# Bulimia nervosa in adults: Pharmacotherapy

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## INTRODUCTION

Pharmacotherapy is efficacious for bulimia nervosa and may be included in the treatment regimen as part of multimodal therapy [1-3]. Antidepressants have been most widely studied, and are typically the drugs of choice due to their demonstrated efficacy and tolerability [2,4-10].

The neurobiology of bulimia nervosa and the mechanism of action for pharmacotherapy are not known [11]. One hypothesis is that central nervous system serotonin pathways are disturbed in at least some patients [12,13].

Pharmacotherapy for bulimia nervosa is reviewed here. The epidemiology, neurobiology, clinical features, assessment, diagnosis, other treatments and outcome, and medical complications of bulimia nervosa and their management are discussed separately.

- (See "Eating disorders: Overview of epidemiology, clinical features, and diagnosis", section on 'Bulimia nervosa'.)
- (See "Bulimia nervosa in adults: Clinical features, course of illness, assessment, and diagnosis".)
- (See "Bulimia nervosa in adults: Cognitive-behavioral therapy (CBT)".)
- (See "Eating disorders: Overview of prevention and treatment".)
- (See "Bulimia nervosa and binge eating disorder in adults: Medical complications and their management".)

## DIAGNOSIS

The core features of bulimia nervosa are binge eating (ie, eating an amount of food that is definitely larger than most people would eat under similar circumstances), inappropriate compensatory behavior to prevent weight gain (eg, self-induced vomiting), and self-evaluation (self-worth) that is unduly influenced by body weight and shape [14]. The diagnostic criteria ( table 1) for bulimia nervosa, as well as its clinical features, are discussed separately. (See "Bulimia nervosa in adults: Clinical features, course of illness, assessment, and diagnosis", section on 'Diagnosis'.)

## DIFFERENT TREATMENTS AND THEIR EFFICACY

Pharmacotherapy is efficacious for bulimia nervosa and may be added to first-line treatment, which consists of nutritional rehabilitation plus psychotherapy [2,3,8]. Nutritional rehabilitation aims to restore a structured and consistent meal pattern, typically three meals and two snacks per day [2]. Cognitive-behavioral therapy and interpersonal psychotherapy can effectively facilitate nutritional rehabilitation. Pharmacotherapy alone is reasonable if specialized nutritional rehabilitation and psychotherapy are not available [8].

Additional information about nutritional rehabilitation and psychotherapy for bulimia nervosa is discussed separately. (See "Eating disorders: Overview of prevention and treatment", section on 'Bulimia nervosa'.)

**Pharmacotherapy combined with psychotherapy** — Combination treatment with pharmacotherapy plus psychotherapy appears to be more efficacious than either treatment alone for treating episodes of bingeing and purging [8,9,15].

**Compared with psychotherapy alone** — Combination treatment is more efficacious than psychotherapy alone. A meta-analysis of six randomized trials (257 patients with bulimia nervosa) found that remission occurred in more patients who received combination treatment compared with psychotherapy alone (49 versus 36 percent) [15,16]. However, dropout rates were higher for combination treatment than psychotherapy alone (30 versus 16 percent).

**Compared with pharmacotherapy alone** — Combination treatment appears to be more efficacious than pharmacotherapy alone [9]. A meta-analysis of four randomized trials (141 patients with bulimia nervosa) found that remission occurred in more patients who received combination treatment compared with medication alone (42 versus 23 percent); this difference was not statistically significant, but if real, would be clinically meaningful [15,16]. In addition,

depressive symptoms improved more with combination treatment. Dropout rates did not differ between combination treatment and pharmacotherapy alone (34 versus 41 percent).

**Pharmacotherapy alone compared with psychotherapy alone** — Pharmacotherapy alone appears to be inferior to psychotherapy alone for treating bulimia nervosa [8,9]. A meta-analysis of five randomized trials (237 patients with bulimia nervosa) found that remission occurred in fewer patients who received pharmacotherapy alone compared with psychotherapy alone (20 versus 39 percent); this difference was not statistically significant, but if real, would be clinically meaningful [15,17]. In addition, dropout rates were higher for pharmacotherapy than psychotherapy (40 versus 18 percent).

## INDICATIONS FOR PHARMACOTHERAPY

Pharmacotherapy combined with nutritional rehabilitation and psychotherapy is indicated for treatment of bulimia nervosa, as well as comorbid anxiety disorders and unipolar depressive disorders [2-7,9,18]. However, if nutritional rehabilitation and psychotherapy are not available, pharmacotherapy alone is reasonable, in conjunction with self-help workbooks and educational material for patients and family members to read.

The clinical features and diagnosis of bulimia nervosa ( table 1) are discussed separately. (See "Bulimia nervosa in adults: Clinical features, course of illness, assessment, and diagnosis".)

## GENERAL PRINCIPLES OF PHARMACOTHERAPY

**Goal of treatment** — The goal of treatment is remission, ie, abstinence of binge eating and purging. However, many authorities regard a 50 to 75 percent reduction in the frequency of bingeing and purging as a clinically meaningful response to pharmacotherapy [6,19]. Clinicians should regularly monitor patients with residual binge eating and purging because continued symptoms even at substantially reduced levels carry a substantial risk for relapse [5,20].

**Pretreatment assessment** — Prior to pharmacotherapy, the clinician should assess the following issues that affect whether and how pharmacotherapy is conducted [2]:

- Intentions regarding pregnancy
- Frequency of binge eating and purging episodes
- Time of day that the patient vomits (if this is the inappropriate compensatory behavior used to prevent weight gain)
- Excessive concern about body weight and shape

- Comorbid psychopathology, such as anxiety and depressive disorders
- Sexual functioning
- Psychosocial impairment

Patients planning to become pregnant should be referred for first-line treatment with nutritional rehabilitation and psychotherapy, rather than pharmacotherapy. Nutritional rehabilitation, psychotherapy, and the possible teratogenic effects of antidepressants are discussed separately. (See "Eating disorders: Overview of prevention and treatment", section on 'Bulimia nervosa' and "Antenatal use of antidepressants and the potential risk of teratogenicity and adverse pregnancy outcomes: Selective serotonin reuptake inhibitors" and "Antenatal use of antidepressants and risks of teratogenicity and adverse pregnancy outcomes: Drugs other than selective serotonin reuptake inhibitors".)

The baseline frequency of bingeing and inappropriate compensatory behavior, as well as the level of other psychopathology, provide an index for tracking progress. Medication should be ingested at least 30 minutes prior to vomiting to facilitate absorption. Assessing baseline sexual functioning is helpful to distinguish medication-induced sexual dysfunction from sexual dysfunction that occurs as a symptom of bulimia nervosa.

The comprehensive assessment of patients with bulimia nervosa is discussed separately. (See "Bulimia nervosa in adults: Clinical features, course of illness, assessment, and diagnosis", section on 'Assessment'.)

**Adverse side effects** — To enhance adherence to medications, clinicians should tell patients that adverse side effects may emerge prior to therapeutic effects and that many side effects are transient.

**Weight change as a side effect** — Medication-induced weight change is a problem for patients with bulimia nervosa, who by definition focus excessively upon body weight and shape and make inappropriate efforts to lose weight [14]. In discussing weight change as part of informed consent, clinicians should ask patients about their fear of gaining weight, and also explain that cessation of purging does not typically lead to weight gain [21].

Antidepressants can cause weight gain [22]. Tricyclics and monoamine oxidase inhibitors are more likely to cause weight gain than selective serotonin reuptake inhibitors [23]. Long-term treatment with selective serotonin reuptake inhibitors may result in weight gain, although little or no weight change may be noticed during the first two to three months of therapy [24-30]. In a study of fluoxetine, paroxetine, and sertraline, paroxetine appeared to cause the most weight gain [31].

Topiramate, a third-line therapy, can cause weight loss in patients with bulimia nervosa [32,33]. Patients who are obese, overweight, or at the high end of the normal range may welcome the weight loss. However, weight loss is a problem for patients who are underweight or at the low end of the normal range, and in addition, may exacerbate eating disorder psychopathology regarding body weight.

Additional information about weight change as a side effect of antidepressants and topiramate is discussed separately. (See "Selective serotonin reuptake inhibitors: Pharmacology, administration, and side effects", section on 'Weight change' and "Tricyclic and tetracyclic drugs: Pharmacology, administration, and side effects", section on 'Antihistaminic' and "Monoamine oxidase inhibitors (MAOIs): Pharmacology, administration, safety, and side effects".)

**Serious side effects** — Antidepressants may cause serious side effects, including a possible risk of increased suicidality in young adults. Bupropion may provoke seizures in patients with bulimia nervosa and is contraindicated (see 'Avoiding bupropion' below). Monoamine oxidase inhibitors can cause a hyperadrenergic crisis. (See "Monoamine oxidase inhibitors (MAOIs): Pharmacology, administration, safety, and side effects", section on 'Safety risks'.)

**Suicidality** — Concerns have been raised about an association between antidepressants and suicidality (suicidal ideation, preparatory act, attempt, or death). There may be an age-specific effect, such that antidepressants raise the risk of suicidality in patients aged 18 to 24 years. The potential effect of antidepressants on suicide risk in adults and children is discussed separately. (See "Effect of antidepressants on suicide risk in adults" and "Effect of antidepressants on suicide risk in children and adolescents".)

**Duration of an adequate trial** — Based upon clinical experience, a medication that fails to show a satisfactory response (≥50 to 75 percent reduction in the frequency of bingeing and purging episodes) within four to eight weeks should be discontinued and substituted with a new medication. Most randomized trials have lasted six to eight weeks [6].

For particularly urgent clinical situations, it may be possible to identify within the first few weeks whether the patient is unlikely to respond to a specific medication. Two studies show that lack of meaningful improvement during the first two to three weeks of treatment suggests that the patient will probably not respond to a longer course of treatment (response was defined as at least a 75 percent reduction in the frequency of bingeing and purging).

- A study of 785 patients involving fluoxetine found that a decrease of <60 percent in bingeing and purging episodes by week 3 of treatment correctly identified nearly 80 percent of the patients who ultimately did not respond by week 8 [19].

- A study of 77 patients involving desipramine found that a decrease of <50 percent in bingeing and purging episodes by week 2 of treatment correctly identified 80 to 85 percent of the patients who ultimately did not respond by week 6 [34].

## ACUTE PHARMACOTHERAPY

We suggest that acute pharmacotherapy for bulimia nervosa proceed according to the sequence that is described in the subsections below. Patients initially receive first-line treatment and progress through each step until they respond. The sequence of treatment is summarized and depicted in the following algorithm ( algorithm 1).

Randomized trials have demonstrated that several drugs are superior to placebo for treating bulimia nervosa [2-4,8-10]. However, no placebo-controlled, head-to-head trials of active drugs have been conducted. In addition, no randomized trials have evaluated the serotonin-norepinephrine reuptake inhibitors.

Among patients with bulimia nervosa who are treated with pharmacotherapy, improvement of symptoms occurs more often than remission [10]. The potential benefits of pharmacotherapy include reduction of binge eating episodes (binges), purges, eating disorder cognitions, and comorbid psychopathology such as anxiety disorders and unipolar depressive disorders. A review of randomized trials found that among patients treated with an antidepressant, the median reduction in the frequency of bingeing and purging was nearly 70 percent [5]. By contrast, reviews and meta-analyses of randomized trials have found that remission occurs in only 20 to 32 percent of patients [5,7,15,16]. There do not appear to be any consistent baseline predictors of acute response [19].

Nearly all randomized pharmacotherapy trials have studied antidepressants, and the evidence indicates that antidepressants are efficacious [2,4-8,10]. As an example, a meta-analysis of eight randomized trials compared antidepressants with placebo in 901 patients with bulimia nervosa; active treatment included selective serotonin reuptake inhibitors (SSRIs), tricyclic antidepressants, and monoamine oxidase inhibitors (MAOIs) [6]. Improvement (reduction of baseline binge eating episodes ≥50 percent) occurred more often with antidepressants than placebo (relative risk 1.6, 95% CI 1.4-1.9). However, discontinuation of treatment due to adverse events was greater with antidepressants.

Medication combinations should generally be avoided because they have rarely been studied [35], and bupropion is contraindicated in bulimia nervosa. (See 'Avoiding bupropion' below.)

For patients with bulimia nervosa who do not respond to one medication and are switching to another drug, we usually cross-taper the drugs, except when switching to an MAOI. Clinicians must cautiously switch patients to or from an MAOI because drug-drug interactions can cause severe toxicity, including hypertensive crisis or serotonin syndrome. (See "Switching antidepressant medications in adults".)

**First-line** — We suggest the SSRI fluoxetine as first-line treatment because of its efficacy for the behavioral and cognitive symptoms of bulimia nervosa, as well as its tolerability ( algorithm 1) [4,8,36,37]. First-line treatment with fluoxetine is consistent with multiple practice guidelines [2,18,38].

Clinicians should prescribe fluoxetine at an initial dose of 20 mg per day for the first week and titrate up by increments of 20 mg per day each week to a target dose of 60 mg per day, depending upon the therapeutic response, tolerability, and clinical urgency.

Fluoxetine is the best studied medication for bulimia nervosa in adults, but the trials have typically been small, limited by high dropout rates, and have compared fluoxetine with only placebo rather than other medications. Evidence supporting the use of fluoxetine includes a review that identified 12 randomized trials with fluoxetine and found that abstinence of symptoms occurred in 18 percent [35]. In a separate review of five randomized trials, four reported reduced bingeing and purging with fluoxetine compared with placebo [4]. In addition, the four trials found that fluoxetine improved dietary restraint, food preoccupation, and excessive concern and dissatisfaction with body weight and shape. Some trials found that fluoxetine decreased depressive symptoms, whereas other trials did not.

Multiple randomized trials have established that the target dose for fluoxetine in bulimia nervosa is 60 mg per day, which is higher than the standard dose for major depression [4,8,9,36,37]. As an example, one randomized trial compared two doses of fluoxetine with placebo in 387 bulimia nervosa patients for eight weeks and found that the frequency of vomiting episodes decreased more in patients who received fluoxetine 60 mg per day, compared with either fluoxetine 20 mg or placebo (56 versus 29 and 5 percent) [36]. The frequency of binge-eating episodes also decreased more with fluoxetine 60 mg (67 versus 45 and 33 percent). Fluoxetine 20 mg per day was superior to placebo for reducing episodes of vomiting, but not binge eating. In addition, adverse events for the two doses of fluoxetine were comparable.

Fluoxetine is also first-line treatment for patients not responding adequately to psychotherapy [39]. Based upon our clinical experience, if psychotherapy provides little or no benefit, it should

be discontinued as patients are switched to pharmacotherapy. If psychotherapy provides some benefit, fluoxetine should be added.

Additional information about fluoxetine is discussed separately. (See "Selective serotonin reuptake inhibitors: Pharmacology, administration, and side effects".)

**Side effects** — To enhance adherence, clinicians should tell patients that side effects may emerge prior to therapeutic effects and that many side effects are transient. Fluoxetine and other SSRIs that are used for bulimia nervosa can cause the same side effects that commonly occur in general clinical use ( table 2). (See "Selective serotonin reuptake inhibitors: Pharmacology, administration, and side effects", section on 'Side effects'.)

One common side effect of SSRIs is sexual dysfunction [40]. In females, this largely manifests as diminished libido and interference with orgasm, and for males, erectile dysfunction. However, maladaptive thoughts about body weight and shape that occur as part of bulimia nervosa can also interfere with sexual functioning. Thus, determining whether sexual dysfunction is an SSRI side effect is facilitated by assessing sexual functioning prior to pharmacotherapy. (See 'Pretreatment assessment' above.)

Based upon our clinical experience, successful treatment of bulimia nervosa often resolves sexual dysfunction that is present at baseline. Managing SSRI-induced sexual dysfunction is discussed separately. (See "Sexual dysfunction caused by selective serotonin reuptake inhibitors (SSRIs): Management".)

**Second-line** — For patients with bulimia nervosa who do not tolerate or respond to fluoxetine, second-line pharmacotherapy is another SSRI. We typically use sertraline, but a reasonable alternative is escitalopram or fluvoxamine ( algorithm 1). SSRIs are second-line choices because they are better tolerated than third-line treatments [2]. Using SSRIs other than fluoxetine as second-line treatment is consistent with multiple practice guidelines [2,18,38].

When switching from first-line to second-line treatment, we usually cross-taper the drugs. (See "Switching antidepressant medications in adults".)

Given the experience with fluoxetine, it's reasonable to expect that sertraline, escitalopram, or fluvoxamine will provide a better response at doses that are higher than the usual dose used to treat major depression [41]; the titration intervals are comparable to those used for depression ( table 3). (See "Selective serotonin reuptake inhibitors: Pharmacology, administration, and side effects", section on 'Dose'.)

The SSRI paroxetine is typically not used for bulimia nervosa due to concerns about weight gain. (See 'Weight change as a side effect' above.)

In addition, the SSRI citalopram is generally not used because of concerns about adverse cardiac effects, especially in light of electrolyte disturbances that can occur in bulimia nervosa. (See "Selective serotonin reuptake inhibitors: Pharmacology, administration, and side effects", section on 'Citalopram' and "Bulimia nervosa and binge eating disorder in adults: Medical complications and their management", section on 'Renal and electrolytes'.)

Evidence for the efficacy of sertraline, escitalopram, or fluvoxamine includes small randomized trials:

- Sertraline – A three-month randomized trial that compared sertraline (100 mg per day) with placebo in 20 women with bulimia nervosa showed that binge eating and purging episodes decreased more with sertraline [42].

- Escitalopram – Escitalopram is one of the two stereoisomers that constitute citalopram and escitalopram more potently inhibits reuptake of serotonin compared with the other stereoisomer. A three-month randomized trial compared citalopram (40 mg per day) with placebo in 27 women with bulimia nervosa and found that self-rated global assessment of symptoms improved more with active drug than placebo; however, reduction in the number of bingeing and purging episodes was comparable [43]. In addition, a three-month, open-label randomized trial compared citalopram (20 to 40 mg per day) with fluoxetine (20 to 60 mg per day) in 37 patients with bulimia nervosa, and found that improvement of the overall severity of illness was comparable for the two groups [44].

  Additional indirect evidence supporting the use of escitalopram includes a three-month randomized trial that compared escitalopram (mean dose 27 mg per day) with placebo in 44 patients with binge eating disorder [45]. Global severity of illness improved more with escitalopram than placebo, and one analysis showed that reduction of binge eating was also greater with active drug. However, another analysis found that reduction of binge eating was comparable for escitalopram and placebo.

- Fluvoxamine – A three-month randomized trial that compared fluvoxamine (200 mg per day) with placebo in 12 women with bulimia nervosa showed that reduction of binge eating and purging episodes was greater with fluvoxamine [46].

Additional information about sertraline, escitalopram and fluvoxamine, including side effects ( table 2), is discussed separately. (See "Selective serotonin reuptake inhibitors: Pharmacology, administration, and side effects".)

**Third-line** — For patients with bulimia nervosa who do not tolerate or respond to first- and second-line medications, we suggest third-line pharmacotherapy with tricyclic antidepressants, trazodone, MAOIs, and topiramate. The order of preference depends upon whether patients have a comorbid anxiety disorder or unipolar depressive disorder and whether patients have a low normal weight (eg, body mass index (calculator 1) ≥18.5 and <22 kg/m$^2$).

For patients with bulimia nervosa who require third-line treatment, and who have a comorbid anxiety disorder or unipolar depressive disorder, or who have a low normal weight, our order of preference for pharmacotherapy is as follows ( algorithm 1):

- Tricyclic antidepressants (eg, desipramine or nortriptyline)
- Trazodone
- MAOIs (eg, phenelzine)
- Topiramate

For patients with bulimia nervosa who require third-line treatment, but do not have a comorbid anxiety disorder or unipolar depressive disorder, and do not have a low normal weight, our order of preference for pharmacotherapy is as follows:

- Topiramate
- Tricyclic antidepressants
- Trazodone
- MAOIs

Using tricyclics, trazodone, MAOIs, and topiramate for bulimia nervosa is consistent with multiple practice guidelines [2,18,38], based upon randomized trials that demonstrated their efficacy [3-5,8,32,33,47]. However, these drugs are generally third-line options because of numerous potential side effects ( table 2) [2-5,8,18,32,33,47]. In addition, MAOIs require a tyramine-free diet; restricting food is problematic in patients with eating disorders, who typically have extensive, self-imposed dietary rules and restrictions that require treatment [8].

When switching from second-line treatment to third-line treatments, or between third-line treatments, we usually cross-taper the drugs, except when switching to an MAOI. Clinicians must cautiously switch patients to or from a MAOI because drug-drug interactions can cause severe toxicity, including hypertensive crisis or serotonin syndrome. (See "Switching antidepressant medications in adults".)

The dose of tricyclics, trazodone, MAOIs, or topiramate for treating bulimia nervosa is usually the same dose that is used in general clinical practice. Bulimia nervosa patients receiving these medications can expect to encounter the same side effects ( table 2) that commonly occur in

general clinical use. Additional information about tricyclics, trazodone, MAOIs, and topiramate is discussed separately. (See "Tricyclic and tetracyclic drugs: Pharmacology, administration, and side effects" and "Serotonin modulators: Pharmacology, administration, and side effects" and "Monoamine oxidase inhibitors (MAOIs): Pharmacology, administration, safety, and side effects".)

Evidence for the efficacy of third-line options for bulimia nervosa includes randomized trials:

- Tricyclic antidepressants – A review identified seven trials that compared a tricyclic with placebo, including four that studied desipramine; the tricyclic was superior in six of the seven trials [10]. As an example, an eight-week randomized trial with 78 patients found that episodes of bingeing and purging decreased more with desipramine compared with placebo [48].

- Trazodone – A trial with 42 patients found that episodes of bingeing and purging decreased more with trazodone than placebo [49].

- MAOIs – A review identified four trials that compared an MAOI with placebo; the MAOI was superior in three of the trials [10]. As an example, a 10-week trial in 50 patients found that episodes of bingeing decreased more with phenelzine than placebo [50].

- Topiramate – Two trials with a total of 129 patients each found that over 10 weeks, the frequency of bingeing and purging decreased more with topiramate than placebo [32,33,47]. In both trials, body weight decreased more in patients who received topiramate compared with placebo, which is potentially problematic for patients with bulimia nervosa [8]. (See 'Weight change as a side effect' above.)

Although one randomized trial found that the anti-emetic ondansetron was efficacious for bulimia nervosa [51], it is generally not prescribed for this disorder.

For patients who do not respond to any of the third-line agents, we generally discontinue pharmacotherapy.

**Avoiding bupropion** — Bupropion can cause seizures in patients with active symptoms of bulimia nervosa and is thus contraindicated in patients with a current or prior diagnosis of bulimia nervosa (or anorexia nervosa) [8,9,52,53].

## MAINTENANCE PHARMACOTHERAPY

Among acutely ill bulimia nervosa patients who respond or remit, 30 percent relapse [5,20]. Thus, most authorities continue pharmacotherapy for at least 6 to 12 months after response or remission [2,5]. The duration of maintenance pharmacotherapy will vary for each patient, depending upon the number of years the patient has been ill and the number of acute episodes and hospitalizations that have occurred. In reassessing the need for medication every 6 to 12 months, the clinician should also consider the stability of the patient's recovery (ie, has the patient remained completely free of symptoms or have there been subsyndromal symptoms), the presence of comorbid psychopathology, and the patient's level of psychosocial functioning. An observational study of 200 patients (mean follow-up duration of 12 years) suggests that pharmacotherapy can eventually be discontinued in many or most patients without recurrence [54].

Although maintenance treatment clearly reduces relapse, premature discontinuation is common, probably due to poor tolerability:

- One randomized trial compared maintenance fluoxetine (60 mg per day) with placebo for up to 12 months in 150 patients who initially responded to open-label fluoxetine [55]. Relapse occurred in fewer patients who received fluoxetine compared with placebo (33 versus 51 percent). However, discontinuation of maintenance treatment due to relapse or other reasons was comparable for fluoxetine and placebo (63 and 68 percent).

- A second randomized trial compared maintenance fluvoxamine (mean dose 182 mg per day) with placebo for up to 15 weeks in 72 patients who initially responded to multimodal treatment that included open-label fluvoxamine [56]. Abstinence of bingeing was greater in patients who received fluvoxamine compared with placebo (70 versus 35 percent). However, discontinuation of maintenance treatment was greater with fluvoxamine (51 versus 14 percent).

## SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Eating disorders".)

## INFORMATION FOR PATIENTS

UpToDate offers two types of patient education materials, "The Basics" and "Beyond the Basics." The Basics patient education pieces are written in plain language, at the 5$^{th}$ to 6$^{th}$ grade reading level, and they answer the four or five key questions a patient might have about a given

condition. These articles are best for patients who want a general overview and who prefer short, easy-to-read materials. Beyond the Basics patient education pieces are longer, more sophisticated, and more detailed. These articles are written at the 10th to 12th grade reading level and are best for patients who want in-depth information and are comfortable with some medical jargon.

Here are the patient education articles that are relevant to this topic. We encourage you to print or e-mail these topics to your patients. (You can also locate patient education articles on a variety of subjects by searching on “patient info” and the keyword(s) of interest.)

- Basics topics (see "Patient education: Bulimia nervosa (The Basics)")

## SUMMARY AND RECOMMENDATIONS

- The diagnostic criteria ( table 1) for bulimia nervosa include binge eating, inappropriate compensatory behavior to prevent weight gain, and self-evaluation that is unduly influenced by body weight and shape. (See "Bulimia nervosa in adults: Clinical features, course of illness, assessment, and diagnosis", section on 'Diagnosis'.)

- Pharmacotherapy alone appears to be less efficacious than psychotherapy alone, and combining the two appears to be the best approach. Nevertheless, pharmacotherapy is efficacious for bulimia nervosa and may be included in the initial treatment regimen, along with nutritional rehabilitation and psychotherapy. However, using pharmacotherapy alone is reasonable if specialized nutritional services or psychotherapy are not available. (See 'Different treatments and their efficacy' above and "Eating disorders: Overview of prevention and treatment".)

- For patients with bulimia nervosa who are treated with pharmacotherapy, we suggest fluoxetine as first-line treatment rather than other medications ( algorithm 1) (**Grade 2C**). The target dose is 60 mg per day. (See 'First-line' above.)

- For patients with bulimia nervosa who do not tolerate or respond to fluoxetine, we suggest second-line pharmacotherapy with a different selective serotonin reuptake inhibitor (**Grade 2C**). We typically use sertraline, but a reasonable alternative is escitalopram or fluvoxamine; these drugs are often prescribed at higher doses for bulimia nervosa than are used to treat major depression. (See 'Second-line' above.)

- Third-line medication options for bulimia nervosa include other antidepressants or topiramate. For patients who have a comorbid anxiety disorder or unipolar depressive

disorder, or who have a low normal weight, our order of preference for pharmacotherapy is as follows: tricyclic antidepressants, trazodone, monoamine oxidase inhibitors, or topiramate. For patients who do not have a comorbid anxiety disorder or unipolar depressive disorder, and do not have a low normal weight, our order of preference is topiramate, tricyclics, trazodone, or monoamine oxidase inhibitors (See 'Third-line' above.)

- Bupropion is contraindicated in bulimia nervosa. (See 'Avoiding bupropion' above.)

- Patients with bulimia nervosa who receive pharmacotherapy can expect to encounter the same side effects ( table 2) that commonly occur in general clinical use. Antidepressants in general may possibly increase the risk of suicidality in young adults, but there is no clear evidence. (See 'Side effects' above and 'Serious side effects' above.)

- Relapse of bulimia nervosa occurs frequently. For patients who respond to or remit with pharmacotherapy, we suggest maintenance pharmacotherapy rather than no pharmacotherapy (**Grade 2C**). Although maintenance treatment prevents relapse, premature discontinuation is common, probably due to poor tolerability.

  The duration of maintenance pharmacotherapy varies, depending upon several clinical factors. Maintenance pharmacotherapy is typically prescribed for at least 6 to 12 months beyond response or remission. (See 'Maintenance pharmacotherapy' above.)



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