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 Regis-

Abstract and commentary also appear in Evidence-Based Mental Health.

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.

COMMENTARY
The reviews by Bacaltchuk et al are laudable for the rigour of their 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 beyond young adult women who have no substantial comorbid illness.

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 clinical implication of Bacaltchuk et al's review is that the easiest route may not be the most effective, cost effective, or acceptable for clinicians and their patients.
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 dropouts).

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.

Antidepressants (AD) v psychological treatment (PT) for bulimia nervosa*

<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>
<tr>
<td></td>
<td></td>
<td></td>
<td>RRR (CI)</td>
<td>NNH</td>
</tr>
<tr>
<td>Clinical improvement</td>
<td>PT + AD v PT</td>
<td>46% v 52%</td>
<td>8% (~70 to 50)</td>
<td>NS</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>RRR (CI)</td>
<td>NNT (CI)</td>
</tr>
<tr>
<td>Dropouts</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>
<tr>
<td></td>
<td></td>
<td></td>
<td>RRI (CI)</td>
<td>NNH (CI)</td>
</tr>
</tbody>
</table>

*NS = not significant; RBI = relative benefit reduction. Other abbreviations defined in glossary; RBR, RRR, RRI, NNT, NNH, and 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.

John F Morgan, MD, MA
St George’s Hospital Medical School, University of London, London, UK