Bulimia Nervosa

Bulimia nervosa affects about 1.6% of adolescent and young women and 0.5% of men of comparable age. Those affected are persistently and overly concerned about body shape and weight. Unlike patients with anorexia nervosa, those with bulimia nervosa are usually of normal weight.

Pathophysiology

Serious fluid and electrolyte disturbances, especially hypokalemia, occur occasionally. Very rarely, the stomach ruptures or the esophagus is torn during a binge, leading to life-threatening complications.

Because substantial weight loss does not occur, the serious nutritional deficiencies that occur with anorexia nervosa are not present. Cardiomyopathy may result from long-term abuse of syrup of ipecac to induce vomiting.

Symptoms and Signs

Patients typically describe binge-purge behavior. Binges involve rapid consumption of an amount of food definitely larger than most people would eat in a similar period of time under similar circumstances accompanied by feelings of loss of control.

Patients tend to consume high-calorie foods (eg, ice cream, cake). The amount of food consumed in a binge varies, sometimes involving thousands of calories. Binges tend to be episodic, are often triggered by psychosocial stress, may occur as often as several times a day, and are carried out in secret.

Binging is followed by purging: self-induced vomiting, use of laxatives or diuretics, excessive exercise, or fasting.

Patients are typically of normal weight; a minority is overweight or obese. Most symptoms and physical complications result from purging. Self-induced vomiting leads to erosion of dental enamel of the front teeth, painless parotid (salivary) gland enlargement, and an inflamed esophagus. Danger signs include

- Swollen parotid glands
- Scars on the knuckles (from induced vomiting)
- Dental erosion

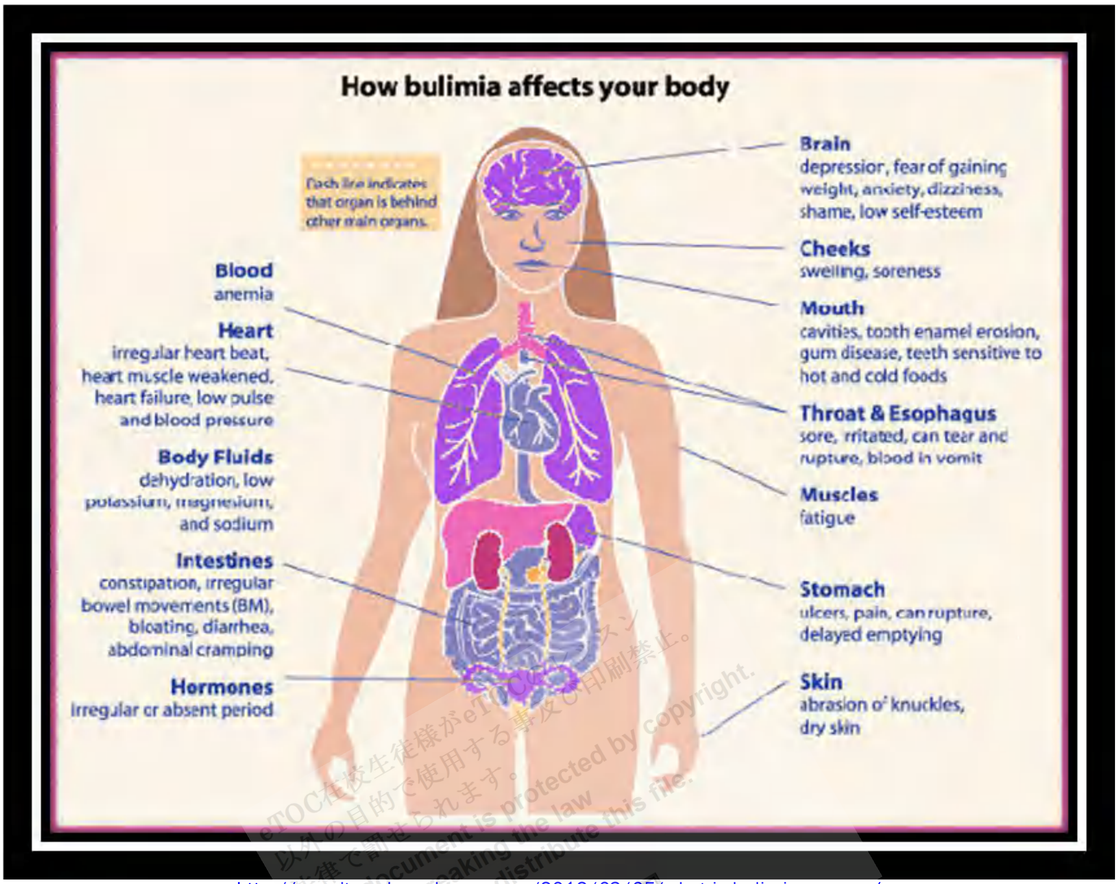
Patients with bulimia nervosa tend to be more aware of and remorseful or guilty about their behavior than those with anorexia nervosa and are more likely to acknowledge their concerns when questioned by a sympathetic physician. They also appear less introverted and more prone to impulsive behavior, drug and alcohol abuse, and overt depression.

Diagnosis

- Clinical criteria

Criteria for diagnosis include the following:

- Recurrent binge eating (the uncontrolled consumption of unusually large amounts of food) at least twice/wk for 3 mo
- Recurrent inappropriate compensatory behavior to influence body weight (at least twice/wk for 3 mo)
- Self-evaluation unduly influenced by body shape and weight concerns



http://emedtravel.wordpress.com/2012/03/05/what-is-bulimia-nervosa/

Treatment

- Cognitive-behavioral therapy (CBT)
- Interpersonal psychotherapy (IPT)
- SSRIs

CBT is the treatment of choice. Therapy usually involves 16 to 20 individual sessions over 4 to 5 mo, although it can also be done as group therapy. Treatment aims to increase motivation for change, replace dysfunctional dieting with a regular and flexible pattern of eating, decrease undue concern with body shape and weight, and prevent relapse. CBT eliminates binge eating and purging in about 30% to 50% of patients. Many others show improvement; some drop out of treatment or do not respond. Improvement is usually well-maintained over the long-term.

In IPT, the emphasis is on helping patients identify and alter current interpersonal problems that may be maintaining the eating disorder. The treatment is both nondirective and noninterpretive and does not focus directly on eating disorder symptoms. IPT can be considered an alternative when CBT is unavailable.

SSRIs used alone reduce the frequency of binge eating and vomiting, although long-term outcomes are unknown. SSRIs are also effective in treating comorbid anxiety and depression.

Reference: http://www.merckmanuals.com

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