Bulimia: Condition or Side Effect?

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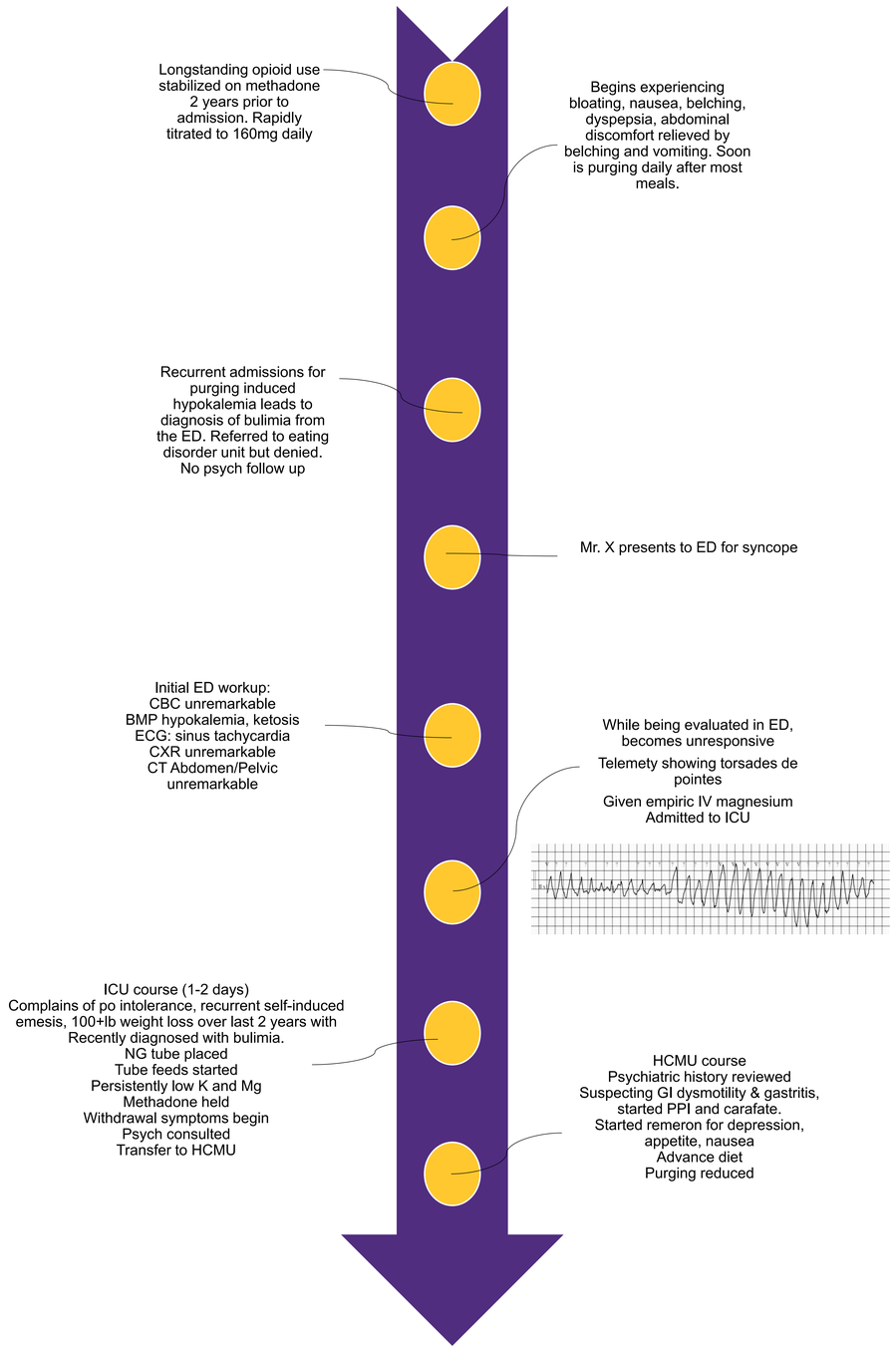
CASE SUMMARY

A 33-year-old male presented to the hospital for recurrent syncope for one week. His past medical history was significant for opioid use disorder on methadone, and a historical diagnosis of bulimia due to purging behaviors. While in the emergency department, the patient had a witnessed syncopal episode. Telemetry indicated that the patient was in torsade de pointes, and he was immediately loaded with magnesium with resolution of his arrhythmia. He was admitted to the Intensive Care Unit for further management. His workup was notable for a significantly prolonged qTC of 680, and multiple electrolyte and metabolic abnormalities. Concern was brought up for the patient's eating disorder being the cause of his presentation; thus, psychiatry was consulted. The patient reported substantial weight loss of about 120 lbs over the preceding two years due to his purging behaviors but denied other symptoms of bulimia such as concerns with weight or body dysmorphia. Further questioning revealed that for the last two years, the patient had persistent sensations of bloating, belching, indigestion that was only relieved by purging which ultimately became compulsive. History revealed that as his dose of methadone had increased, so too did his upper gastrointestinal symptoms and purging behaviors. In the two weeks prior to admission, his dose had been increased to 160 mg coinciding with nearly continuous purging. GI was consulted for endoscopy and deferred to outpatient. Methadone was tapered, a PPI and carafate were started for suspected gastritis, and Remeron for his depression and appetite stimulation with significant improvement. Given improvement and methadone dose-dependent GI distress, patient likely suffering from opioid induced bowel dysmotility causing gastritis. With discontinuation of methadone, he achieved resolution of his symptoms and remission of his purging.

OPIOID INDUCED BOWEL DYSFUNCTION

- Constipation and other gastrointestinal issues caused by opioid use
- Prevalence varies, but estimates 40-90% of patients on chronic opioids
- Opioids act on mu receptors centrally for analgesia but also act on peripheral receptors located diffusely along the GI tract. Peripheral effects include gut dysmotility, increased fluid absorption, disrupted peristalsis, etc
- Clinical symptoms go beyond constipation and include abdominal pain, bloating, dysphagia, incomplete evacuation, malabsorption, reflux, and more
- Appropriate management of OIBD can improve patient's quality of life and prevent complications
- Prevention and education are key: hydration, movement, fiber, stool softeners, stimulants, osmotic laxatives, lubricants
- Opioid antagonists only block the peripheral receptors: Methylnaltrexone & Naloxegol
- Secretagogues act on intestinal chloride channels to increase stool water content: Lubiprostone & Linaclotide

HOSPITAL COURSE



DISCUSSION

- This patient had severe opioid induced bowel dysfunction that was misdiagnosed as bulimia. He was on high doses of methadone that caused symptoms of gastritis and dysmotility. Purging relieved his GI symptoms and caused further malnourishment and electrolyte derangements which, in combination with prolonged Qt interval likely due to methadone, led to the development of arrythmias and syncope.
- Biases, namely anchoring, may have played a role in delayed recognition of his condition. Patients who have recurrent presentation with a psychiatric history may require re-evaluation of their historical diagnoses.
- As opioid use continues to rise, close follow up is necessary for prevention of complications like OIBD. This may involve improving coordination between PCPs, patients, and in certain cases opioid prescribers or opioid treatment centers.

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