Psychopharmacology for the Clinician
Psychopharmacologie pratique

To submit questions for this regular feature, please send them to the Journal of Psychiatry & Neuroscience / Revue de psychiatrie & de neuroscience, *Canadian Medical Association, 1867 Alta Vista Dr., Ottawa ON K1G 3Y6, Canada; fax 613 729-9545; jpn.office@sympatico.ca Please include details of any relevant case and your name, address, telephone and fax numbers as well as your email address.*

Should some drugs be avoided when treating bulimia nervosa?

Accumulating evidence suggests that antidepressants in combination with psychotherapy can be effective in the treatment of bulimia nervosa. Clinical experience supports the use of most selective serotonin reuptake inhibitors (i.e., fluoxetine, sertraline and citalopram) as well as some of the newer antidepressants (i.e., venlafaxine). The following case illustrates some of the factors that must be taken into account when considering pharmacological treatment for bulimia nervosa.

Ms. A. is a normal weight 28-year-old woman with a 5-year history of daily bingeing and self-induced vomiting. She describes recurrent seasonal depressions, generalized anxiety, mood lability, impulsivity and mild obsessive–compulsive symptoms. She admits to frequent dizziness, sporadic pinkish blood in her vomitus, heartburn and occasional leg cramps. She uses ecstasy once per week and caffeine pills daily to promote diuresis. Recent laboratory investigations and electrocardiogram were unremarkable except for sinus bradycardia with a rate of 58 beats/min.

A trial of sertraline, gradually increased to 125 mg and combined with cognitive-behaviour therapy, was successful in decreasing binge–purge frequency and in preventing seasonal depressive episodes. Within a few weeks of starting medication, the patient also reported decreased anxiety, irritability and mood lability.

This case illustrates that it is not unusual to find patients who fulfill criteria for other concomitant disorders in addition to bulimia nervosa. Studies have documented higher rates of major depression, bipolar disorder, anxiety disorders, obsessive–compulsive disorder, personality disorders and alcohol and substance abuse disorders among eating disorder sufferers. Although antidepressants tend to be effective for bulimia and several of its associated conditions, other conditions such as bipolar disorder or severe personality disorders may require the use of drugs from other classes, such as mood stabilizers and neuroleptics. The choice of medication should take into account the high prevalence of impulsivity in this population, even in the absence of borderline personality disorder; drugs that are potentially toxic in overdose should therefore be avoided. In addition, the high prevalence of recreational drug use as well as the tendency to abuse appetite suppressants, stimulants, fat burners, laxatives and diuretics, invites caution to avoid unexpected drug interactions or adverse effects.

Medical complications that arise from bingeing and purging must also be considered in the choice of medications. Drugs that prolong the QT interval (e.g., tricyclic antidepressants, some neuroleptics) may result in fatal arrhythmias in the context of intermittent hypokalemia induced by vomiting or laxative abuse. Drugs excreted by the kidney, such as lithium, should be avoided because of risk of toxicity due to recurrent dehydration and electrolyte disturbances. Bupropion is contraindicated because of the increased risk for seizures; patients should also be warned against its use for smoking cessation.

Finally, drugs that can increase appetite or cause weight gain (e.g., olanzapine, mirtazapine, paroxetine) are not recommended. In the context of the weight phobia, increasing appetite will not only affect compliance but also likely intensify the vicious cycle of dietary restriction, bingeing and purging.

Although medications can play a beneficial role in the treatment of bulimia nervosa, the choice of agent should be guided by a careful consideration of concomitant psychological characteristics, as well as by potential medical complications that may modify drug response.

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Competing interests: None declared.

The information in this column is not intended as a definitive treatment strategy but as a suggested approach for clinicians treating patients with similar histories. Individual cases may vary and should be evaluated carefully before treatment is provided.