However, everyday more evidence supports that disordered eating could be a significant factor, at least, in development and maintenance of obesity.
Objectives Describe the eating behavior of a 180 obese sample.
Methods One hundred and eighty patients with obesity that went to the endocrinology service in order to lose weight are referred to the Psychiatry department to be assessed. To explore the eating behavior it was administered the Bulimic Investigatory Test of Edinburgh, BITE.
Results A total of 68.7% of patients showed a disordered eating pattern, 71.6% tend to eat a lot when feeling anxious, 63.8% eat rapidly large amounts of food, 72.8% worry about not to have control over how much eat, 40.5% consider that their pattern of eating severely disrupt their life, 40.7% eat sensibly in front of others and make up in private, 59.1% cannot stop eating when they want to and 58.3% admit binges of large amounts of food.
Conclusions Most of our patients showed a pattern of disordered eating, and then our findings support the idea of disordered eating as a significant factor in the development and maintenance of obesity. Therefore, obesity requires a multidisciplinary approach that goes beyond the traditional nutritional guidance.
Disclosure of interest The authors have not supplied their declaration of competing interest.

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EW203

Randomized controlled trial testing behavioral weight loss versus multi-modal stepped-care treatment for binge eating disorder

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Introduction Binge eating disorder (BED) is prevalent, associated with obesity and elevated psychiatric co-morbidity, and represents a treatment challenge.
Objective and aims A controlled comparison of multi-modal, stepped-care versus behavioral-weight-loss (BWL) for BED.
Methods One hundred and ninety-one patients (71% female, 79% white) with BED and co-morbid obesity (mean BMI 39) were randomly assigned to 6 months of BWL ($n = 39$) or stepped-care ($n = 152$). Within stepped-care, patients started BWL for one month; treatment-responders continued BWL while non-responders switched to cognitive-behavioral-therapy (CBT) and all stepped-care patients were additionally randomized to anti-obesity medication or placebo (double-blind) for five months. Independent assessments were performed by research-clinicians at baseline, throughout treatment, and post-treatment (90% assessed) with reliably-administered structured interviews.
Results Intent-to-treat analyses of remission rates (0 binges/month) revealed BWL and stepped-care did not differ significantly overall (74% vs 64%); within stepped-care, remission rates differed (range 40% - 79%) with medication significantly superior to placebo ($P < 0.005$) and among initial non-responders switched to CBT ($P < 0.002$). Mixed-models analyses of binge eating frequency revealed significant time effects but BWL and stepped-care did not differ overall; within stepped-care, medication was significantly superior to placebo overall and among initial non-responders switched to CBT. Mixed models revealed significant weight-loss but BWL and stepped-care did not differ overall; within stepped-care, medication was significantly superior to placebo overall and among both initial responders continued on BWL and non-responders switched to CBT.
Conclusions Overall, BWL and stepped-care treatments produced improvements in binge-eating and weight loss in obese BED patients. Anti-obesity medication enhanced outcomes within a stepped-care model.
Disclosure of interest The author has not supplied his/her declaration of competing interest.

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EW204

Binge-eating disorder and major depressive disorder co-morbidity: Sequence and clinical significance

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Introduction Binge-eating disorder (BED) is associated with obesity and with elevated rates of co-occurring major depressive disorder (MDD) but the significance of the diagnostic comorbidity is ambiguous—as is the significance of the onset sequence for MDD and BED.
Objective and aims We compared eating-disorder psychopathology and psychiatric comorbidity in three subgroups of BED patients: those in whom onset of BED preceded onset of MDD, those with onset of MDD prior to onset of BED, and those without MDD or any psychiatric comorbidity.
Methods A consecutive series of 731 treatment-seeking patients meeting DSM-IV-TR research criteria for BED were assessed reliably by doctoral-clinicians with semi-structured interviews to evaluate lifetime psychiatric disorders (SCID-I/P) and ED psychopathology (EDE Interview).
Results Based on SCID-I/P, 191 (26%) patients had onset of BED preceding onset of MDD, 114 (16%) had onset of MDD preceding onset of BED, and 426 (58%) had BED without co-occurring disorders. Three groups did not differ with respect to age, ethnicity, or education, but a greater proportion of the group without MDD was male. Three groups did not differ in body-mass-index or binge-eating frequency, but groups differed significantly with respect to eating-disorder psychopathology, with both MDD groups having significantly higher levels than the group without co-occurring disorders. The group having earlier onset of MDD had elevated rates of anxiety disorders compared to the group having earlier onset of BED.
Conclusions MDD in combination with BED—with either order of onset—has a meaningful adverse effect on ED psychopathology and overall psychiatric co-morbidity.
Disclosure of interest The authors have not supplied their declaration of competing interest.

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EW206

Changes in the electrical properties of the tissues in patients with anorexia nervosa measured by bioelectrical impedance analysis

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Introduction Monitoring patient with anorexia nervosa (AN) include clinical, biological and psychological factors. In recent years many researchers criticize the BMI as useful measure for controlling evolution of AN.

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Objectives Bioelectrical impedance analysis (BIA) is one of the main methods for nutritional status assessment.
Aims The aim of this study was the assessment of the nutrition status in a group of patients with anorexia nervosa in comparison to healthy population (HP).
Methods The study involved 37 participants: 21 patients with AN and 16 healthy volunteers constituting the control group (HP). The patients were divided into two groups according a BMI: I group 14 < BMI < 15,5 (n = 11; age 18.0 ± 4.37) and II group: 15,5 < BMI < 17,5 (n = 10; age 17.82 ± 3.68). The mean age of HP was 17.68 ± 1.57 and BMI 20.56 ± 1.16 kg/m^2. BIA was performed by using ImpediMed bioimpedance analysis SFB7 BioImp. The parameters: phase angle (PA), TBW%, ECW, ICW, ECW/ICW were analyzed.
Results PA was decreased significantly in the I (4.5°±0,6) and II group (4.7°±0,6) of AN patients' in comparison with HP (5.6°±0,7). TBW was 9% higher in I group and ECW was increased 6% in the both AN groups compared with HP (P < 0.01). Additionally ECW/ICW ratio indicated the higher transfer of water into the extracellular compartment in AN group (P < 0.01).
Conclusions BIA is accurate tool to indicate the valuable indicators of detecting malnutrition in AN. Further studies are needed to validate the significance of these parameters for the full identification of the nutrition status of AN patients'.
Keywords Anorexia nervosa; Bioelectrical impedance; Phase angle; TBW; ECW; ICW
Disclosure of interest The authors have not supplied their declaration of competing interest.

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EW208

Trends of hospitalization for anorexia nervosa in USA: A nationwide analysis

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Objectives Anorexia Nervosa (AN) is an important cause of morbidity and mortality in hospitalized patients. While AN has been extensively studied in the past, the contemporary data for impact of AN on cost of hospitalization are largely lacking.
Methods We queried the Healthcare Cost and Utilization Project's Nationwide Inpatient Sample (HCUP-NIS) dataset between 1998-2011 using the ICD-9 codes for AN. Severity of co-morbid conditions was defined by Deyo modification of Charlson co-morbidity index. Primary outcome was in-hospital mortality and secondary outcome was total charges for hospitalization. Using SAS 9.2, chi-square test, t-test and Cochran-Armitage test were used to test significance.
Results 28,150 patients were analyzed. 93.94% were female and 6.06% were male (P < 0.0001). 88.67% were white, 2.93% were black and 8.4% were of other race (P < 0.0001). Rate of hospitalization decreased from 1530/million to 1349.5/million from 1998-2011. Overall mortality was 0.78% and mean cost of hospitalization was 25,829.82$. The in-hospital mortality reduced from 0.95% to 0.44% (P < 0.0001) and mean cost of hospitalization increased from 11,956.55$ to 39,831.51$. Total yearly spending on AN related admissions increased from $145.33 million/year to $420.61 million/year.
Conclusions While mortality has slightly decreased from 1998 to 2011, the cost has significantly increased from $145.33 million/year to $420.61 million/year, which leads to an estimated $275.28 million additional burden to the US health care system. In the era of cost conscious care, preventing AN related Hospitalization could save billions of dollars every year. Focused efforts are needed to establish preventive measures for AN related hospitalization.
Disclosure of interest The authors have not supplied their declaration of competing interest.

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EW209

Trends of hospitalization for bulimia nervosa in USA: A nationwide analysis

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Objectives Bulimia Nervosa (BN) is an important cause of morbidity and mortality in hospitalized patients. While BN has been extensively studied in the past, the contemporary data for impact of BN on cost of hospitalization are largely lacking.
Methods We queried the Healthcare Cost and Utilization Project's Nationwide Inpatient Sample (HCUP-NIS) dataset between 1998-2011 using the ICD-9 codes. Severity of co-morbid conditions was defined by Deyo modification of Charlson co-morbidity index. Primary outcome was in-hospital mortality and secondary outcome was total charges for hospitalization. Using SAS 9.2, chi-square test, t-test and Cochran-Armitage test were used to test significance.
Results 19,441 patients were analyzed. 94.13% were female and 5.87% male (P < 0.0001). 85.72% were white, 4.55% black and 9.73% of other race (P < 0.0001). Rate of hospitalization decreased from 1136.99/million to 802.47/million from 1998-2011. Overall mortality was 0.20% and mean cost of hospitalization was 15,496.82$. The in-hospital mortality reduced from 0.23% to 0.15% (P < 0.0001) and mean cost of hospitalization increased from 8,194.53$ to 22,547.86$. Total spending on BN related admissions have increased from $73.96 million/year to $139.93 million/year over the last decade.
Conclusions While mortality has slightly decreased from 1998 to 2011, the cost has significantly increased from $73.96 million/year to $139.93 million/year, which leads to an estimated $65.97 million/year additional burden to US health care system. In the era of cost conscious care, preventing BN related Hospitalization could save billions of dollars every year. Focused efforts are needed to establish preventive measures for BN related hospitalization.
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EW210

Current and emerging drugs treatment for night eating syndrome

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Introduction The night eating syndrome (NES) is a categorized in the diagnostic and statistic manual (DSM-5) as an "Other Specified Feeding or Eating Disorder" and it is characterized by a reduced feeding during the day, evening hyperphagia accompagned by frequent nocturnal awakenings associated with conscious episodes of compulsive ingestion of food and abnormal circadian rhythms of food and other neuroendocrine factors. Frequently it is associated with obesity and depressed mood.
Objectives The purpose of this review is to investigate the state of art concerning the psychopharmacological treatment of NES.
Methods A Medline enquiry of published articles from 2005 to October 2015 was performed using the following keywords: "NES,