Journal of Dental Applications

Open Access

Austin Publishing Group

Special Article – Eating Disorders

Eating Disorders: Could Dentists Contribute to Improve the Secondary Prevention in Males?

Manzato E[1]* and Gualandi M[2]

[1]Psychiatrist, University of Ferrara, Former Chief of Eating Disorders Unit, University-Hospital, Ferrara, Italy

[2]Former Internist of Eating Disorders Unit, University-Hospital, Ferrara, Italy

***Corresponding author:** Manzato Emilia, University of Ferrara, Viale Cavour 190, 44121 Ferrara, Italy

Received: November 17, 2016; **Accepted:** November 23, 2016; **Published:** November 25, 2016

Editorial

Eating Disorders (ED) are mental disorders that can lead to severe medical complications, sometimes fatal, and tend to persist and to relapse. The most common ED is anorexia nervosa (AN), bulimia nervosa (BN) and binge-eating disorder (BED).

The prevalence of ED appears to increase over time and especially AN prevalence in the general male population seems to be significantly increased [1].

Eating disorders, particularly AN and BN, have long been assumed to be found exclusively in women even though male patients represent approximately 10% of the whole ED [2].

Males, as a matter of fact, have a biologic (hormonal) substrate more resistant to develop an eating disorder namely AN [3] but the striking gender difference in prevalence of AN and BN has been enhanced by difficulty in accepting and/or in recognizing the disorder finally under-diagnosed and under- treated [4]. In addition, specific tests and, specially, diagnostic criteria for ED were thought for females more than males until last edition of Diagnostic and Statistical Manual of Mental Disorders, DSM-5 [5]. The new diagnostic criteria have become more sex neutral by removing the criterion amenorrhea and contextualizing the diagnostic values of BMI.

Furthermore in DSM -5, BED was recognized as a separate diagnosis of ED that affects overweight and obese men as well as women. BED represents the most prevalent Ed in men [6].

A recent and increasing phenotype of body image distortion, typically prevalent in males is represented by Bigorexia or Body Dysmorphic Disorder (BDD) whose psychopathological core is the obsessive idea that one's body is not sufficiently lean and muscular [7]. Despite this disorder appears to overlap with ED, by sharing a distortion of body image with AN and BN, it is still classified according to DSM-5 as Obsessive Compulsive Disorder (OCD). This condition is characterized by extreme workout routines, dieting, supplement intake, use of anabolic steroids and growth hormones to enhance muscle mass.

In general it does not seem that the course and prognosis of EDs substantially differ by gender as regards the medical aspects and mortality due to medical complications [8,9] even though a delayed diagnosis, more frequent in males, has been associated to a worse medical condition at first observation [10].

Early diagnosis and treatment in both sexes is a crucial point in order to get a positive prognosis and prevent the organic-sometimes irreversible- consequences of ED. Unfortunately early diagnosis and consequently secondary prevention are still a challenge especially in bulimia, the less visible and more hidden eating disorder and especially in bulimic male subjects [11].

It is estimated that approximately 50% of ED are under detected in clinical settings and- even if correctly diagnosed- they rarely undergo an adequate treatment [12].

The stigmatization of ED constitutes a significant barrier against seeking treatment, especially in males: "stigma" as discriminatory judgement may lead the patients to be ashamed to suffer from a typical female disorder and to hide it.

Furthermore AN is characterized by ego-syntonic self starvation, denial of illness and ambivalence towards treatment: so the patients rarely address spontaneously to the doctor for their ED, in spite of the presence of serious medical and psychiatric comorbidity.

Some studies point out how there are significant differences between the attitudes of men and women towards health services [13]. Males have more difficulty than women in identifying themselves as patients and accepting the impact of their disease on everyday life. Therefore men are less likely to request medical evaluation [14].

In a family context men are also unlikely to be the first to seek help: usually is the wife who seeks help for "the absent man".

Another important problem in approaching a suspected ED subject is represented by the lack of training of the most of physicians or specialists that could come in contact with ED male patients [15].

Currently- thank to the increased attention on gender differences- men, particularly adolescents, should be more perceived by family, teachers, coaches as a population no more excluded by the risk of an ED. Healthcare figures such as general practitioners, gastroenterologist, dentists should become more skilled in recognizing the signs and symptoms of ED among men and enabled to address the subject towards a multidisciplinary diagnostic phase .

Medical complications of ED are the result of malnutrition – from restrictive to excessive nutrition, binging, purging and not purging compensative behaviours (vomiting and laxative abuse, excessive exercise). Even though bone health and growth appear to be more compromised in anorectic adolescent males than females [16-18] medical consequences involving multiple systems and functions are not different by gender [9,19,20].

Laxative use has been reported to be less frequent in men while vomiting is as frequent in males as women in a wide Canadian

Citation: Manzato E and Gualandi M. Eating Disorders: Could Dentists Contribute to Improve the Secondary Prevention in Males?. J Dent App. 2016; 3(3): 347-348.

Community-Based Study [20] despite first reports observed a minor frequency in males probably due to a small sample [21].

Level of physical exercise is not statistically different by gender [20] but women have a higher drive for thinness differently from men who are more focused on muscularity.

Purging Anorexia and purging Bulimia have the most severe medical complications.

Oral manifestations are a well known complication of AN and BN, specially when vomiting is used as compensative behaviour [22] but only 43.8% of patients with BN disclosed their ED to their dentist [23] and on the other hand knowledge of ED especially of males has been reported as insufficient among dentists and oral hygienist [24].

Oral manifestations may be due to the nutritional deficiency especially when iron or vitamins are poor or to the effects of gastric acid reflux during vomiting or even to exaggerate assumption of acidic supplements.

In the nutritional deficiency a mucosal damage can be observed as well as angular cheilitis, glossitis and candidiasis.

Vomiting is associated to perymolisis, a particular type of erosion of enamel due to the contact with acid gastric juice, an increase of teeth sensitivity, caries. Hiatal ernia and consequent gastroesophageal reflux -not inusual complications of purging behaviours- can further worsen this picture.

Enlargement of salivary glands may be another important and early sign of a purging behaviour.

Recently it has been reported that oral panoramic radiographs may be useful tools to screen for reduced skeletal bone mineral density (BMD) even though they are not primarily recommended for diagnosing a bone loss. These observations may nevertheless suggest to investigate for an ED in presence of cortical erosion [25,26].

Dentists should be enabled to consider an ED even in males when they detect oral or dental abnormalities, forgetting the common stereotype of a malnourished female and having in mind that also men , particularly adolescent but not only, with a normal weight and strong muscularity can be affected by an eating disorders.

A training program addressing these issues could be of great advantage in secondary prevention in both sexes but particularly in males [27].

References

1. Qian J, Hu Q, Wan Y, Li T, Wu M, et al. Prevalence of eating disorders in the general population: a systematic review. Shanghai Archives of Psychiatry. 2013; 25: 212-223.
2. Raevuori A, Keski Rahkonen A, Hoek HW. A Review in Males of Eating Disorders. Curr Opin Psychiatry. 2014; 27: 426-430.
3. Klump KL, Gobrogge KL, Perkins P, Thorne D, Sisk CL, Breedlove SM. Preliminary evidence that gonadal hormones organize and activate disordered eating. Psychol Med. 2006; 36: 539-546.
4. Strother E, Lemberg R, Stanford SC, Turberville D. Eating disorders in men: under diagnosed, undertreated, and misunderstood. Eat Disord. 2012; 20: 346-355.
5. American Psychiatric Association: Diagnostic and Statistical manual of Mental Disorders. 5th edn. Arlington, VA: American Psychiatric Association. 2013.
6. Smink FR, van Hoeken D, Oldehinkel AJ and Hoek HW. Prevalence and severity of DSM-5 eating disorders in a community cohort of adolescents. Int. J. Eat. Disord. 2014; 47: 610–619.
7. Pope H, Phillips K, Olivardia R. The Adonis complex: How to identify, treat, and prevent body obsession in men and boys. New York, NY: Touchstone. 2002.
8. Gueguen J, Godart N, Chambry J, Brun-Eberentz A, Foulon C, Divac SM, et al. Severe anorexia nervosa in men: comparison with severe AN in women and analysis of mortality. Int J Eat Disord. 2012; 45: 537-545.
9. Crisp A. Anorexia Nervosa in Males: Similarities and Differences to anorexia nervosa in females. Eur Eat Disord Rev. 2006; 4: 163-167.
10. Siegel HJ, Hardoff D, Golden NH, Shenker R. Medical complications in male adolescent with anorexia nervosa. J Adolesc Health. 1993; 16: 448-453.
11. Carlat DJ, Camargo CA, Herzog DB. Eating Disorders in Males: A report on 135 patients. Am J Psychiatry. 1997; 154: 1127-1132.
12. Wallera G, Micalib N, James A. General Practitioners is poor at identifying the eating disorders. Advances in Eating Disorders: Theory, Research and Practice. 2014; 2: 146–157.
13. Manzato E, Gualandi M, Zanetti T, Strumia R. Eating Disorders in Males. New York: Nova Science edn. 2011.
14. Galdas PM, Cheater F, Marshall P. Men and health help seeking behaviour: literature review. J Adv Nurs. 2005; 49: 616- 623.
15. Johansson AK, Johansson A, Nohlert E, Norring C, Nordrehaug Åstrøm A and Tegelberg Å. Eating disorders - knowledge, attitudes, management and clinical experience of Norwegian dentists. BMC Oral Health. 2015; 15: 124.
16. Modan-Moses D, Yaroslavsky A, Novikov I, Segev S, Toledano A, Miterany E, et al. Stunting of growth as a major feature of anorexia nervosa in male adolescents. Pediatrics. 2003; 111: 270-276.
17. Mehler PS, Sabel AL, Watson T, Andersen AE. High risk of Osteoporosis in male patients with Eating Disorders. Int J Eat Disord. 2008; 41: 666-672.
18. Andersen EA, Watson T, Schlechte J. Osteoporosis and osteopenia in men with eating disorders. The Lancet. 2000; 355: 1967-1968.
19. Woodside DB. Eating Disorders in Men: An Overview. Healthy Weight Journal. 2002; 16: 6-9.
20. Gadalla TM. Eating Disorders in Men: A Community-Based Study. Intern J of Men's Health. 2009; 8: 72-81.
21. Weltzin T. Eating disorders in men: Update. J of Men's Health & Gender. 2005; 2: 186–193.
22. Misra N, Mehra A, Misra P, mehra J. Oral manifestations of eating Disorders. J of Indian Academy of oral medicine and radiology. 2010; 22: s19-22.
23. Willumsen T, Graugaard PK. Dental fear, regularity of dental attendance and subjective evaluation of dental erosion in women with eating disorders. Eur J Oral Sci. 2005; 113: 297-302.
24. DeBate RD, Tedesco LA, Kerschbaum WE. Knowledge of oral and physical manifestations of anorexia and bulimia nervosa among dentists and dental hygienists. J Dent Educ. 2005; 69: 346-354.
25. Calciolari E, Donos N, Park JC, Petrie A, Mardas N. Panoramic measures for oral bone mass in detecting osteoporosis: a systematic review and meta-analysis. J Dent Res. 2015; 94: 17S-27S.
26. Shaughnessy BF, Feldman HA, Cleveland R, Sonis A, Brown JN, Gordon CM. Oral Health and Bone Density in Adolescents and Young Women with Anorexia Nervosa. The Journal of clinical pediatric dentistry. 2008; 33: 87-92.
27. Piat M, Pearson A, Sabetti J, Steiger H, Israel M, Shalini Lal S. International training programs on eating disorders for professionals, caregivers, and the general public: A scoping review. J of Eat Disord. 2015; 3: 28.