



Original Article

Sleep-related eating disorder: a descriptive study in Chilean patients



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ABSTRACT

Objectives: We aimed to describe a group of adults diagnosed with sleep-related eating disorder (SRED) at the Sleep Medicine Center of the Pontificia Universidad Católica de Chile.

Methods: We performed a descriptive study of 34 consecutive patients who met the criteria of the *International Classification of Sleep Disorders* for SRED evaluated during a 3-year period who did not have an eating disorder according to the criteria of the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition. All patients had a structured clinical interview performed by a sleep specialist and completed the Beck Depression Inventory (BDI). Polysomnography (PSG) was performed when clinically indicated for ruling out other sleep-related disorders (18 patients; 52.9%). Patients' demographic and clinical data, comorbidities, and treatment response also were analyzed.

Results: Most patients were women ($n = 23$; 67.6%). The average age at the time of diagnosis was 39 ± 13.8 (17–67 years) and the latency since symptom onset was 8.3 ± 8.8 years. Most patients had several episodes per night (average, 2.6 ± 1.6 ; 1–8) and all except one patient had partial or total amnesia of these events ($n = 33$; 97%). Comorbidities were frequent and included insomnia ($n = 20$; 58.8%), restless legs syndrome (RLS) ($n = 16$; 47%), sleep-disordered breathing (SDB) ($n = 9$; 26%), psychiatric disorders ($n = 13$; 38.2%), and overweight or obesity ($n = 14$; 41.1%). Most patients were hypnotic users ($n = 21$; 61.7%) and reported weight-centered anxiety ($n = 23$; 67.6%). Twenty patients (58.8%) were treated with topiramate, 17 of whom had adequate symptomatic responses.

Conclusion: Our SRED patients showed female preponderance, amnesia during the episodes, association with other sleep disorders, use of hypnotics, weight-centered anxiety, and positive response to topiramate. The presence of anxiety focused on weight in most patients may be an important element in the emergence of this behavior during sleep.

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1. Introduction

Sleep-related eating disorder (SRED) is a parasomnia which was first described in 1991 [1,2]. The prevalence of SRED in the general population is not well-established but has been estimated between 1% and 5% in adults; however, it could be as high as 16.7% in patients who have eating disorders [3]. This most likely underdiagnosed condition is characterized by recurrent episodes of compulsive and involuntary eating and drinking at night after falling asleep, which frequently occurs during the first half of the night. Usually patients eat highly caloric food, including inedible and unusual meal combinations, or even substances like cigarettes or cologne. Weight gain and gastrointestinal disturbances can be seen as consequences of this behavior, and patients also can get injured during the careless preparation and consumption of food. SRED generally starts in young adults, with a female predominance

[4,5]. Symptoms take a chronic course and the diagnosis is clinical. The pathophysiology of SRED is unknown, though it has been suggested that the dopaminergic system might be involved or that a genetic predisposition could exist [3]. SRED can be induced by several drugs (e.g., hypnotics), such as zolpidem, tricyclic antidepressant agents, anticholinergic agents, lithium, olanzapine, quetiapine, and risperidone [5–12]. Most SRED patients have other concomitant sleep disorders, like restless legs syndrome (RLS), obstructive sleep apnea (OSA), and sleepwalking, among others [4,13,14]. In our study, we present the clinical findings in a prospective series of 34 consecutive patients diagnosed with SRED, evaluated at the Sleep Disorders Clinic of the Pontificia Universidad Católica de Chile between June 2005 and May 2010.

2. Methods

We performed a prospective observational study of consecutive SRED patients treated at the Sleep Disorders Clinic of the Pontificia Universidad Católica de Chile between 2005 and 2010. The study was reviewed and approved by the institutional ethics committee.

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All patients who met the criteria of the *International Classification of Sleep Disorders* for SRED were included. We excluded patients with a previous diagnosis or history compatible with other eating disorders included in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, classifications (e.g., bulimia nervosa, anorexia nervosa). Patients who had evening hyperphagia with full awareness during their eating, complete recall, and ingestion of usual foods only before a sleep period were considered to have night eating syndrome (NES) and were not included in our study. All patients had a structured clinical interview, which included a sleep disorders evaluation and a psychiatric assessment; the Beck Depression Inventory (BDI), which was adapted into Spanish and validated by Bonilla et al. [15], was used for each patient. Patients also had a general physical and neurologic examination performed. Patients with symptoms suggestive of sleep-disordered breathing or periodic limb movements were studied with polysomnography (PSG). We also recorded demographic and clinical characteristics, comorbidities, and therapies used.

3. Results

A total of 34 consecutive patients with SRED evaluated at the Pontificia Universidad Católica de Chile Sleep Disorders Clinic between June 2005 and May 2010 met the diagnostic criteria for SRED. Seven patients (20.6%) were interviewed with spouses (five cases) or parents (two cases).

3.1. General characteristics

Table 1 shows the main demographic and clinical characteristics of the group. There was a clear predominance of women (67.6%). Most patients (56%) started SRED episodes as adolescents or in early adulthood. The average age at the time of the diagnosis was 39.0 years (range, 17–67 years) and the delay to the diagnosis

Table 1
Clinical and demographic characteristics of the patients.

Characteristics	
Sex	
Men	11 (32.3%)
Women	23 (67.6%)
Age (y)	39.0 ± 13.8 (17–67)
BMI (kg/m ²)	25.5 ± 4.3 (18–34)
Nighttime ingestion frequency	Every night*
No. of episodes per night	
1	10 (29.4%)
2–5	20 (58.8%)
>5	4 (11.7%)
Family history with SRED	2 (5.9%)
Amnesia of the episodes	
With amnesia	33 (97.1%)
Without amnesia**	1 (2.9%)
Partial in all	17 (50%)
Total in all	9 (26.4%)
Partial or total	7 (20.5%)
Weight gain	23 (67.6%)
Diagnosis latency (y)	8.3 ± 8.8 (0–37)
Medication	21
Benzodiazepines	13 (61.9%)
Other hypnotics	15 (71.4%)

Abbreviations: y, years; BMI, body mass index; No., number; SRED, sleep-related eating disorder.

Data are shown in numbers and percentages, except age and BMI, which are shown as average values, standard deviations, and ranges.

Medication use is expressed as percentage of the total number of patients on medication.

* One patient (woman) only had 3 ingestion episodes a month.

** One patient (woman) did not have amnesia of any of the ingestion episodes.

was 8.3 years (range, 0–37 years), according to the information provided by the patients. Two-thirds of the patients ($n = 23$; 67.6%) reported anxiety regarding their weight. At diagnosis, 6 patients (18.7%) were obese (body mass index ≥ 30 kg/m²); and another 8 (23.5%) were overweight (body mass index between 25 and 30 kg/m²). Two of the obese patients had undergone bariatric surgery before SRED diagnosis. Both of these patients had significant increase in weight after SRED onset, though both were previously overweight.

3.2. Episode characteristics

No patient had ever specifically consulted for night-eating episodes and only sought consultation after seeing reports on SRED in the media. Almost all patients ($n = 32$; 94.1%) reported more than one eating episode per night. All but one patient had amnesia of the episodes, which was either always partial ($n = 17$; 50%), always complete (9/34; 26.4%), or partial in some episodes and total in others in 20.5% ($n = 7$).

3.3. Use of hypnotics and amnesia

Twenty three patients (67.6%) used hypnotics (benzodiazepines only [$n = 5$], benzodiazepine receptor agonists only [$n = 4$], and a mix of both [$n = 14$]). In 4 of these patients there was a clear temporal relation between the SRED onset and the use of benzodiazepine receptor agonists, in two cases as the sole medication and in the other 2 after adding them to benzodiazepines. All patients under hypnotics had amnesia of the episodes, either complete ($n = 14$; 60.8%) or partial ($n = 9$; 39.2%). Patients who did not use hypnotics mainly had partial amnesia during the episodes ($n = 7$; 64%), though two patients had complete amnesia episodes ($n = 2$; 18%). One patient from this group had no amnesia.

3.4. Other medications

Several other medications were used by SRED patients, which included selective serotonin reuptake inhibitors, trazodone, melatonin, quetiapine, cyclobenzaprine, pregabalin, gabapentin, thyroid hormone replacement, and antidiabetic and antihypertensive agents.

3.5. Comorbidities

All but one patient ($n = 33$; 97%) had one or more additional sleep disorder (Table 2). Other comorbidities also are listed in Table 2. Depression also was a common comorbidity ($n = 13$; 38.2%). The BDI scale in these latter patients was 11.1 ± 7.45 , with

Table 2
Comorbidities.

Associated sleep disorders	33
Insomnia	20 (58.8%)
PSG-documented OSA	9 (26%)
RLS	16 (47%)
Sleepwalking	4 (11.7%)
Night terrors	1 (2.9%)
Bruxism	6 (17.6%)
Medical comorbidities	
Type 2 diabetes mellitus	4 (11.7%)
Thyroid disease*	3 (8.8%)
Psychiatric comorbidities	
Depression	13 (38.2%)

Abbreviations: PSG, polysomnography; OSA, obstructive sleep apnea; RLS, restless legs syndrome.

Data are shown in numbers and percentages.

* Chronic autoimmune thyroiditis.

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