experiences, I have found that fat persons do indeed eat much more than lean persons. In fact, most obese persons compulsively overeat *in secret*. A minority of normal and underweight persons also have periods of compulsive overeating. Because binge eating is generally always done secretly, accurate food intake is nearly impossible to determine by any of the methods mentioned in the article.

Various techniques that are used by compulsive overeaters to conceal actual food intake include eating normally in public followed by a binge in private afterward, eating several normal-sized public restaurant meals in a series, purchasing binge food from several different stores or restaurants so as to avoid buying an excessive amount of food at any one place, hiding binge foods in nonfood areas, such as under the bed or in the clothes closet, hoarding food in a cache to be used when the need for a binge occurs, stealing binge foods while working around food, eating leftovers and repositioning the remnants to conceal the portions taken, and lying about food intake when confronted by others. Compulsive overeaters will often prepare double the amount of binge food needed at any one time, such as two birthday cakes or two pizzas, and eat half in secret before the normal meal is eaten in public. Binge eaters will often dispose of food wrappers and remnants in public trash receptacles or conceal the extra wrappers inside the one legitimate wrapper so that neither family nor acquaintances will find all the packaging and become aware of the actual food intake. Occasionally, entire families will engage in binge eating. Self-report in the form of food diaries is notoriously inaccurate because compulsive overeaters are in denial about their excessive food intake. In my experience, a normal meal entered on a food diary will often be followed by a snack, such as a 1-pound bag of peanut chocolate candies accompanied by a half-gallon of ice cream, which will not be entered on the food diary.

Genetics plays a large role in determining body type but probably plays only a relatively small role in determining actual amount of body fat. This is obvious when one repeatedly observes, as I do in my area of the country, very slim Asian-born immigrant parents accompanied by their very plump American-born children. Using simple logic, food intake equals energy expenditure plus fat storage. Obese persons usually have increased calorie-dense food intake with or without decreased energy expenditure. Either must necessarily lead to increased storage in the form of excess body fat. Any sedentary society such as our own that encourages the consumption of large amounts of low-cost, easily available, highly palatable, calorie-dense foods will inevitably have a large obese population.

Compulsive overeaters often self-medicate by using binge foods for their mind-altering effects. Not all foods are used compulsively. Sugary or salty foods that are high in fat have tranquilizing, calming, and comforting properties and are the foods usually used in binges. Compulsive eating binges are often triggered by stress, depression, boredom, or loneliness. Chronic overeating provides a means to avoid confronting and solving other problems in a person's life. The emotional pain of compulsive overeating is great and generally leads to increasing isolation. The authors are indeed correct in maintaining that dieting is an ineffective treatment for obesity. Obesity can in fact be defined by compulsive seeking and continuing intake of certain foods despite increasing evidence of adverse effects. Obesity due to compulsive overeating has so many qualities in common with other addictions, such as alcohol, tobacco, and drug abuse, that it might be best characterized as a "binge food addiction." Although food abuse has been given very little attention in the medical literature, compulsive overeating would fulfill the diagnostic criteria for psychoactive substance dependence as outlined in the *DSM III-R*, 1987.[1]

In the health care field, we now refer those with alcohol abuse to rehabilitation programs coupled with Alcoholics Anonymous or other similar self-help groups. We avoid enabling them by confronting abusers with the truth about their excess use. We should do no less for those suffering from food abuse. We should refer compulsive overeaters to nutritional programs stressing a healthy lifestyle coupled with Overeaters Anonymous. Resistance to a referral to Overeaters Anonymous is to be expected because denial is so great; however, the benefits of abstinence from compulsive overeating are even greater.

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References

1. Diagnostic and statistical manual of mental disorders. 3rd ed, revised. Washington, DC: American Psychiatric Association, 1987.

The above letters were referred to the author of the article in question, who offers the following reply:

To the Editor: It is clear from the two responses to our article "Obesity: A Move From Traditional To More Patient-oriented Management" that the topic of obesity is a highly controversial issue that generates strong feelings in many physicians. While we by no means believe that the final word on the causes or treatment of obesity is in, we wanted to present an alternative perspective that we believe has gained increasing acceptance among many segments of the public and some segments of the medical and psychological communities.

Dr. DeFazio raises some challenging questions about the "reliance on multiple studies with flawed methodology" to prove that fat persons might not, as a group, overeat. While we agree that indeed these studies are flawed, most studies have flaws, but that does not mean they are wrong and useless. He correctly notes that an adequate (I would say flawless) study on persons' diets requires round-the-clock surveillance for years. Unfortunately, the cost of such a study would be prohibitive. The studies we reviewed used methodology in line with current practice for assessing eating and

used various techniques to help control for some of the more obvious flaws. There are relatively few areas in medicine where practice is guided by absolute proof.

We agree with Dr. DeFazio that for many obese persons who might not eat more than their thinner counterparts, to maintain a normal weight requires a lifelong commitment and struggle against food, a struggle not required of those who are of average weight. We recommend that physicians be honest with their fat patients about the unceasingly difficult nature of this struggle and tell them that strict discipline with regard to extensive eating restrictions and daily exercise is required without letup for the rest of their lives. As many of us know there are few who can maintain this level of commitment for a lifetime, but there are many persons, fat and thin alike, who show extraordinary levels of commitment and discipline in this area. It would certainly help to have the resources to hire personal trainers and cooks specializing in low-fat foods, as some celebrities such as Oprah Winfrey have done, to help us in this formidable struggle. Studies of the persons who are able to lose and keep weight off permanently would be useful and instructive, as suggested by Dr. DeFazio.

Dr. DeFazio rightly questions the evidence available that doing a "brief dietary and exercise history" is beneficial for the patient, given that physician intervention has not been proved to affect obesity. At least the history can give the physician specific information about that particular patient, which would enable the physician to make recommendations based on some knowledge of the patient's eating and exercise history, rather than some general, and we would argue dangerously unfounded, belief that all fat persons eat too much. It is hard to see how such an intervention can be harmful. Our admonition about the dangers of dieting is backed up by serious concerns, not only about weight cycling, which as Dr. DeFazio correctly points out is still being investigated, but also the dangers of triggering eating disorders and failure experiences, exposing patients to professionals who hold them in low regard, causing them to see themselves as deviant, flawed, and inadequate, and diverting their attention away from other problems or achievements.

Dr. Bett argues that she knows that "fat persons do indeed eat much more than lean persons" and notes that "in fact, most obese persons compulsively overeat in secret." She defines obesity as "compulsive seeking and continuing intake of certain foods despite increasing evidence of adverse effects." She then goes on to discuss the various techniques that compulsive overeaters use to conceal actual food intake and the psychological motivations and effects of such eating on the overeater.

We do not argue with Dr. Bett's description of compulsive overeating or that this disorder exists. We believe that this disorder could in fact be triggered by rigid dieting that the dieter is unable to maintain, which sets up the wild swings from diet-purge to binge and back again. Further, we do not believe that all, as Dr. Bett seems to imply, or even most fat persons are compulsive overeaters. In fact, as we discussed earlier, the preponderance of research on this subject suggests just the opposite. We are quite disturbed by her definition of obesity, which is characteristic of exactly the type of thinking about obesity we are challenging. We believe that genetics does play an important role in contributing to obesity as indicated by several references in our bibliography.

Dr. Bett cites her "extensive personal and professional experience" to back up her ensuing claims. In addition to our extensive review of the research literature, Dr. Robinson, the first author, has extensive clinical experience with the eating diaries of approximately 100 fat patients during the course of 12 years of work with this population. Her clinical experience confirms the research literature cited, i.e., most were eating average calorie amounts, i.e., approximately 2000 calories or less and maintaining above-average amounts of weight.

I certainly agree with Dr. Bett's contention that "any sedentary society such as our own that encourages the consumption of large amounts of low-cost, easily available, highly palatable, calorie-dense foods will inevitably have a large obese population." We are not arguing that food consumption has nothing to do with body weight, only that persons can eat similar amounts and types of food and have widely differing body weights. Certainly those whose bodies were very efficient with food would have survival value, because most of human history is one of food deprivation, not plentitude. These efficient metabolisms would be among the first to become obese in a society, like ours, that enjoys an abundance of food and freedom from starvation. In the past, this efficiency was adaptive; today it could be associated with health problems.

In sum, we want to stress the major message we were trying to get across to physicians working with their obese patients: be respectful of the emotional pain borne by many obese persons who live in a culture that stigmatizes them. Try to approach them respectfully and individually, and try to avoid some of the degrading techniques used in the past that just prevent fat patients from feeling comfortable and respected when they come for help and might prevent them from seeking the help they need.

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Rapid Antigen Detection Testing

To the Editor: The article by Joslyn, et al.[1] provides useful information guiding the care of patients with suspected streptococcal pharyngitis. The authors make some misstatements, however, and draw some incorrect and incomplete conclusions in discussing their findings.

They state: "Results of these pilot studies indicate that an extremely low percentage (<1 percent) of subjects with GABHS [group A β-hemolytic streptococcus] escaped detection with our rapid screening test methods." In fact, based upon their published data, 4.55 percent (1 of 22) of patients in their sample who actually had GABHS tested negative by the screening