BRIEF REPORT

MANAGEMENT OF BINGE EATING DISORDER

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KEYWORDS

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ABSTRACT

Binge eating disorder (BED) is a mental health condition characterized by recurrent episodes of consuming large amounts of food, in the absence of the compensatory behaviors seen in bulimia nervosa. Patients with BED often first present to primary care physicians (PCPs), who play a pivotal role in diagnosing and managing BED. BED is a complex condition that may require an interdisciplinary team for effective management. The first-line treatment with the most evidence is eating disorder–informed cognitive behavioral therapy. However, pharmacotherapy with an antidepressant (like a selective-serotonin reuptake inhibitor) or lisdexamfetamine (the only FDA-approved medications for BED) is a reasonable alternative for patients who prefer medications or have barriers to psychotherapy. PCPs must be equipped to address the comorbidities and consequences associated with BED with a comprehensive and evidence-informed approach.

INTRODUCTION

Binge eating disorder (BED) is a psychiatric condition that involves episodes of binge eating, defined as eating a larger amount of food than most people would eat within 2 hours, at least once a week on average for 3 months. These episodes involve a lack of control and distress related to eating behavior. To meet *Diagnostic and Statistical Manual of Mental Disorders. 5th ed. (DSM-5)* criteria, episodes must involve at least three of the following features: binge eating when not hungry, eating more rapidly than normal, eating until feeling uncomfortably full, eating alone or feeling embarrassed about eating, and feeling disgusted or guilty after a binge. To differentiate between BED and bulimia nervosa, it is essential to ask about compensatory behavior, including purging, using laxatives or diuretics, fasting, misusing prescription medication (eg, insulin, thyroid replacement), or exercising excessively. BED usually involves a long-term remitting and relapsing course.[1]

The goals of treatment for a patient with BED should be distinct from the treatment goals for obesity. While many patients meet the criteria for both, a patient with BED may have goals surrounding reducing the frequency or intensity of binge eating episodes in addition to losing weight. Some patients with BED may have a body mass index (BMI) in the healthy range and may want to prevent weight gain or not focus on their weight at all.[2]

A patient who meets the criteria for BED should be comprehensively assessed before establishing a treatment plan. In addition to asking about how often binge eating episodes occur and with what associated symptoms, history taking should gather information about the patient's weight and dieting history and the current pattern of eating outside of binge eating episodes. Common comorbidities should be assessed by collecting psychiatric history and measuring height and weight (to calculate BMI), waist circumference, blood pressure, fasting blood glucose, and cholesterol levels. It is appropriate to manage a patient with BED in the outpatient setting unless they have psychiatric comorbidities that require a higher level of care.

Psychotherapy alone has been shown to be more effective in the treatment of BED than pharmacotherapy alone. The first-line treatment for BED is eating disorder–focused cognitive-behavioral therapy (CBT), a 1C recommendation by the American Psychiatric Association.[3] A meta-analysis in 2010 found a large clinical effect in reducing binge eating behavior in patients receiving CBT or dialectical behavior therapy.[4] Interpersonal therapy has shown similar efficacy.[5] Self-help CBT that specifically addresses binge eating has been demonstrated as superior to controls and is a good option, especially to bridge care while waiting for alternative interventions with a higher level of evidence.[6-8] Family therapy has limited data but is a reasonable option, especially for pediatric patients. Behavioral weight loss therapy does not target binge eating but may be helpful for patients who are overweight or

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obese and may be used in combination with CBT. Other emerging options include emotion-focused therapy and physical exercise plus dietary therapy.[9,10]

Using medication for BED is a second-line option but may be a reasonable first-line option in patients who prefer pharmacotherapy (eg, less time commitment, lower costs, limited access to psychotherapy). Medications that have been studied for BED include antidepressants like selective-serotonin reuptake inhibitors (SSRIs), lisdexamfetamine, antiepileptics (eg, topiramate, zonisamide), methylphenidate, atomoxetine, and modafinil.[10] Using an antidepressant or lisdexamfetamine for patients who did not respond to psychotherapy or in patients who prefer medication is a 2C suggestion by the American Psychiatric Association.[3] SSRIs have shown a small clinically significant effect in a meta-analysis of randomized controlled trials.[12] SSRIs can be prescribed for BED with similar doses as what is prescribed for major depressive disorder and are typically preferred over other agents, which are associated with more side effects.[2]

Lisdexamfetamine is the first FDA-approved treatment of BED in adults.[13] Though there have not been any investigations directly comparing efficacy to SSRIs, lisdexamfetamine has shown modest short-term effects in BED. Sold under the brand name Vyvanse, this stimulant acts as a dopamine and norepinephrine reuptake inhibitor and releaser. It reverses the theoretical shift occurring in BED when reward-related feedback from impulsive eating becomes a compulsive habit. It is also indicated for attention-deficit hyperactivity disorder (ADHD) and used off label for treatment-resistant depression. The starting dose of lisdexamfetamine for BED is 30 mg/day, which can be increased by 20 mg per week to a target dose of 50 to 70 mg/day. Patients may see immediate effects following the first dose, but a full effect may not be seen until several weeks later. Potential side effects include tremors, nausea, insomnia, headache, and irritability. Dangerous adverse effects include psychosis, seizures, tachycardia, and hypertension. Lisdexamfetamine should not be used in patients with preexisting hypertension and could cause sudden death in patients with preexisting cardiac structural abnormalities. If side effects occur, consider adjusting the dose, switching to another agent, changing the timing of the dose, or adding an augmenting agent like a beta-blocker (for tachycardia or hypertension). As a schedule II drug, patients may develop dependence or start to misuse lisdexamfetamine.[14]

One randomized placebo-controlled crossover trial showed the efficacy of phentermine/topiramate, but topiramate is known to cause significant side effects, like cognitive dysfunction, even at low doses.[15] Glucagon-like peptide-1 (GLP-1) receptor agonists, medications used to treat diabetes mellitus, activate the GLP-1 receptor to reduce food intake, lower body weight, and stimulate insulin secretion. Observational studies have shown the benefit of decreasing episodes of binge eating, but there have not been any randomized controlled trials to demonstrate safety or efficacy in treating BED.[16-18] In a randomized trial, treatment with naltrexone/bupropion after acute treatment of BED has been shown to lead to higher rates of remission, but the results were not statistically significant.[19] There is also growing evidence showing the benefits of neuromodulation in patients with BED.[20]

The treatment team may involve a PCP, therapist (for psychotherapy), psychiatrist (for management of severe psychiatric comorbidity or referral for medication management if needed), and registered dietician (for behavioral weight loss therapy). In the United States, only about half of patients with BED seek treatment, partly due to stigma, shame, and a lack of awareness about BED.[21,22] PCPs hold a vital role in making the diagnosis of BED, assessing for comorbidities, prescribing medication, coordinating referrals (if applicable), and managing the medical consequences of BED.

LITERATURE SEARCH AND DATA SOURCES

Sources were found by searching "binge eating disorder" on PubMed, Cochrane Library, ACESSSS, ECRI Guidelines, and Up to Date in May-July, 2024, using a filter for publications in the last 5 years (2019-2024).

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