Review: antidepressants increase remission and clinical improvement in bulimia nervosa


QUESTION: In patients with bulimia nervosa (BN), are antidepressants effective for increasing remission and clinical improvement?

Data sources
Studies were identified by searching Medline; EMBASE/Excerpta Medica; LilACS; PsycLIT; SCISEARCH; the Cochrane Depression, Anxiety, and Neurosis Group Database of Trials; the Cochrane Controlled Trials Register; Clinical Evidence; and reference lists. The International Journal of Eating Disorders was also hand searched, and authors and pharmaceutical companies were contacted.

Study selection
Studies were selected if they were randomised controlled trials (RCTs) that compared any antidepressant with placebo for >4 weeks in patients with BN. RCTs were excluded if patients had binge-eating or purging-type anorexia nervosa or binge-eating disorder.

Data extraction
2 reviewers assessed the quality of RCTs and extracted data on patients, study characteristics, drug regimens, and outcomes (including remission [100% reduction in binge or purge episodes], clinical improvement [≥50% reduction in binge or purge episodes], and dropouts).

Main results
16 RCTs (1300 patients) met the selection criteria. Any antidepressant was better than placebo for increasing remission at a mean follow up of 8 weeks (8 RCTs) and clinical improvement at a mean follow up of 9 weeks (8 RCTs) (table). Groups did not differ for dropout rates (14 RCTs) (table).

Conclusion
In patients with bulimia nervosa, antidepressants are effective in the short term for increasing remission and clinical improvement rates.

Antidepressants v placebo for bulimia nervosa at 6 to 16 weeks*

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Antidepressant type</th>
<th>Weighted event rates</th>
<th>RBI (95% CI)</th>
<th>NNT (CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remission</td>
<td>All types</td>
<td>20% v 7.9%</td>
<td>105% (32 to 219)</td>
<td>9 (6 to 16)</td>
</tr>
<tr>
<td>TCAs</td>
<td>14% v 9.1%</td>
<td>136% (~4 to 476)</td>
<td>Not significant</td>
<td></td>
</tr>
<tr>
<td>MAOIs</td>
<td>25% v 6.3%</td>
<td>229% (~22 to 1289)</td>
<td>Not significant</td>
<td></td>
</tr>
<tr>
<td>Other antidepressants</td>
<td>15% v 0%</td>
<td>664% (~1 to 5773)</td>
<td>7 (4 to 27)</td>
<td></td>
</tr>
<tr>
<td>Clinical improvement</td>
<td>All types</td>
<td>64% v 33%</td>
<td>84% (38 to 145)</td>
<td>4 (3 to 5)</td>
</tr>
<tr>
<td>TCAs</td>
<td>77% v 17%</td>
<td>294% (59 to 872)</td>
<td>2 (2 to 3)</td>
<td></td>
</tr>
<tr>
<td>SSRIs</td>
<td>58% v 38%</td>
<td>51% (26 to 81)</td>
<td>5 (4 to 9)</td>
<td></td>
</tr>
<tr>
<td>Other antidepressants</td>
<td>44% v 8.2%</td>
<td>321% (74 to 919)</td>
<td>3 (3 to 5)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Antidepressant type</th>
<th>RRR (CI)</th>
<th>NNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drop outs</td>
<td>SSRIs</td>
<td>34% v 40%</td>
<td>18% (1 to 32)</td>
</tr>
<tr>
<td>Other antidepressants</td>
<td>30% v 32%</td>
<td>6% (~3 to 52)</td>
<td>Not significant</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Antidepressant type</th>
<th>RRI (CI)</th>
<th>NH</th>
</tr>
</thead>
<tbody>
<tr>
<td>All types</td>
<td>34% v 31%</td>
<td>3% (~20 to 32)</td>
<td>Not significant</td>
</tr>
<tr>
<td>TCAs</td>
<td>26% v 11%</td>
<td>93% (15 to 225)</td>
<td>Not significant</td>
</tr>
<tr>
<td>MAOIs</td>
<td>34% v 29%</td>
<td>20% (~33 to 113)</td>
<td>significant</td>
</tr>
</tbody>
</table>

*MAOIs = monoamine oxidase inhibitors; SSRIs = selective serotonin reuptake inhibitors; TCAs = tricyclic antidepressants. Other abbreviations defined in glossary; RBI, RRR, RRI, NNT, NH, and CI calculated from data in article.

COMMENTARY

The reviews by Bacaltchuk et al are laudable for the rigour of the data analyses, but they rightly generate more questions than answers. Bacaltchuk and Hay have comprehensively reviewed 16 published RCTs of antidepressant treatments for BN. Although modest effectiveness is shown, high dropout rates among patients limit the clinical application of these data, and the authors comment on the need for more studies of tolerability and cost effectiveness. The studies included were generally of short duration in young adult women who did not have any substantial psychiatric comorbid conditions. The results therefore cannot be generalised to the substantial minority of bulimic patients with comorbid “multi-impulsive” personality characteristics or substance abuse or to adolescents.

Pharmacological treatment trials of BN are dominated by the reported reduction in bulimic symptoms, but clinicians and their patients are more interested in remission of symptoms. The emphasis of this review on remission is therefore of greater clinical application than the emphasis of its sources. The review discusses the limitations of outcome measures and is right to conclude that the use of antidepressants as sole treatment “does not seem sufficient to effectively treat these patients”.

Bacaltchuk et al review a scant number of studies comparing combined antidepressant medication and psychotherapy with each treatment alone. In clinical practice, cognitive behavioural therapy (CBT), which is limited by its availability, is generally regarded as the treatment of choice for BN, with antidepressant medication as an adjunct. This review supports that approach by using restricted data from fairly small studies. However, the clinical risk associated with a pharmacological approach to BN seems to be a higher dropout rate than with CBT and, again, the results cannot necessarily be generalised beyond young adult women who have no substantial comorbid illness.

The UK Department of Health's National Service Framework for Mental Health has stressed the importance of managing such eating disorders as BN in primary care, and the reviews by Bacaltchuk and Hay provide the rationale for increased treatment success rates for BN. A more comprehensive review of other treatments is also needed. Further research may help to answer such questions.
Review: psychological treatment is as effective as antidepressants for bulimia nervosa, but a combination is best


QUESTION: In patients with bulimia nervosa (BN), are antidepressants as effective as psychological treatment (PT) for increasing remission and clinical improvement rates? Is a combination of antidepressants and PT better than each intervention alone?

Data sources
Studies were identified by searching Medline; EMBASE/Excerpta Medica; Lilacs; PsycLIT; Scisearch; the Cochrane Depression, Anxiety, and Neurosis Group Database of Trials; the Cochrane Controlled Trials Register; Clinical Evidence, and reference lists. The International Journal of Eating Disorders and book chapters on BN were also hand searched, and authors and pharmaceutical companies were contacted.

Study selection
Studies were selected if they were randomised controlled trials (RCTs) that compared antidepressants with PT in patients with BN. Studies were excluded if patients had binge-eating or purging-type anorexia nervosa or binge-eating disorder.

Data extraction
2 reviewers assessed the quality of studies and extracted data on patients, study characteristics, interventions, and outcomes (including remission [100% reduction in binge or purge episodes], clinical improvement [≥ 50% reduction in binge or purge episodes], and drop-outs).

Main results
5 RCTs (257 patients) compared antidepressants with PT. Groups did not differ significantly for remission (5 RCTs); only 1 RCT reported on clinical improvement. More dropouts occurred in the antidepressant group than in the PT group (4 RCTs) (table). 5 RCTs (247 patients) compared combination and single interventions.

Antidepressants versus combination: more patients in the combination group than in the PT alone group had remission (6 RCTs); fewer patients in the PT alone group than in the combination group dropped out (6 RCTs) (table). Groups did not differ for clinical improvement (2 RCTs) (table).

Conclusions
In patients with bulimia nervosa, psychological treatment and antidepressants do not differ in remission rates, but dropout rates are lower with psychological treatment. A combination of antidepressants and psychological treatment is best for increasing remission.

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Comparisons</th>
<th>Weighted event rates</th>
<th>RBI (95% CI)</th>
<th>NNT (CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remission</td>
<td>PT v AD</td>
<td>41% v 20%</td>
<td>63% (~14 to 210)</td>
<td>NS</td>
</tr>
<tr>
<td></td>
<td>AD + PT v AD</td>
<td>47% v 23%</td>
<td>79% (11 to 188)</td>
<td>5 (3 to 21)</td>
</tr>
<tr>
<td></td>
<td>PT + AD v PT</td>
<td>50% v 36%</td>
<td>30% (1 to 68)</td>
<td>8 (5 to 37)</td>
</tr>
</tbody>
</table>

Clinical improvement

<table>
<thead>
<tr>
<th></th>
<th>PT + AD v PT</th>
<th>46% v 52%</th>
<th>8% (~70 to 50)</th>
<th>NS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drop outs</td>
<td>PT v AD</td>
<td>18% v 41%</td>
<td>54% (9 to 76)</td>
<td>5 (3 to 10)</td>
</tr>
<tr>
<td></td>
<td>AD + PT v AD</td>
<td>35% v 41%</td>
<td>16% (~45 to 51)</td>
<td>NS</td>
</tr>
<tr>
<td></td>
<td>PT + AD v PT</td>
<td>26% v 16%</td>
<td>74% (14 to 167)</td>
<td>10 (6 to 40)</td>
</tr>
</tbody>
</table>

*NS = not significant; RBI = relative benefit reduction. Other abbreviations defined in glossary; RBI, RBR, RRR, RRI, NNH, CI calculated from data in article. Follow up ranged from 5 to 24 weeks.

Commentary—continued from previous page

However, in the busy world of primary care, the treatment of BN will continue to be driven by available resources. CBT for BN is generally preferred by the family doctor when specialists with such training are available. But the Royal College of Psychiatrists, in collaboration with the Consumers’ Association, has recently reported the dearth of specialist eating disorder services beyond southeastern England. Thus, in the more likely scenario of limited eating disorder services, use of antidepressant medication may seem more attractive. These 2 reviews agree with that approach and suggest that antidepressant medication will produce positive short term results; however, BN is not a short term illness. Relapse prevention deserves greater scrutiny for patients with BN and anorexia nervosa, and longer term follow up studies should drive the next generation of treatment intervention studies.

Regarding treatment of BN in particular, a pressing need exists for longer term studies examining relapse rates, health economics, and comparisons of classes of antidepressants for treatment concordance.

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