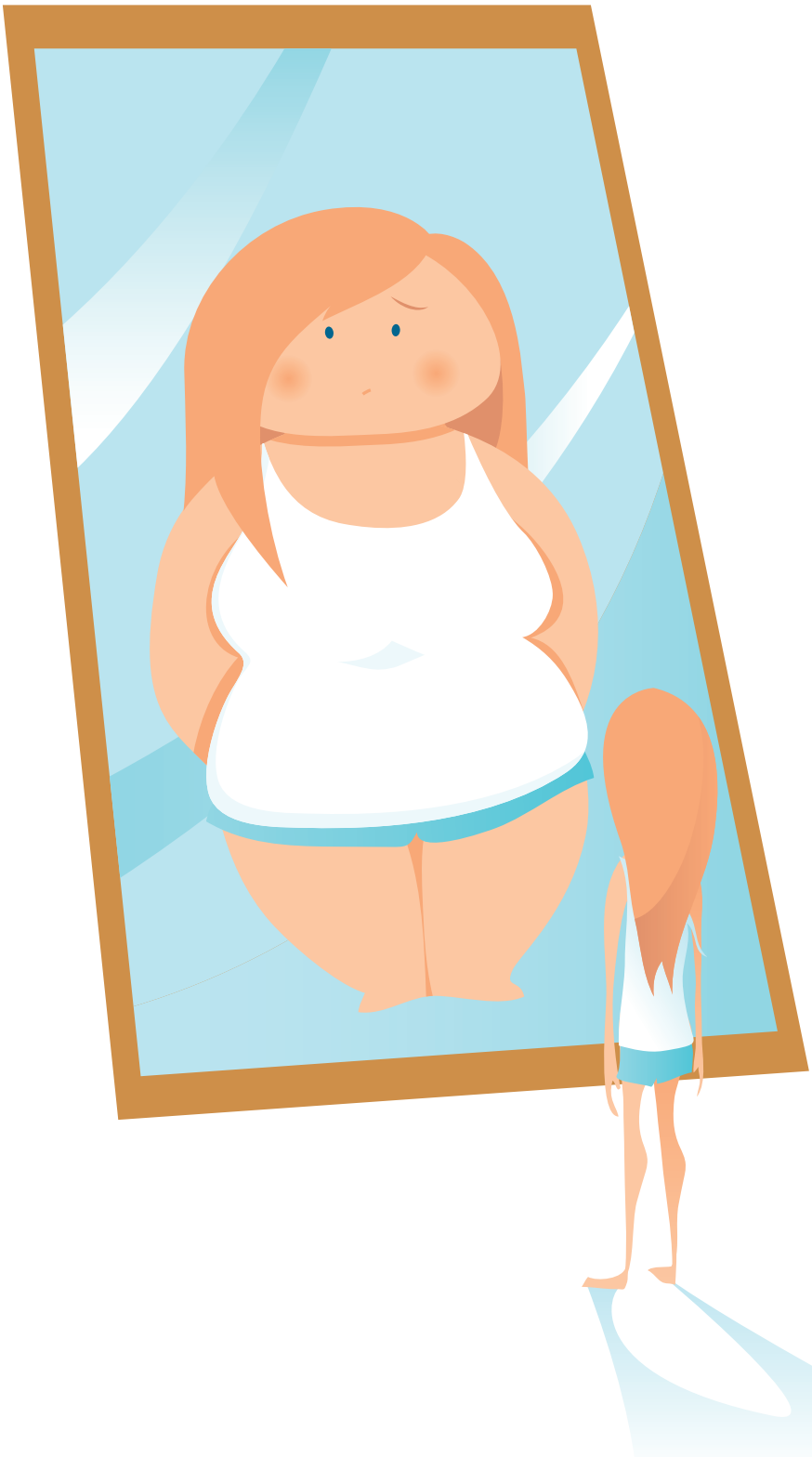

The effect of *bulimia* on the dentition

During this year's Eating Disorders Awareness Week, **Andrew Eder**[1] explores the effects of bulimia on oral health, most specifically in terms of erosion as a result of self-induced vomiting, and how patients may be helped.

Eating Disorders Awareness Week took place between 27 February and 5 March 2017, focusing, in part, on early intervention. A leading charity in this area, BEAT (www.b-eat.co.uk) is looking to educate both healthcare professionals and the wider public about eating disorders, so that they are equipped to help if a patient or someone they know may be suffering.

Dental professionals are no exception, and with 'The Costs of Eating Disorders - Social, Health and Economic Impacts'[1] report estimating that more than 725,000 people in the UK are affected by an eating disorder, there is a very good chance that more than a few of your patients may need help in this area.

The eating disorder that tends to have the greatest effect on oral health is bulimia nervosa, which involves the sufferer caught in a cycle of eating large quantities of food and then vomiting (known as purging), in order to prevent weight gain. This can result in severe damage to the teeth in the form of erosion, so it is certainly something that we, as dental professionals, should be keeping an eye out for.

Indeed, the extended periods of intentional vomiting suffered by bulimics can have

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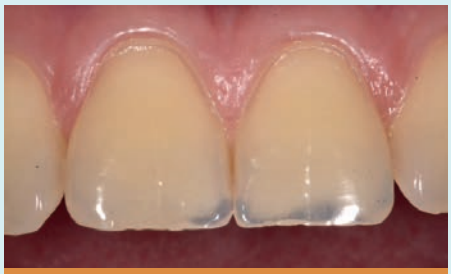
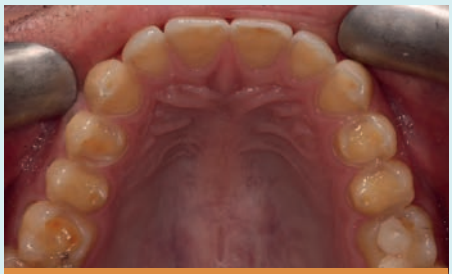
considerable impact on the dentition and result in substantial oral health complications, including:

- The teeth can become rounded, smooth and shiny and lose their surface characteristics
- Incisal edges appear translucent
- Cupping forms in the dentine
- Cervical lesions are shallow and rounded
- Restorations tend to be unaffected by erosion and will therefore stand proud of the surrounding tooth tissue.



34-year-old with erosion and incisal thinning



34-year-old with palatal erosion

Advice is the first step

This can, of course, be a challenging issue to raise with a patient, as shame and denial are common features of an eating disorder. To try and overcome such barriers, it is essential that we do our very best to make the patient feel comfortable and not intimidated. Assure them you have time to talk things through and ask questions in a non-judgemental way aimed at encouraging the patient to identify the origin of their oral health problems. One way that can help in this endeavour is to share your examination findings with the patient and explain how their symptoms may be linked.

'ULTIMATELY, PREVENTIVE ORAL CARE MAY NOT BE ENOUGH TO SAVE THE DENTITION. ACTION BEYOND PREVENTIVE ADVICE ALONE MAY NEED TO BE TAKEN...'

Advice rather than treatment features heavily during the initial stage of helping a patient suffering with bulimia. Diet analysis and general guidance on how to reduce the effect of acidic food and drinks should be given, such as:

- Drinking water or low fat milk in preference to other liquids
- Using a straw positioned toward the back of the mouth when drinking acidic beverages
- Avoiding swishing acidic drinks around the mouth
- Rinsing the mouth with water or fluoridated mouthwash after consuming acidic foodstuffs.

In addition, oral health advice for a patient whose dentition is compromised by bulimia includes:

- Issuing a fluoride rinse or gel and prescribing a highly-fluoridated toothpaste and a soft toothbrush for daily use
- Not brushing immediately after vomiting or consuming acidic foodstuffs, but rinsing with a fluoridated mouthwash and chewing sugar-free, xylitol-sweetened gum afterwards.

Extra protection can be provided via calcium and phosphate ions, such as those found in GC Tooth Mousse, helping to restore the mineral balance, neutralise acidic challenges and stimulate salivary flow.

Extra protection

It will come as no surprise to dental professionals that patients with bulimia can find it extremely hard to overcome the disorder, which may mean that, ultimately, preventive oral care may not be enough to save the dentition.

In such a situation, action beyond preventive advice alone may need to be taken to protect the remaining tooth structure. This may include the direct application of composite resin if at least an enamel halo exists or glass ionomer to sensitive areas, an occlusal guard to protect the teeth during purging, and an alkali or fluoride gel placed within the fitting surface of the guard to neutralise any acid pooling. Such mouthguards should not be worn for prolonged periods without any such protective gels and when acids are present in the mouth to avoid these acids being held in direct contact with the teeth.

Once any treatment has been completed, it is imperative that the patient attends for very regular check-ups so that the rate of wear can be monitored, further guidance provided, adjustments to lifestyle made, and motivation provided.

As an aside, if you believe from a patient or their dentition that they may be bulimic, it may be prudent (with the patient's permission) to make contact with their GP or other healthcare professional overseeing their care before beginning any course of treatment, as a team approach will normally help facilitate a course of action that will offer the best possible outcomes in the given circumstances.

1. beat. The Costs of Eating Disorders - Social, Health and Economic Impacts. 25 February 2015. Available at: https://www.b-eat.co.uk/assets/000/000/302/The_costs_of_eating_disorders_Final_original.pdf?1424694814 (accessed March 2017).

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