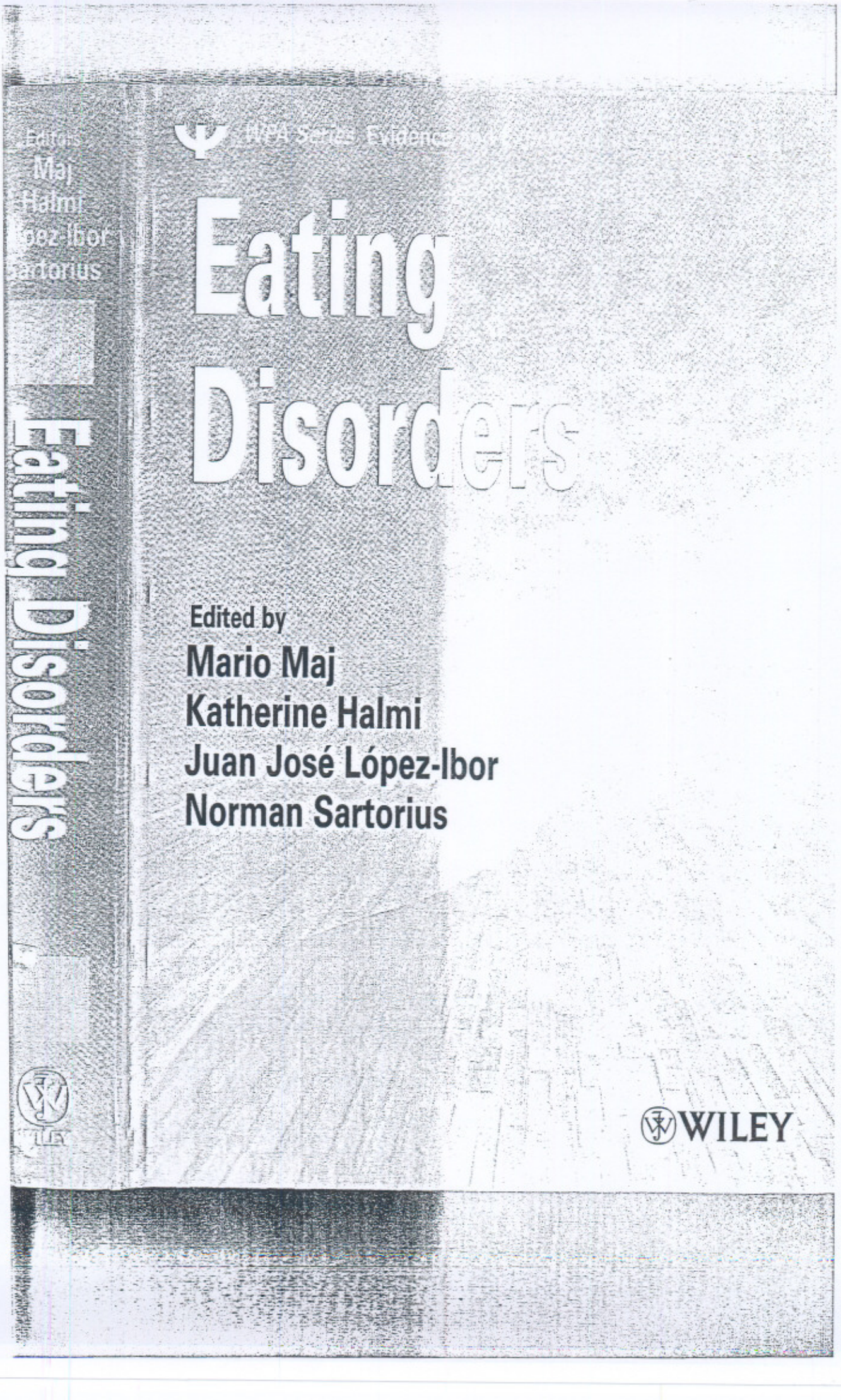
WPA Series Evidence
Eating Disorders
Edited by
Mario Maj
Katherine Halmi
Juan José López-Ibor
Norman Sartorius
WILEY
Eating Disorders
Maj
Halmi
López-Ibor
Sartorius

4.8

Is Psychopharmacological Treatment of Patients with Eating Disorders Necessary?

Cecilia Bergh[1]

Patients with eating disorders, particularly those with anorexia nervosa, are considered difficult to treat. Few, if any, interventions have proved effective in randomized controlled trials (RCT) [1]. By contrast, many RCTs have shown that cognitive–behavioural therapy (CBT) is effective in bulimia nervosa. However, only 50% of the patients respond to CBT. Addition of psychoactive drugs may be helpful but, as is made clear in de Zwaan and Roerig's in-depth review, in comparison with CBT, their effects are minor. The most thoroughly studied drugs are the selective serotonin reuptake inhibitors (SSRIs), but their effects are also small. In anorexia, there is in fact no demonstration that an SSRI is helpful. This is not surprising, because SSRIs are indirect serotonergic agonists, and serotonin suppresses food intake, which is why serotonin agonists are used to treat obesity. Also, many anorexic patients are peripubertal and, because serotonin is inhibitory both to pituitary gonadotropin secretion and sexual behaviour, SSRIs might delay sexual maturation. Furthermore, as Figure 4.8.1 shows, symptoms of depression, anxiety and obsession among anorexic patients admitted to our clinic do not differ between those who are treated with SSRIs and those who are not.

Many clinicians think of anorexia nervosa as a chronic disorder with frequent periods of relapse after weight restoration. Relapse prevention is therefore a main issue. In an often cited RCT, SSRIs were found to reduce the rate of relapse in anorexics in remission [2]. However, in that study the high and rapid rate of relapse among placebo-treated controls—16/19 (84%) relapsed in 4 months—was more conspicuous than the reduction in relapse among the SSRI-treated patients: 6/16 (37%) relapsed in 8 months, which is in fact also a high rate. This dramatic rate of relapse raises the issue of how the body weight of the patients was restored. Most weight-restored anorexic patients described in the literature display a variety of psychiatric symptoms. They may not fulfil the diagnostic criteria of an eating disorder, but they can only be considered to be in remission if these psychopathological symptoms are thought of as independent of their eating disorder. The presence of an altered neurochemical parameter in such patients, as well as bulimics in remission, is often considered a risk factor for the eating disorder (e.g. [3]) but, obviously, is more likely concomitant to their psychiatric comorbidity.

[1] *Karolinska Institutet, Center for Eating Disorders, Novum, S-141 57 Huddinge, Sweden*

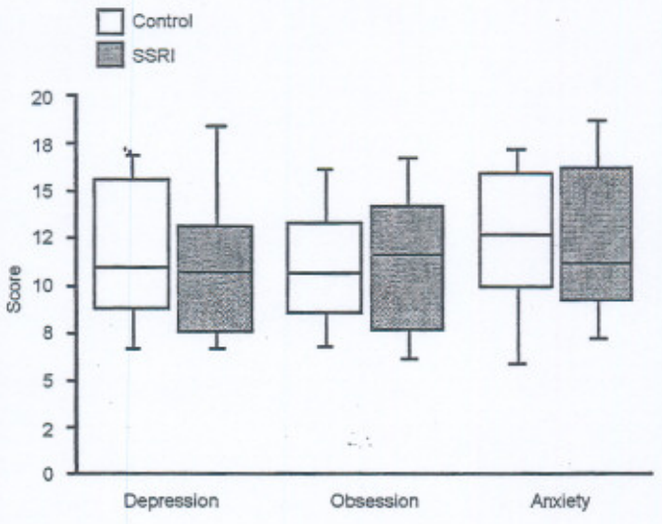

Figure 4.8.1 Score (medians, box plots and outliers) on the Comprehensive Psychopathological Rating Scale in 22 anorexic patients treated with 20–60 mg/day fluoxetine (SSRI) and in 28 anorexic patients not given fluoxetine (Control) at the time of admission

The evidence for the usefulness of SSRIs and most other psychoactive drugs in patients with eating disorders is therefore weak. However, knowledge in the neurobiology of eating behaviour and body weight control is rapidly expanding, and pharmacological manipulation of signalling molecules from peripheral fat stores (e.g. leptin) soon might offer new treatment strategies [4]. While we await the outcome of this research, we withdraw all psychoactive drugs when treating our patients. Instead, we implement non-invasive methods targeting what we believe are the main symptoms in anorexia and bulimia. Thus, patients are trained to eat using computer support, their physical activity is restricted, they rest in warm rooms after eating and they participate in a programme of social restoration. Supply of external heat has a rapid anti-anxiolytic effect and most psychiatric problems yield as the eating behaviour is normalized and the body weight is restored in anorexics, and as the eating behaviour is normalized and bingeing and purgeing are eliminated in bulimics. A recent RCT testifies to the effectiveness of this strategy, not only in bringing the patients into remission but also in minimizing relapse [5]. The development of new tools, including psychopharmacological tools, that may further improve this treatment is awaited with great interest.

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4.9
Evidence vs. Experience in Eating Disorders

Robert H. Belmaker[1]

The title of this series is "Evidence and Experience in Psychiatry" and indeed medicine is an empirical field that some have said is an art. Psychiatry in recent years has increasingly emphasized, and rightly so, its scientific aspects, and evidence-based medicine is clearly a philosophy that is more and more important and applicable in psychiatry. However, in all areas of medicine we know that individual clinical patients generate the ideas that later form the hypotheses for controlled trials. Without clinical experience, without chance observations and without an individual making a guess (perhaps basic science based, but a guess nonetheless) there would be no development of clinical science and evidence-based medicine. Moreover, we know that controlled clinical trials give us the results in the mean, i.e. we may decide that selective serotonin reuptake inhibitors (SSRIs) are significantly better than placebo for bulimia nervosa. However, the variance within the clinical population is clearly tremendous. Some patients have a nearly miraculous full therapeutic response and some patients show no benefits whatsoever. Would an evidence-based clinician continue the SSRI treatment of a patient who did not seem to respond? When would he/she be justified in stopping the "best evidence-based treatment"?

[1] *Department of Psychiatry, Ben Gurion University of the Negev, PO Box 4600, Beersheva, Israel*