating and inappropriate compensatory behaviours both occur, on average, at least once a week for 3 months
4. Self-evaluation is unduly influenced by body shape and weight
5. The disturbance does not occur exclusively during episodes of anorexia nervosa

Severity may be:

- Mild: 1-3 episodes of inappropriate compensatory behaviours / week
- Moderate: 4-7 episodes of inappropriate compensatory behaviours / week
- Severe: 8-13 episodes of inappropriate compensatory behaviours / week
- Extreme: 14+ episodes of inappropriate compensatory behaviours / week

Differential Diagnosis and Comorbid Conditions

Anorexia nervosa, binge-eating/purging type	Does the binge eating occur only during episodes of anorexia? If so, then consider anorexia nervosa, binge-eating/purging type
Binge-eating disorder	Is there binge eating, but without inappropriate compensatory behaviours? If so, consider binge-eating disorder
Klein-Levin syndrome	Is there disturbed eating behaviour, but without features such as concern with body shape and weight?
Borderline personality disorder	Does the patient report problems with borderline personality disorder? Fears of abandonment in relationships? Suicidal ideation and self-cutting?

Comorbidity

- Most patients with bulimia nervosa have at least one other mental health concern:

- Depressive disorders
- Anxiety disorders (esp. GAD and social phobia)
- Substance abuse (alcohol and stimulant use)
- Personality disorders (most commonly borderline personality disorder)
- Impulsivity/ risk-taking behaviours

Physical Exam

General appearance	Appears healthy Within a normal or overweight range Hoarse voice due to reflux Decreased concentration and mood changes
Vitals	May be normal
HEENT	Permanent loss of dental enamel (especially lingual surfaces of front teeth) Teeth may become chipped and ragged “moth eaten” May have increased frequency of dental caries Parotid gland enlargement
Cardiac	Arrhythmias (due to electrolyte abnormalities) Palpitations and hypertension (due to diet pills) Cardiomyopathy with the use of the emetic agent ‘Ipecac’
GI	Bloating and flatulence Constipation (due to laxative abuse) Hematemesis Esophagitis Reflux
Extremities	Russell’s sign: Calluses (or scars) on the knuckles or back of the hand due to repeated self-induced vomiting over long periods of time Peripheral edema
MSK	Muscle cramps (hypokalemia)
Gyne	Amenorrhea or oligomenorrhea

Investigations

- Bulimia nervosa is a clinical diagnosis, however, investigations may be helpful for evaluating medical complications
- Laboratory abnormalities may occur due to purging:
    - Fluid and electrolyte abnormalities – hypokalemia, hypochloremia, hyponatremia
    - Metabolic alkalosis (high serum bicarbonate) due to loss of gastric acid
    - Metabolic acidosis – frequent diarrhea or dehydration due to laxative and diuretic misuse
    - Slightly elevated serum amylase
    - Elevated BUN (dehydration)
    - Hypoglycaemia
    - Hypoestrogenism (associated with low bone mineral density)
    - Consider ECG for arrhythmias and echocardiogram for cardiomyopathy

Management: Overview

- Role of the primary care provider:
    - Assess medical complications

    - Monitor weight
    - Monitor nutrition status
    - Serve as care coordinator

- Treatment setting
    - Outpatient-based treatment is preferred and hospitalization is not necessary for most patients with bulimia nervosa

- Treatment modality
    - CBT combined with Fluoxetine treatment is superior to either treatment alone

Indications for Hospitalization for Bulimia

Criteria for inpatient hospitalization in bulimia include:

- Severe depression and suicidality
- Marked fluid and electrolyte imbalances
- Need for withdrawal from laxatives, diuretics, emetics, or diet pills;
- Significant substance abuse

Management: Psychological

Cognitive behaviour therapy (CBT) for Bulimia (Rushing JM et al., 2003):
3 phases in 20-week therapy

1. Education: help patients understand the disease and the actions perpetuating the situation with food records and binging/purging records
2. Broaden food choices and work on the dysfunctional thoughts concerning food and body
3. Maintenance and relapse prevention

Management: Medications

- SSRI
    - Fluoxetine (Bulimia Nervosa Collaborative Study Group, 1992)
        - Start at 10-20 mg daily, and titrate up to 60 mg daily
        - Maximum 60 mg daily
- Only drug approved by the FDA for the treatment of bulimia nervosa
- Decreases binge eating and vomiting (4 weeks of treatment)

When and Where To Refer

- Consider referring to an Eating Disorders Program or eating disorders specialist if:
    - Symptoms of the disorder are persistent
    - Comorbid psychiatric or medical illnesses
    - Risk of self-harm or harm to others

Case, Part 2

- You wonder if your patient might have problems with eating
- You screen further and she reveals that she copes with her stress through eating (e.g. eating a bag of potato chips, or a box of ice cream), however afterwards, feels extremely guilty

- As a result, she vomits several times a day (after meals or binges) and compulsively exercises at least 2-hrs a day
- You become worried about her eating behaviours, but stop yourself from lecturing her to stop binging
- You ask more about her stress and she tells you that she is so stressed, that she copes by eating
- You agree with her that indeed, she must be under incredible stress, if she is having to do what she is doing
- She breaks down crying, saying that nobody else understands this, and that all her family members criticize her
- You give her a Kleenex and after crying she tells you that she actually feels better having had a chance to let out her feelings
- Her vitals are normal, and she does not have any acute signs of dehydration or electrolyte imbalance that would make you acutely worried
- You schedule a follow-up for a week's time, at which time you will explore her symptoms further, continue with a motivational interviewing approach, and give her options...

Practice Guidelines

- APA Practice Guideline for the Treatment of Patients with Eating Disorders Third Edition. June 2006.
- Eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. NICE Guidelines [CG9], published Jan 2004.

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About this Document

Written by Talia Abecassis (Medical Student, Class of 2017) and Khizer Amin (Medical Student, Class of 2016). Reviewed by Dr. Dhiraj Aggarwal, along with members of the eMentalHealth.ca Primary Care Team, which includes Dr's M. St-Jean (family physician), E. Wooltorton (family physician), F. Motamedi (family physician), M. Cheng (psychiatrist).

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