03 - 15.3 Binge Eating Disorder and Other Eating D

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To be diagnosed with binge eating disorder the binges must be characterized by four features: (1) eating more rapidly than normal and to the point of being uncomfortably full, (2) eating large amounts of food even when not hungry, (3) eating alone, and (4) feeling guilty or otherwise upset about the episode. Binges must occur at least once a week for at least 3 months. The guidelines from the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders are presented in Table 15.3-1. Table 15.3-1 DSM-5 Diagnostic Criteria for Binge Eating Disorder

Approximately half of individuals with binge eating disorder are obese. Additionally, obese individuals with binge eating disorder have an earlier onset of obesity than those

without the disorder. Patients with binge eating disorder are also more likely to have an unstable weight history with frequent episodes of weight cycling (the gaining or losing of more than 10 kg). The disorder may be associated with insomnia, early menarche, neck or shoulder and lower back pain, chronic muscle pain, and metabolic disorders. Differential Diagnosis Binge eating disorder and bulimia nervosa share the same core feature of recurrent binge eating. Binge eating disorder is distinct from bulimia nervosa, however, in that binge eating disorder patients do not report recurrent compensatory behavior such as vomiting, laxative abuse, or excessive dieting. Binge eating disorder is distinct from anorexia nervosa in that patients do not exhibit an excessive drive for thinness and are of normal weight or are obese. The prevalence of binge eating disorder is higher in overweight populations (3 percent) than in the general population (approximately 2 percent). However there are some distinctions. Obese patients with binge eating disorder have a greater caloric intake during binging and nonbinging episodes, greater eating disorder pathology (i.e., more emotional eating, chaotic eating habits), and higher rates of comorbid psychiatric disorders. Binge eating disorder is also more prevalent in families than obesity. Course and Prognosis Little is known about the course of binge eating disorder. Severe obesity is a long-term effect in over 3 percent of patients with the disorder. One prospective study of women in the community with binge eating disorder suggested that by 5 years of follow-up fewer than one fifth of the sample still had clinically significant eating disorder symptoms. Treatment Psychotherapy. Cognitive-behavioral therapy (CBT) is the most effective psychological treatment for binge eating disorder. CBT has been shown to lead to decreases in binge eating and associated problems (e.g., depression); however, studies have not shown marked weight loss as a result of CBT, and CBT combined with psychopharmacological treatments such as selective serotonin reuptake inhibitors (SSRIs) show better results than CBT alone. Exercise has also shown a reduction in binge eating when combined with CBT. Interpersonal psychotherapy (IPT) has also shown to be effective in the treatment of binge eating disorder; however, therapy focuses more on the interpersonal problems that contribute to the disorder rather than disturbances in eating behavior. Self-Help Groups. Self-help groups such as Overeaters Anonymous (OA) have proven to be helpful in patients with binge eating disorder. For the treatment of moderate obesity, organizations such as Weight Watchers can be extremely helpful and

do not involve common fads or quick fixes. Psychopharmacotherapy. Symptoms of binge eating may benefit from medication treatment with several SSRIs, desipramine (Norpramin), imipramine (Tofranil), topiramate (Topamax), and sibutramine (Meridia). SSRI medications that have demonstrated improvement in mood as well as binge eating include fluvoxamine (Luvox), citalopram (Celexa), and sertraline (Zoloft). Some studies showed that highdose SSRI treatment (e.g., fluoxetine [Paxil] at 60 to 100 mg) often initially resulted in weight loss. However, the weight

loss was ordinarily short lived, even when medication was continued, and weight always returned when medication was discontinued. Amphetamine and amphetamine-like drugs may help but are of little use over the long term. Most, but not all, studies show that medication added to CBT is more effective than medication alone. For example, studies indicate that CBT did better than fluvoxamine or desipramine as a monotherapy for binge eating disorder; however, when CBT was used in combination with these agents, more improvement was seen in terms of weight loss compared with CBT alone. OTHER SPECIFIED FEEDING OR EATING DISORDER The diagnostic category of “other specified feeding or eating disorder” can be used for eating conditions that may cause significant distress but do not meet the full criteria for a classified eating disorder. Conditions included in this category include night eating syndrome, purging disorder, and subthreshold forms of anorexia nervosa, bulimia nervosa, and binge eating disorder. Night Eating Syndrome Night eating syndrome is characterized by the consumption of large amounts of food after the evening meal. Individuals generally have little appetite during the day and suffer from insomnia. Epidemiology. Night eating syndrome occurs in approximately 2 percent of the general population; however, it has a higher prevalence among patients with insomnia, obesity (10 to 15 percent), eating disorders, and other psychiatric disorders. The disorder usually begins in early adulthood. Etiology. Little is known about the cause of night eating disorder; however, the hormones melatonin, leptin, ghrelin, and cortisol have been studied in relation to the disorder. Night eating syndrome also appears to run in families; patients with night eating syndrome are five times more likely to have a first-degree relative with night eating syndrome. Diagnosis and Clinical Features

The diagnosis of night eating disorder includes recurrent episodes of hyperphagia or night eating; the lack of desire for food in the morning; and insomnia. Symptoms must persist for at least 3 months and cannot be secondary to another medical or mental condition. Patients with night eating syndrome usually consume a large portion of their daily calorie intake after the evening meal. They are also more likely to wake up during the night and to eat upon awakening. Nocturnal eating tends to occur during non-rapid eye movement (REM) sleep and is usually short in duration. Patients are also prone to low sleep efficiency. Patients believe that they can only sleep if they eat. Depressed mood is common among these patients, especially during the evening and night hours. Differential Diagnosis. Night eating disorder is common among patients with other eating disorders, particularly bulimia nervosa and binge eating disorder. Although night eating can be found in bulimia nervosa and binge eating disorder, it is the characteristic sign of night eating disorder. Also, the amount of food consumed during eating episodes is usually lower in night eating disorder than in bulimia nervosa and binge eating disorder. Unlike other eating disorders, patients with night eating syndrome are not overly concerned about body image and weight. Patients with night eating disorder are also at higher risk for obesity and metabolic syndrome. Sleep-related eating disorder is characterized by recurrent episodes of involuntary eating during the night. These episodes can lead to serious consequences such as the ingesting of nonedible foods or substances, dangerous behaviors while searching for or preparing food, and sleep-related injury. The eating episodes usually occur after the patient has gone to sleep and may occur while the patient is unconscious or asleep. Sleep-related eating disorder also has a high comorbidity with sleepwalking, restless leg syndrome, and obstructive sleep apnea, conditions that are rarely found among night eating syndrome patients. Episodes of sleep-related eating disorder have been reported after the use certain medications, including zolpidem (Ambien), triazolam (Halcion), olanzapine (Zyprexa), and risperidone (Risperdal). Course and Prognosis. The age of onset for night eating syndrome ranges from the late teens to late 20s and has a long-lasting course with periods of remission with treatment. Patients who experience poor sleep quality are more likely to develop diabetes, obesity,

hypertension, and cardiovascular disease. Treatment. Various studies have shown positive results in patients treated with SSRIs who showed improvement in nighttime awakenings, nocturnal eating, and postevening caloric intake. Weight loss and a reduction in nocturnal eating have been associated with an addition of topiramate to medication regimens. In patients with comorbid major depression and night eating syndrome, bright light therapy has shown to decrease depressed mood. CBT has also been helpful. Purging Disorder

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