Behandling av spiseforstyrrelser

Notat
Systematisk litteratursøk
med sortering
Desember 2010

kunnskapssenteret

Bakgrunn: Kunnskapssenteret fikk i oppdrag fra Helsedirektoratet å utføre et systematisk litteratursøk med påfølgende sortering av mulig relevante systematiske oversikter. Helsedirektoratet skal bruke dette i sitt arbeid med nasjonale retningslinjer. Oppdraget var å finne oversikter om behandling av spiseforstyrrelser med vekt på familieterapi, kognitiv terapi, medikamentell, poliklinisk behandling og selvhjelp for personer med anoreksi, bulimi og overspisningslidelse. **Metode:** Vi utarbeidet et systematisk litteratursøk. I juni 2010 søkte vi i følgende databaser; Medline, Embase, PsycInfo, Cinahl, SveMed + og Cochrane Library. Tre medarbeidere gikk uavhengig av hverandere gjennom identifiserte publikasjoner/referanser og vurderte relevans etter inklusjonskriteriene. **Resultat:** Søket resulterte i 4 269 referanser. Vi vurderte de identifiserte referansene til å være mulig relevante i henhold til de forhånsdefinerte inklusjonskriteriene og av disse ble 41 oversikter og metaanlyser inkludert. Vi sorterte oversiktene etter behandlingstiltak; 1) familieterapi, kognitiv terapi, medikamentell, poliklinisk behandling eller selvhjelp, 2) etter diagnosegruppene anoreksi,

(fortsetter på baksiden)

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(fortsettelsen fra forsiden) bulimi, og overspisningslidelse. **Konklusjon:** Denne kartleggingen av forskningspublikasjoner viser hva som finnes av oppsummert forskning om medikamentelle og psykososiale tiltak i behandlingen av personer med spiseforstyrrelser. Oversiktene vi henviser til er ikke nødvendigvis systematiske eller av høy kvalitet. Konsekvensen er at vi anbefaler å kritisk vurdere oversiktene vi henviser til før de eventuelt brukes i nasjonal retningslinjer av spiseforstyrrelser.

Tittel	Behandling av spiseforstyrrelser
Institusjon	Nasjonalt kunnskapssenter for helsetjenesten
Ansvarlig	John-Arne Røttingen, *direktør*
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Nøkkelord	Spiseforstyrrelser, anoreksi, bulimi, overspisningslidelse, medikamentell, kognitiv terapi, familieterapi, selvhjelp, poliklinisk behandling
Sitering	Steiro, A., Hammerstrøm, KT, Fønhus, MS. Behandling av spiseforstyrrelser – systematisk litteratursøk med sortering. Notat 2010. Oslo: Nasjonalt kunnskapssenter for helsetjenesten, 2010.

Nasjonalt kunnskapssenter for helsetjenesten fremskaffer og formidler kunnskap om effekt av metoder, virkemidler og tiltak og om kvalitet innen alle deler av helsetjenesten. Målet er å bidra til gode beslutninger slik at brukerne får best mulig helsetjenester. Senteret er formelt et forvaltningsorgan under Helsedirektoratet, uten myndighetsfunksjoner. Kunnskapssenteret kan ikke instrueres i faglige spørsmål.

Nasjonalt kunnskapssenter for helsetjenesten
Oslo, november 2010

Sammendrag

Hva er effekten av medikamentell og psykososial behandling for personer med spiseforstyrrelser?

Kunnskapssenteret fikk i oppdrag fra Helsedirektoratet å utføre et systematisk litteratursøk med påfølgende sortering av mulig relevante systematiske oversikter. Helsedirektoratet skal bruke dette i sitt arbeid med nasjonale retningslinjer. Oppdraget var å finne oversikter om behandling av spiseforstyrrelser med vekt på familieterapi, kognitiv terapi, medikamentell, poliklinisk behandling og selvhjelp for personer med anoreksi, bulimi og overspisningslidelse.

Vi utarbeidet et systematisk litteratursøk. I juni 2010 søkte vi i følgende databaser; Medline, Embase, PsycInfo, Cinahl, SveMed + og Cochrane Library. Tre medarbeidere gikk uavhengig av hverandere gjennom identifiserte publikasjoner/referanser og vurderte relevans etter inklusjonskriteriene.

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Denne kartleggingen av forskningspublikasjoner viser hva som finnes av oppsummert forskning om medikamentelle og psykososiale tiltak i behandlingen av personer med spiseforstyrrelser. Oversiktene vi henviser til er ikke nødvendigvis systematiske eller av høy kvalitet. Konsekvensen er at vi anbefaler å kritisk vurdere oversiktene vi henviser til før de eventuelt brukes i nasjonal retningslinjer av spiseforstyrrelser.

Behandling av spiseforstyrrelser

Hva slags notat er dette?

Systematisk litteratursøk med sortering
Systematisk litteratursøk med sortering er resultatet av å søke etter relevant litteratur ifølge en søkestrategi og sortere denne litteraturen i grupper.

Hva er inkludert?

Systematiske oversikter, randomiserte kontrollerte studier, prospektive kohortstudier

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Hvem står bak denne rapporten?

Nasjonalt kunnskapssenter for helsetjenesten på oppdrag fra Heledirektoratet

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Når ble den laget?

Søk etter studier ble avsluttet juni 2010.

Executive summary

What is the effect of medication and psychosocial treatment for persons with eating disorder?

The Norwegian Knowledge Centre for the Health Services was commissioned by the Norwegian Directorate of Health to perform a systematic search for systematic reviews on psychosocial and medical interventions for persons with eating disorder, and sorting into medicational treatment, cognitive therapy, family therapy, self help and outpatient treatment, for persons diagnosed according to anorexia, bulimic or binge eating disorder.

We developed a systematic literature search. We performed systematic searches in Medline, Embase, PsycInfo, Cinahl, SveMed+ and Cochrane Library june 2010. Three of the project team read and assessed title and abstracts independently and assessed relevance after predefined inclusion criteria.

The search identified 4269 articles. We included 41 reviews that were considered relevant after using predefined inclusion criteria, and sorted these references according to type of population and intervention. Abstracts of included reviews are presented in the appendix. We did not assess the methodological quality of the reviews, nor did we summarize or grade the evidence. We highly recommend using checklist to assess the quality of the reviews.

Our mapping of research publications showed the existing summarized research of medication and psychosocial treatment for persons with eating disorder. The reviews we refer to are not necessarily systematic or of high quality. These potential weaknesses show the need for thorough assessment. We strongly recommend a critical appraisal, before utilization of this evidence into practice.

Innhold

Forord

Nasjonalt kunnskapssenter for helsetjenesten fikk i oppdrag fra Helsedirektoratet ved seniorrådgiver Åste Herheim å foreta et søk og sorter av internasjonal forskning om effekten av familieterapi, kognitiv terapi, medikamentell, poliklinisk behandling og selvhjelp for personer med anoreksi, bulimi og overspisningslidelse.

Bakgrunnen for bestillingen var arbeidet med Nasjonale retningslinjer for behandling av spiseforstyrrelser der en ønsket å få en oversikt over oppsummert forskning på effekten av behandling. Vi har ikke lest oversiktene vi identifiserte i fulltekst eller vurdert den metodiske kvaliteten av dem. I vedlegget til Kunnskapssenterets håndbok "Slik oppsummerer vi forskning" finnes det sjekklister som kan brukes til å vurdere kvaliteten på oversiktene.
(http://www.kunnskapssenteret.no/binary?download=true&id=10570).

I dette notatet viser vi til systematiske oversikter, metaanlyser og oversiktsartikler som vi har identifisert via litteratursøkene våre.

Prosjektgruppen har bestått av:

- Prosjektleder: forsker, Asbjørn Steiro, Kunnskapssenteret
- Prosjektmedarbeider, forskningsbibliotekar, Karianne Thune Hammerstrøm, Kunnskapssenteret og forsker, Marita Sporstøl Fønhus, forsker.
- Takk til Marita Heintz, Helsedirektoratet som gjennomførte søk og utviklet søkestrategien.
- Takk for faglige bidrag med å formulere problemstillinger fra Nasjonalt klinisk Nettverk for spiseforstyrrelser representert ved Stein Frostad, Haukland Sykehus, Øyvind Rø, Modum Bad, Sigrid Bjørnelv, Regionalt Kompetansesenter for spiseforstyrrelser Levanger og Inger Halvorsen, Regionalt Kompetansesenter for spiseforsytrrelser (RASP) ved Ullevål Universitetsykhus.

Gro Jamtvedt	Liv Merete Reinar	Asbjørn Steiro
Avdelingsdirektør	*Seksjonleder*	*Prosjektleder*

Innledning

Spiseforstyrrelser er et betydelig helseproblem som særlig rammer jenter i tenårene og unge kvinner. Medisinsk forskning på store befolkningsgrupper viser nå at andelen gutter og menn er økende, og at barn rammes i større grad enn tidligere. De fleste som rammes av spiseforstyrrelser har behov for poliklinisk behandling, mens en liten del er så alvorlig syke at de vil ha behov for sykehusinnleggelse. Alle landets poliklinikker, både innen psykisk helsevern for voksne og for barn og unge samt distriktspsykiatriske sentre, skal ha generell kompetanse på spiseforstyrrelser når det gjelder diagnostikk og behandling. De regionale helseforetakene har ansvar for å koordinere behandlingskjeden og utvikle et klinisk spesialtilbud for de aller sykeste.

De vanligste spiseforstyrrelsene er anoreksi, bulimi og overspising, som hovedsakelig diagnostiseres og behandles i spesialisthelsetjenesten. En persons erfaringer kan ikke alltid bare plasseres i én kategori, fordi spisemønsteret kan forandre seg over tid. Behandling med kognitiv terapi gir god effekt, men det mangler god vitenskapelig dokumentasjon på en rekke andre behandlinger. Barn og unge vurderes av klinikere til å være mer mottakelige for behandling av spiseforstyrrelser, noe som gir bedre prognose for gode effekter av behandlingen.

Omkring 50 000 mennesker i Norge har en form for spiseforstyrrelse, med store personlige og samfunnsmessige kostnader. Spiseforstyrrelser fører til nedsatt funksjonsevne, beinskjørhet, underernæring, psykososiale faktorer som angst og depresjon. Nasjonal forskning anslår at prevalensen av sykdommen for kvinner mellom 15 og 44 år for anoreksi er 0,3 %, for bulimi 2 % og overspisingslidelse 3 % (Folkehelseinstituttet). Flere kvinner enn menn blir syke, og forekomsten øker med alderen. Spiseforstyrrelser medfører store kostnader ved behandling og oppfølging av pasienter. Dessuten påløper det store indirekte kostnader knyttet til yrkesuførhet, og personlig belastning sykdommen påfører den enkelte pasient og pårørende. I Norge behandles spiseforstyrrelser tverrfaglig, og hvor pasienten kan få tilbud om ernæringsrådgivning, psykososiale tiltak og medikamentell behandling. De nevnte behandlingene kan gis alene, eller i kombinasjon med annen behandling.

Problemstilling

Vi har søkt etter internasjonale forskningslitteratur i form av systematiske oversikter som vurderer effekten av medikamentell, kognitiv terapi, familieterapi, selvhjelp og poliklinisk behandling som har fått en diagnose på anoreksi, bulimi, eller overspisningslidelse (DSM-IV-TR[1] diagnostic criteria eller ICD-10[2]).

- Hva er effekten av familieterapi for personer som har fått en diagnose på anoreksi, bulimi, eller overspisningslidelse?
- Hva er effekten av kognitiv terapi for personer som har fått en diagnose på anoreksi, bulimi, eller overspisningslidelse?
- Hva er effekten av medikamentell behandling for personer som har fått en diagnose på anoreksi, bulimi, eller overspisningslidelse?
- Hva er effekten av poliklinisk behandling for personer som har fått en diagnose på anoreksi, bulimi, eller overspisningslidelse?
- Hva er effekten av selvhjelpsgrupper for personer som har fått en diagnose på anoreksi, bulimi, eller overspisningslidelse?

Den fullstendige listen over problemstillinger (PICO) ligger helt bakerst i vedlegget.

[1] Kilde: *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition, Text Revision. Washington, DC, American Psychiatric Association,2000. Copyright 2000, American Psychiatric Association. Used with permission.
[2] International Classification of Diseases, 10th Edition

Metode

Metodekapittelet innholder datakilder og søkestrategi, utvelgelse av studier (inklusjons- og eksklusjonskriterier).

Litteratursøk

Vi søkte systematisk etter oversikter og enkeltstudier i følgende databaser:

- Medline
- Embase
- PsycInfo
- Cinahl
- SveMed+
- Cochrane Library

Forskningsbibliotekar Marita Heintz (MH) planla og utførte samtlige søk i samarbeid med prosjektleder Asbjørn Steiro (AS) og Karianne Thune Hammerstrøm (KTH). Den fullstendige søkestrategien er presentert i vedlegg 1.

Vi la bestillingen til grunn ved utarbeiding av litteratursøket og søkte etter systematiske oversikter som oppfylte våre inklusjonskriterier for de nevnte diagnosegruppene og tiltakene. Emneord og tekstord i litteratursøket ble satt sammen av en bibliotekar etter diskusjon med oppdragsgiver og prosjektgruppen.

Vi brukte et filter for systematiske oversikter og ett for randomiserte kontrollerte studier. I de tilfeller der det var mulig valgte vi det filteret med høyest spesifisitet. Grunnen til at vi også søkte etter enkeltstudier var for å ha mulighet til å supplere der vi ikke fant relevante systematiske oversikter. Eller at eksisterende systematiske oversikter var av eldre dato og at nyere studier ville kunne endre konklusjonene.

Vi begrenset ikke søket etter type behandling av spiseforstyrrelser, men valgte heller å søke på alle randomiserte kontrollerte forsøk eller systematiske oversikter som omhandlet spiseforstyrrelser. Ved ikke å begrense søket på tiltak, sikret vi oss et sensitivt søk som ville kunne fange opp maksimalt av relevant forskning.

Vi utførte også scopingsøk etter relevant litteratur i databaser/nettsider hos andre organisasjoner som lager oversikter og medisinske metodevurderinger. Rapporter fra slike organisasjoner blir ikke alltid indeksert i for eksempel Medline. Søkene ble gjort i National Institute for Health and Clinical Excellence (NICE), Danish Centre for Evaluation and Health Technology Assessment (DACEHTA), Finnish Office for Health Technology Assessment (Finohta) og Statens beredning för medicinsk utvärdering (SBU).

Inklusjonskriterier

Studiedesign:	Systematiske oversikter, randomiserte kontrollerte studier, prospektive kohortestudier
Populasjon:	Personer med anoreksi, bulimi og overspisningslidelse
Tiltak (intervensjon):	Medikamentell, kognitiv terapi, familieterapi, selvhjelp og poliklinisk behandling
Sammenlikning:	Ordinær behandling, annen behandling, tilleggsbehandling, venteliste, placebo, sykehus, poliklinisk behandling
Utfall:	Vekt, symptomer på psykologiske og fysisk bedring av helsetilstand, akseptabilitet, sunt kosthold, tilbakefall, klinisk forverring av tilstanden, holdninger til vekt og kropp, dødsfall, medisinske komplikasjoner, psykososiale faktorer, vekttap, overaktivitet, oppkasting, bulimi og BMI
Setting:	Poliklinikk, sykehus
Språk:	Alle, med sammendrag på engelsk

Vi vurderte referansene ut fra populasjonene, anoreksi, bulimi og overspisningslidelse, og de fem behandlingene. Vi har også sett på sammenlikninger og utfallsmål, der det var rapportert enten i tittel eller sammendrag.

Artikkelutvelging

Etter en gjennomgang av titler og sammendrag, laget vi en liste over mulig relevante referanser. Kriteriene for å anses som mulig relevant var en eksplisitt bruk (enten i tittel, nøkkelord eller sammendrag) av følgende: Systematisk oversikt med søkestrategi og oppsummering av effekter/metaanalyser. Tre prosjektmedarbeidere, Marita Fønhus (MF), KTH og AS gikk gjennom alle titler og sammendrag for å vurdere relevans etter inklusjonskriteriene. Vurderingene ble gjort uavhengig av hverandre og sammenlignet i etterkant. Der det var uenighet om vurderingene, ble inklusjon eller eksklusjon avgjort ved konsensus.

Utvelgelse av litteratur ble kun gjort basert på tittel og sammendrag. Vi bestilte ikke fulltekst av artiklene. I første omgang sorterte vi ut alle duplikater og irrelevante treff. Etter at referansene var identifisert som mulig relevante publikasjoner sorterte vi dem i følgende to hovedkategorier:

1) Behandlingstype som familieterapi, kognitiv terapi, medikamentell, poliklinisk behandling og selvhjelp.

2) Diagnosegruppene ved spiseforstyrrelser anoreksi, bulimi og overspisningslidelse.

Resultat

Resultat av søk

Søket resulterte i 4 269 referanser. Vi vurderte de identifiserte referansene til å være mulig relevante i henhold til inklusjonskriteriene og inkluderte til slutt 41 referanser som systematiske oversiktet eller metaanalyser.

Vi fant flest oversikter som vurderte medikamentell behandling, kognitiv behandling og familieterapi, og spesielt for yngre pasienter med spiseforstyrrelser på sistnevnte tiltak. Videre fant vi færre referanser med vekt på selvhjelpsgrupper, som var fra genuin selvhjelp, eller selvhjelp med noe profesjonell rådgivning. Vi fant også flere oversikter, der medikamentell behandling ble gitt i kombinasjon med annen type behandling som kognitiv terapi.

Resultat av sorteringen

Vi kategoriserte etter tiltakene; familieterapi, kognitiv terapi, medikamentell og medikamentell i kombinasjon med annen behandling, poliklinisk behandling og selvhjelp. Medikamentell behandling er ofte gitt i kombinasjon med annen behandling, og det finnes derfor enkeltstudier, systematiske oversikter og retningslinjer, som har sett nærmere på effekten av behandlingen når den er sammensatt av flere tiltak (se vedlegg 2).

De mulig relevante referansene ble også sortert i kategorier ut fra diagnosegruppene anoreksi, bulimi, overspisningslidelse, og også der alle diagnosegruppene var oppsummert.

I vedlegg 2 presenterer vi oversiktene fordelt i kategoriene og alfabetisk etter førsteforfatter. Vi oppgir forfattere, tittel på publikasjonen, publikasjonssted og sammendrag av artikkelen slik de fremkom i de elektroniske databasene.

Tabell 1: *Antall oversiktsartikler sortert etter behandlingstype*

Tiltak	Antall referanser: 41

Familieterapi (4-9)	6
Kognitiv terapi (10-18)	9
Medikamentell behandling (19-30)	13
Medikamentell i kombinasjon med annen behandling (1;31-35)	6
Poliklinisk behandling (36-38)	4
Selvhjelp (39;40;41)	3

Tabell 2: *Antall referanser sortert etter diagnosegruppe*

Diagnose	Antall referanser: 41
Anoreksi (4;7;16;21;22;24;25;32;33;36;38)	11
Bulimi (5;13;15;17-19;27;35)	8
Overspisningslidelse (10;12;20;26;28-30;34;39)	9
Alle diagnosegruppene (1-3;6;8;9;11;14;23;31;37;40,41)	13

Diskusjon

Vi søkte etter systematiske oversikter og fant et forskningsfelt hvor det fremdeles publiseres nye randomiserte kontrollerte studier. Ettersom vi fant systematiske oversikter som dekket alle fem spørsmål sorterte vi ikke enkeltstudiene som ble identifisert i søket. Disse er tilgjengelig for interessert i en fil i Reference Manager. Forskningslitteraturen er av forholdsvis ny dato, og vi har ikke inkludert systematiske oversikter publisert før 2000.

Ved systematiske litteratursøk med sortering gjennomfører vi litteratursøk for en gitt problemstilling. Resultatene fra søket blir i sin helhet overlevert oppdragsgiver, eller vi kan gjennomgå søkeresultatet og sortere ut ikke-relevante artikler. Dette er basert på tittel og sammendrag. Artiklene innhentes ikke i fulltekst. Manglende innhenting av artikler i fulltekst gjør at vi kan ha inkludert referanser som vil vise seg ikke å være relevante ved gjennomlesning i fulltekst. Vi benytter kun databaser for identifisering av litteratur og kan derfor ha gått glipp av potensielt relevante studier. Andre måter å identifisere studier på som søk i referanselister, kontakt med eksperter på fagfeltet og upublisert litteratur ble ikke utført i dette oppdraget. Vi gjennomførte ingen kvalitetsvurdering av oversiktene.

Oversiktene vi henviser til er ikke nødvendigvis systematiske eller av høy kvalitet. Vi anbefaler derfor å kritisk vurdere kunnskapen vi referer til før den eventuelt tas i bruk i nasjonal behandling av spiseforstyrrelser.

Referanser

1. National Institute for Clinical Excellence. Eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders (DARE structured abstract). London: National Institute for Clinical Excellence; 2004. (2004:35.)

2. Devlin MJ, Halmi KA, Herzog DB, Mitchell III JE, Powers P, Zerbe KJ, et al. Treatment of patients with eating disorders third edition. American Journal of Psychiatry 2006;163(7 SUPPL.):1-54.

3. Meads C, Burls A, Gold L. In-patient versus Out-patient Care for Eating Disorders. University of Birmingham: Department of Public Health and Epidemiology; 1999.

4. Fisher CA, Hetrick SE, Rushford N. Family therapy for anorexia nervosa. COCHRANE DATABASE SYST REV 2010;4:CD004780.

5. le GD, Schmidt U. The treatment of adolescents with bulimia nervosa. J MENT HEALTH 2005;14(6):587-97.

6. McLean N, Griffin S, Toney K, Hardeman W. Family involvement in weight control, weight maintenance and weight-loss interventions: a systematic review of randomised trials. International Journal of Obesity and Related Metabolic Disorders: Journal of the International Association for the Study of Obesity 2003;27(9):987-1005.

7. Tierney S, Wyatt K. What works for adolescents with AN? A systematic review of psychosocial interventions. Eating and Weight Disorders: EWD 2005;10(2):66-75.

8. Von SK, Beher S, Schweitzer-Rothers J, Retzlaff R. Systemic family therapy with children and adolescents as index patients. A meta-content analysis of 47 randomized controlled outcome studies. Psychotherapeut 2006;51(2):107-43.

9. Von SK, Beher S, Retzlaff R, Schweitzer-Rothers J. Systemic therapy for adult index patients. A meta-content analysis of 28 randomized, controlled trials. Psychotherapeut 2007;52(3):187-211.

10. Duchesne M, Appolinario JC, Range BP, Freitas S, Papelbaum M, Coutinho W. Evidence of cognitive-behavioral therapy in the treatment of obese patients with binge eating disorder. Revista de Psiquiatria do Rio Grande do Sul 2007;29(1):80-92.

11. Fischer S, Doyle AC, Le Grange D. Cognitive-behavior therapy for eating disorders in childhood and adolescence. McKay, Dean [Ed]; Storch, Eric A [Ed] (2009) Cognitive-behavior therapy for children: Treating complex and refractory

cases (pp 259-291) xxi, 586 pp New York, NY, US: Springer Publishing Co; US 2009;(2009):586.

12. Guzman GAR, Lemus CAD, Garcia RR, Agraz FP. Cognitive behavioral therapy for binge eating disorder: A review. Psiquiatria Vol 21(1), Jan-Apr 2005, pp No Pagination Specified 2005;(1):Jan-Apr.

13. Hay PP, Bacaltchuk J, Stefano S, Kashyap P. Psychological treatments for bulimia nervosa and binging. Cochrane database of systematic reviews (Online) 2009;(4):CD000562.

14. Kotova E. A meta-analysis of Interpersonal Psychotherapy. Dissertation Abstracts International: Section B: The Sciences and Engineering Vol 66(5-B),2005, pp 2828 2005;(5-B):2005, pp.

15. Shapiro JR, Berkman ND, Brownley KA, Sedway JA, Lohr KN, Bulik CM. Bulimia nervosa treatment: a systematic review of randomized controlled trials. International Journal of Eating Disorders 2007;40(4):321-36.

16. St.Amant K. A systematic review of the treatment for anorexia nervosa in adolescents: The search for evidence-based practice. Dissertation Abstracts International: Section B: The Sciences and Engineering Vol 68(12-B),2008, pp 8414 2008;(12-B):2008, pp.

17. Thompson-Brenner HJ. Implications for the treatment of bulimia nervosa: A meta-analysis of efficacy trials and a naturalistic study of treatment in the community. Dissertation Abstracts International: Section B: The Sciences and Engineering Vol 63(10-B), Apr 2003, pp 4928 2003;(10-B):Apr.

18. Thompson-Brenner H, Glass S, Westen D. A multidimensional meta-analysis of psychotherapy for bulimia nervosa. Clinical Psychology: Science and Practice 2003;10(3):269-87.

19. Bacaltchuk J, Hay P. Antidepressants versus placebo for people with bulimia nervosa. COCHRANE DATABASE SYST REV 2003;(4):CD003391.

20. Carter WP, Pindyck LJ. Pharmacologic Treatment of Binge-Eating Disoder. Primary Psychiatry 2003;10(10):31-6.

21. Claudino AM, Hay P, Lima MS, Bacaltchuk J, Schmidt U, Treasure J. Antidepressants for anorexia nervosa. COCHRANE DATABASE SYST REV 2006;(1):CD004365.

22. Court A, Mulder C, Hetrick SE, Purcell R, McGorry PD. What is the scientific evidence for the use of antipsychotic medication in anorexia nervosa? EAT DISORD 2008;16(3):217-23.

23. Couturier J, Lock J. Psychopharmacology update: A review of medication use for children and adolescents with eating disorders. Journal of the Canadian Academy of Child and Adolescent Psychiatry 2007;16(4):173-6.

24. Dunican KC, DelDotto D. The role of olanzapine in the treatment of anorexia nervosa. Annals of Pharmacotherapy 2007;41(1):111-5.

25. Kim SS. Role of fluoxetine in anorexia nervosa. Annals of Pharmacotherapy 2003;37(6):890-2.

26. Reas DL, Grilo CM. Review and meta-analysis of pharmacotherapy for binge-eating disorder. Obesity 2008;16(9):2024-38.

27. Rossi A, Barraco A, Donda P. Fluoxetine: A review on evidence based medicine. Annals of General Hospital Psychiatry Vol 3 Feb 2004, ArtID 2 2004;ArtID.

28. Stefano SC, Bacaltchuk J, Blay SL, Appolinario JC. Antidepressants in short-term treatment of binge eating disorder: Systematic review and meta-analysis. Eating Behaviors 2008;9(2):129-36.

29. Tata AL, Kockler DR. Topiramate for binge-eating disorder associated with obesity. Annals of Pharmacotherapy 2006;40(11):1993-7.

30. Woods TM, Eichner SF, Franks AS. Weight Gain Mitigation with Topiramate in Mood Disorders. Annals of Pharmacotherapy 2004;38(5):887-91.

31. Berkman ND, Bulik CM, Brownley KA, Lohr KN, Sedway JA, Rooks A, et al. Management of eating disorders. Evidence Report/Technology Assessment 2006;(135):1-166.

32. Beumont P, Hay P, Beumont R. Summary Australian and New Zealand clinical practice guideline for the management of anorexia nervosa (2003). Australasian Psychiatry 2003;11(2):129-33.

33. Beumont P, Hay P, Beumont D, Birmingham L, Derham H, Jordan A, et al. Australian and New Zealand clinical practice guidelines for the treatment of anorexia nervosa. Australian and New Zealand Journal of Psychiatry 2004;38(9):659-70.

34. Brownley KA, Berkman ND, Sedway JA, Lohr KN, Bulik CM. Binge eating disorder treatment: a systematic review of randomized controlled trials. International Journal of Eating Disorders 2007;40(4):337-48.

35. Hay Phillipa PJ, Claudino AM, Kaio MH. Antidepressants versus psychological treatments and their combination for bulimia nervosa. Cochrane Database of Systematic Reviews: Reviews. In: Cochrane Database of Systematic Reviews 2001 Issue 4. Chichester (UK): John Wiley & Sons, Ltd; 2001.

36. Hay P, Bacaltchuk J, Claudino A, Ben-Tovim D, Yong PY. Individual psychotherapy in the outpatient treatment of adults with anorexia nervosa. COCHRANE DATABASE SYST REV 2003;(4):CD003909.

37. Keel PK, Brown TA. Update on course and outcome in eating disorders. International Journal of Eating Disorders 2010;43(3):195-204.

38. Wallier J, Vibert S, Berthoz S, Huas C, Hubert T, Godart N. Dropout from inpatient treatment for anorexia nervosa: critical review of the literature. International Journal of Eating Disorders 2009;42(7):636-47.

39. Stefano SC, Bacaltchuk J, Blay SL, Hay P. Self-help treatments for disorders of recurrent binge eating: a systematic review. Acta Psychiatrica Scandinavica 2006;113(6):452-9.

40. Perkins SJ, Murphy R, Schmidt U, Williams C. Self-help and guided self-help for eating disorders. COCHRANE DATABASE SYST REV 2006;3:CD004191.

41. McLean N, Griffin S, Toney K, Hardeman W. Family involvement in weight control, weight maintenance and weight-loss interventions: a systematic review of randomised trials. Int J Obes Relat Metab Disord 2003;27(9):987-1005.

42. Meads C, Gold L, Burls A. How effective is outpatient care compared to inpatient care for the treatment of anorexia nervosa? A systematic review. European Eating Disorders Review 2001;9(4):229-41.

Vedlegg

Vedlegg 1 – søkestrategi

Søk: Marita Heintz
Database: Ovid MEDLINE(R) 1950 to June Week 2 2010
Dato: 17.06.10
Antall treff: 1958

#	Searches	Results
1	Eating Disorders/	8309
2	Anorexia Nervosa/	9243
3	Binge-Eating Disorder/	42
4	Bulimia Nervosa/	969
5	((appetite or eating) adj2 disorder?).tw.	8283
6	(((anorexia or bulimia) adj2 (nervosa or nevrosa)) or anorexic or bulimic).tw.	10913
7	(binging or (binge adj1 eating) or bingeeating or overeat$ or (compulsive adj2 (eat$ or vomit$)) or (food$ adj2 (bing$ or aversion)) or (self?induc$ adj2 vomit$) or (restrict$ adj2 eat$) or hyperrexia or polyphagia).tw.	3914
8	or/1-7	23171
9	limit 8 to yr="2003 -Current"	7797
10	randomized controlled trial.pt.	292891
11	controlled clinical trial.pt.	81749
12	randomized.ab.	200220
13	placebo.ab.	119669
14	drug therapy.fs.	1386928
15	randomly.ab.	145580
16	trial.ab.	206989
17	groups.ab.	975167
18	10 or 11 or 12 or 13 or 14 or 15 or 16 or 17	2554230
19	humans.sh.	11266617
20	18 and 19	2085004
21	9 and 20	1876
22	limit 9 to "reviews (specificity)"	147

23	21 or 22	1958

Database: EMBASE 1980 to 2010 Week 23
Dato: 17.06.10
Antall treff: 1910

#	Searches	Results
1	eating disorder/	7416
2	Anorexia nervosa/	8917
3	binge eating disorder/	2183
4	bulimia/	7425
5	food aversion/	113
6	Appetite disorder/	1997
7	((appetite or eating) adj2 disorder?).tw.	9063
8	(((anorexia or bulimia) adj2 (nervosa or nevrosa)) or anorexic or bulimic).tw.	10659
9	(binging or (binge adj1 eating) or bingeeating or overeat$ or (compulsive adj2 (eat$ or vomit$)) or (food$ adj2 (bing$ or aversion)) or (self?induc$ adj2 vomit$) or (restrict$ adj2 eat$) or hyperrexia or polyphagia).tw.	3762
10	or/1-9	24216
11	limit 10 to yr="2003 -Current"	11527
12	Clinical Trial/	600670
13	Randomized Controlled Trial/	189654
14	Randomization/	28348
15	Double Blind Procedure/	78190
16	Single Blind Procedure/	9526
17	Crossover Procedure/	23107
18	PLACEBO/	143216
19	Placebo$.tw.	119401
20	Randomi?ed controlled trial$.tw.	40333
21	rct.tw.	3553
22	random allocation.tw.	694
23	randomly allocated.tw.	11199
24	allocated randomly.tw.	1416
25	(allocated adj2 random).tw.	575
26	single blind$.tw.	8180
27	double blind$.tw.	90635

28	((treble or triple) adj blind$).tw.	152
29	Prospective study/	96023
30	or/12-29	788880
31	Case study/	7212
32	case report.tw.	132722
33	Abstract report/	71217
34	Letter/	469522
35	Human/	7063453
36	Nonhuman/	3428835
37	ANIMAL/	51739
38	Animal Experiment/	1363689
39	36 or 37 or 38	3698016
40	39 not (35 and 39)	3080486
41	or/31-34,40	3702589
42	30 not 41	743174
43	11 and 42	1868
44	limit 11 to "reviews (2 or more terms high specificity)"	119
45	43 or 44	1910

Database: PsycINFO 1806 to June Week 3 2010
Dato: 17.06.10
Antall treff:973

#	Searches	Results
1	Eating Disorders/	8641
2	Anorexia Nervosa/	7174
3	Binge Eating Disorder/	409
4	Bulimia/	5859
5	"Purging (Eating Disorders)"/	201
6	Binge Eating/	1840
7	((appetite or eating) adj2 disorder?).tw.	13521
8	(((anorexia or bulimia) adj2 (nervosa or nevrosa)) or anorexic or bulimic).tw.	12148
9	(binging or (binge adj1 eating) or bingeeating or overeat$ or (compulsive adj2 (eat$ or vomit$)) or (food$ adj2 (bing$ or aversion)) or (self?induc$ adj2 vomit$) or (restrict$ adj2 eat$) or hyperrexia or polyphagia).tw.	4395
10	or/1-9	23706
11	limit 10 to yr="2003 -Current"	8973

12	empirical methods/	2452
13	Experimental methods/	7878
14	Quasi experimental methods/	87
15	experimental design/	7592
16	between groups design/	96
17	followup studies/	12284
18	repeated measures/	463
19	experiment controls/	607
20	experimental replication/	3693
21	exp "sampling (experimental)"/	2035
22	placebo/	2578
23	clinical trials/	4023
24	treatment effectiveness evaluation/	11433
25	experimental replication.md.	6541
26	followup study.md.	32045
27	prospective study.md.	11844
28	treatment outcome clinical trial.md.	16401
29	placebo$.tw.	23848
30	randomi?ed controlled trial$.tw.	7471
31	rct.tw.	856
32	random allocation.tw.	103
33	(randomly adj1 allocated).tw.	1233
34	(allocated adj2 random).tw.	43
35	((singl$ or doubl$ or treb$ or tripl$) adj (blind$3 or mask$3)).tw.	14731
36	(clinic$ adj (trial? or stud$3)).tw.	18386
37	or/12-36	129216
38	comment reply.dt.	76707
39	editorial.dt.	16961
40	letter.dt.	9194
41	clinical case study.md.	49006
42	nonclinical case study.md.	12012
43	animal.po.	239073
44	human.po.	2355886
45	43 not (43 and 44)	224246
46	or/38-42,45	381037
47	37 not 46	118323

48	11 and 47	772
49	limit 11 to "reviews (high specificity)"	239
50	48 or 49	973

Database: CINAHL
Dato: 17.06.10
Antall treff: 228

(MH "Eating Disorders") or (MH "Anorexia Nervosa") or (MH "Bulimia Nervosa") or (MH "Food Aversions") or TI appetite N2 disorder? or AB appetite N2 disorder? or TI eating N2 disorder? or AB eating N2 disorder? or TI anorexia N2 nervosa or AB anorexia N2 nervosa or TI anorexia N2 nevrosa or AB anorexia N2 nevrosa or TI bulimia N2 nervosa or AB bulimia N2 nervosa or TI bulimia N2 nevrosa or AB bulimia N2 nevrosa or TI anorexic or AB anorexic or TI bulimic or AB bulimic or TI binging or AB binging or TI binge N1 eating or AB binge N1 eating or TI bingeeating or AB bingeeating or TI overeat* or AB overeat* or TI compulsive N2 eat* or AB compulsive N2 eat* or TI compulsive N2 vomit* or AB compulsive N2 vomit* or TI food* N2 bing* or AB food* N2 bing* or TI food* N2 aversion or AB food* N2 aversion or TI self#induc* N2 vomit* or AB self#induc* N2 vomit* or TI restrict* N2 eat* or AB restrict* N2 eat* or TI hyperrexia or AB hyperrexia or TI polyphagia or AB polyphagia	5920
Published Date from: 20030101-20101231	3703
Clinical Queries: Therapy - High Sensitivity, Review - High Specificity	1306
Exclude MEDLINE records	228

Database: The Cochrane Library. Other Reviews, Clinical Trials, Methods Studies, Technology Assessments og Economic Evaluations

Dato: 17.06.10
Antall treff: 534 (Cochrane Reviews: 11, Other Reviews: 20, Clinical Trials: 475, Methods Studies: 7, Technology Assessments: 9, Economic Evaluations: 12)

ID	Search	Hits
#1	MeSH descriptor **Eating Disorders**, this term only	269
#2	MeSH descriptor **Anorexia Nervosa**, this term only	243
#3	MeSH descriptor **Binge-Eating Disorder**, this term only	6
#4	MeSH descriptor **Bulimia Nervosa**, this term only	99
#5	((appetite or eating) NEAR/2 disorder?):ti,ab	327
#6	(((anorexia or bulimia) NEAR/2 (nervosa or nevrosa)) or anorexic or bulimic):ti,ab	811
#7	(binging or (binge adj1 eating) or bingeeating or overeat* or (compulsive NEAR/2 (eat* or vomit*)) or (food* NEAR/2 (bing* or aversion)) or (self?induc* NEAR/2 vomit*) or (restrict* NEAR/2 eat*) or hyperrexia or polyphagia):ti,ab	138
#8	(#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7)	1349
#9	(#8), from 2003 to 2010	534

Database: Svemed+
Dato: 21.06.10
Antall treff: 100

Sökmängd	Sökvillkor	Antal poster
S1	Eating-Disorders.fm.	139
S2	Anorexia -Nervosa.fm.	118
S3	Binge-E ating-Disorder.fm.	0
S4	Bulimia-Nervosa.fm.	11
S5	appetite disorder$ OR eating disorder$ OR anorexia nervosa OR bulimia nervosa OR anorexic OR bulimic OR binging OR binge eating OR bingeeating OR overeat$ OR compulsive eat$ OR compulsive vomit$ OR food bing$ OR food aversion OR self induced vomit$ OR restricted eat$ OR restricive eat$ OR hyperrexia OR polyphagia	276
S6	S1 OR S2 OR S3 OR S4 OR S5	276
20	03-	100

Vedlegg 2 – sorterte refanser

Familieterapi (6)

1200. Fisher CA, Hetrick SE, Rushford N. Family therapy for anorexia nervosa. COCHRANE DATABASE SYST REV 2010;4:CD004780.

Ref ID: 17

Abstract: BACKGROUND: Anorexia Nervosa (AN) is characterised by distorted body image and deliberately maintained low body weight. The long term prognosis is often poor, with severe medical, developmental and psychosocial complications, high rates of relapse and mortality. Different variants of family therapy have been commonly used for intervention. OBJECTIVES: To evaluate the efficacy of family therapy compared with standard treatment and other treatments. SEARCH STRATEGY: The Cochrane Collaboration Depression, Anxiety and Neuroses Controlled Trials Register (CCDANCTR) was searched until August 2008; MEDLINE, PsycInfo and EMBASE and ClinicalTrials.gov were searched up to January 2008. A conference abstract book and included studies reference lists were searched. All lead authors of included studies were also contacted. SELECTION CRITERIA: Randomised controlled trials (RCTS) of interventions described as 'family therapy' compared to any other intervention or other types of family therapy were eligible for inclusion. Patients of any age or gender with a primary clinical diagnosis of anorexia nervosa (AN) were included. DATA COLLECTION AND ANALYSIS: Two review authors selected the studies, assessed quality and extracted data. We used a random effects meta-analysis. Relative risk was used to summarise dichotomous outcomes and both the standardised mean difference and mean difference to summarise continuous measures. MAIN RESULTS: 13 trials were included, the majority investigating family based therapy, or variants. Reporting of trial conduct was generally inadequate. The full extent of the risk of bias is unclear. There was some evidence (from two studies, 81 participants) to suggest that family therapy may be more effective than treatment as usual on rates of remission, in the short term (RR 3.83 95% CI 1.60 to 9.13). Based on one study (30 participants) there was no significant advantage for family therapy over educational interventions (RR 9.00 95% CI 0.53, 153.79) or over other psychological interventions (RR 1.13 95% CI 0.72 to 1.76) based on four studies (N=149).All other reported comparisons for relapse rates, cognitive distortion, weight measures and dropouts yielded non-significant results. AUTHORS' CONCLUSIONS: There is some evidence to suggest that family therapy may be effective compared to treatment as usual in the short term. However, this is based on

few trials that included only a small number of participants, all of which had issues regarding potential bias. There appears to be little advantage of family therapy over other psychological interventions. The field would benefit from a large, well-conducted trial. [References: 95]

2146. le GD, Schmidt U. The treatment of adolescents with bulimia nervosa. J MENT HEALTH 2005;14(6):587-97.
Ref ID: 3041
Abstract: Background: Bulimia nervosa appears to be quite common among adolescents and poses high rates of psychiatric and medical morbidity. Yet, no published accounts of treatment for this population are available. Aims: To briefly describe the clinical presentation of bulimia nervosa in adolescents and review the available information regarding psychological and pharmacological treatments from the adult literature. Method: A narrative review of the available literature. Results: Relatively little information about the treatment of adolescents with bulimia nervosa are available. Family-based treatments as well as cognitive behavioural guided self-help are both promising interventions. Except for one small open trial of fluoxetine, pharmacotherapy remains entirely unexplored. Conclusion: Most of what is known regarding the treatment of adolescents with bulimia nervosa is based on the adult literature, which does not specifically allude to the applicability of these data for adolescent populations. While we await the publication of two current randomized controlled trials, much more work is needed to establish the best treatments for adolescent bulimia nervosa. Declaration of interest: DLG was supported by a grant from the National Institute of Mental Health, USA (MH01923). The adolescent bulimia nervosa study was supported by the Health Foundation, UK. Conflict of interests: None. copyright Shadowfax Publishing and Taylor & Francis

2469. McLean N, Griffin S, Toney K, Hardeman W. Family involvement in weight control, weight maintenance and weight-loss interventions: a systematic review of randomised trials. International Journal of Obesity and Related Metabolic Disorders: Journal of the International Association for the Study of Obesity 2003;27(9):987-1005.
Ref ID: 1819
Abstract: OBJECTIVE: To conduct a descriptive systematic review into the nature and effectiveness of family involvement in weight control, weight maintenance and weight-loss interventions. METHOD: We searched Medline and Psyclit for English language papers describing randomised trials with at least 1-y follow-up that evaluated interventions incorporating a family-based component. Studies involving people with eating disorders, learning disabilities and undernutrition or malnutrition were excluded. Data were extracted on characteristics of the participants, study design, target behaviours, nature of the intervention and study outcomes. A taxonomy was developed and used to classify family involvement in behaviour change interventions. Interventions were also classified according to an existing taxonomy that characterised the behaviour change techniques employed. RESULTS: A total of 21 papers describing 16 intervention studies were identified. Studies were small (mean sample size: 52), heterogeneous, poorly described but with few losses to follow-up (median

15%). The majority were North American and aimed at weight loss. Few studies described a theoretical underpinning to the behaviour change techniques employed. There was a suggestion that spouse involvement increased effectiveness but that adolescents achieved greater weight loss when treated alone. In studies including children, beneficial effects were seen when greater numbers of behaviour change techniques were taught to both parents and children. CONCLUSION: Relatively few intervention studies exist in this important area, particularly studies targeting adolescents, and they highlight continued uncertainty about how best to involve family members. The studies provide limited support for the involvement of spouses. They suggest that parental involvement is associated with weight loss in children, and that use of a greater range of behaviour change techniques improves weight outcomes for both parents and children. The development of future interventions and assessment of factors influencing effectiveness may be improved by paying careful attention to which family members are targeted and how they are involved in the intervention in terms of setting goals for behaviour change, providing support and training in behaviour change techniques. [References: 35]

3795. Tierney S, Wyatt K. What works for adolescents with AN? A systematic review of psychosocial interventions. Eating and Weight Disorders: EWD 2005;10(2):66-75.
Ref ID: 1327
Abstract: OBJECTIVE: To determine the effectiveness of psychosocial interventions for adolescents with AN. METHODS: An extensive and systematic literature search was conducted for randomised controlled trials (RCTs) addressing the effectiveness of psychosocial interventions for teenagers (11-18 years) with AN. RESULTS: Eight RCTs were located meeting the review's inclusion criteria, the majority of which focused on some form of family-related intervention. DISCUSSION: Unfortunately, a lack of robust primary research on which to base the review meant that clear recommendations could not be made. More good quality research, examining a range of interventions, and involving larger samples, is required before a similar systematic review is executed. [References: 43]

3964. Von SK, Beher S, Schweitzer-Rothers J, Retzlaff R. Systemic family therapy with children and adolescents as index patients. A meta-content analysis of 47 randomized controlled outcome studies. Psychotherapeut 2006;51(2):107-43.
Ref ID: 2963
Abstract: Objective. Systemic Family Therapy (FT) is recognized as a scientifically validated treatment in the US and many European countries, but not so in Germany. Method. All randomized (or parallelized) controlled trials (RCT) evaluating Systemic FT with children and adolescent as index patients published in English, German or Spanish up to the end of 2004 were identified through data base searches and cross-references in other meta-analyses and reviews. A systematic meta-content analysis was performed. Results. 47 RCT (90 publications) evaluating Systemic FT with child/adolescent index patients suffering from clinical disorders (ICD 10) were identified. Systemic FT is efficacious with regard to eating disorders, conduct disorders and juvenile delinquency, substance disorders and mental factors with regard

to somatic disorders. There also exist reports about successful treatments of depression, suicidality/severe mental crisis, ADHD and child abuse/neglect. The results are stable across follow-up periods of up to 5 years. Conclusion. According to the criteria of the German Scientific Advisory Board on Psychotherapy (Wissenschaftlicher Beirat Psychotherapie) there seems to be good evidence for the efficacy of Systemic FT in at least three diagnostic groups relevant to psychotherapy with children and adolescents. copyright Springer Medizin Verlag 2006

3965. Von SK, Beher S, Retzlaff R, Schweitzer-Rothers J. Systemic therapy for adult index patients. A meta-content analysis of 28 randomized, controlled trials. Psychotherapeut 2007;52(3):187-211.
Ref ID: 2630
Abstract: Background. Systemic therapy is a scientifically acknowledged form of psychotherapy in the US and many European countries, but not yet in Germany. Method. All randomized (or parallelized) controlled trials (RCT) evaluating systemic couples/family/individual therapy with adult index patients published in English, German or Spanish up to the end of 2004 were identified via data base searches and cross-references in other meta-analyses and reviews. A meta-analysis of the identified RCT was performed. Results. 28 RCT (43 publications) evaluating systemic therapy with adult index patients suffering from clinical disorders (ICD-10) were identified. Systemic therapy is efficacious with regard to substance disorders, mental/social factors interacting with somatic disorders, schizophrenia, depression and eating disorders. The results are stable across follow-up periods of up to 5 years. Conclusion. According to the criteria of the German Scientific Advisory Board Psychotherapy (Wissenschaftlicher Beirat Psychotherapie) there seems to be good evidence for the efficacy of systemic therapy in at least four fields of application of adult psychotherapy. copyright 2005 Springer Medizin Verlag

Kognitiv terapi (9)

1025. Duchesne M, Appolinario JC, Range BP, Freitas S, Papelbaum M, Coutinho W. Evidence of cognitive-behavioral therapy in the treatment of obese patients with binge eating disorder. Revista de Psiquiatria do Rio Grande do Sul 2007;29(1):80-92.
Ref ID: 2588
Abstract: Objective: To investigate evidence of the efficacy of cognitive-behavioral therapy in the treatment of obese patients with binge eating disorder. Method: This review included clinical trials and meta-analyses published in all languages from January 1980 to February 2006. Studies assessing the efficacy of cognitive-behavioral therapy associated with medication, cognitive-behavioral therapy in self-help manuals, case reports or series and letters to editors were excluded. The following electronic databases were used: MEDLINE, PsycINFO, Embase, LILACS and Cochrane Library. Search strategies also included consulting the references of selected articles and chapters of specialized books. Results: Two open and 15 con-

trolled clinical trials were included. The primary outcome in most studies was binge eating. In general, the clinical trials suggest that cognitive-behavioral therapy results in significant improvement in binge eating and other psychopathological symptoms related to binge eating disorder. However, no substantial weight loss was reported. Conclusions: Available evidence suggests that cognitive-behavioral therapy is an effective intervention method for psychological aspects of binge eating disorder, although its efficacy in body weight reduction and long-term maintenance of results still needs further investigation. Copyright copyright Revista de Psiquiatria do Rio Grande do Sul – SPRS

1198. Fischer S, Doyle AC, Le Grange D. Cognitive-behavior therapy for eating disorders in childhood and adolescence. McKay, Dean [Ed]; Storch, Eric A [Ed] (2009) Cognitive-behavior therapy for children: Treating complex and refractory cases (pp 259-291) xxi, 586 pp New York, NY, US: Springer Publishing Co; US 2009;(2009):586.
Ref ID: 3995
Abstract: (from the chapter) The purpose of this chapter is to review the use of cognitive-behavioral therapy (CBT) for the treatment of child and adolescent eating disorders, with a focus on using cognitive-behavioral techniques in difficult-to-treat cases. Although this task seems fairly straightforward, a number of issues in the current state of research and treatment of child and adolescent eating disorders present several stumbling blocks. First, there are three primary diagnostic categories subsumed under the diagnosis of eating disorder: anorexia nervosa (AN), bulimia nervosa (BN), and eating disorder not otherwise specified (EDNOS). In fact, the primary diagnosis of an adolescent presenting for treatment in an outpatient setting is likely to be EDNOS (Eddy, CelioDoyle, Hoste, Herzog, & le Grange, 2008). Symptoms of AN versus BN may necessitate different approaches to treatment; this is certainly true in adults. Second, if a clinician were to search the available literature for randomized controlled trials (RCTs) for treatment of eating disorders in children and adolescents, he or she would find relatively little guidance. For example, to date, there are only two published RCTs that examine the treatment of BN in adolescents (le Grange, Crosby, Rathouz, & Levanthal, 2007; Schmidt et al., 2007). Adolescents with EDNOS are often excluded from trials. And only one of the trials with BN participants used a form of CBT as a treatment condition. Thus, there is a dearth of well-controlled research on treatment of adolescents with eating disorders, on CBT in particular. This is both surprising and a matter of concern because the age of onset of BN, AN, and EDNOS is typically in adolescence. In this chapter we briefly review the etiology, symptoms, and incidence of eating disorders in adolescents. We present information about the treatment of AN and BN separately, as empirical literature suggests some differences in the effectiveness of various treatments for the two disorders. For both of these disorders, however, it was necessary to review literature on treatment and outcome predictors in adults as well as adolescents, as there are so few studies that used child and adolescent samples. Thus, we provided information on how the data on adult samples may or may not be extrapolated to child and adolescent samples. (PsycINFO Database Record (c) 2010 APA, all rights reserved)

1511. Guzman GAR, Lemus CAD, Garcia RR, Agraz FP. Cognitive behavioral therapy for binge eating disorder: A review. Psiquiatria Vol 21(1), Jan-Apr 2005, pp No Pagination Specified 2005;(1):Jan-Apr.

Ref ID: 4475

Abstract: The Aim of the present study was to review scientific literature regarding cognitive behavioral treatment (CBT) for binge eating disorder (BED) treatment. Method: A search of 1992-2004 scientific articles about CBT for BED in PSYC-INFO and MEDLINE data bases was performed. Results: A description of effectiveness studies outcomes is made, and the basic procedures of CBT for BED are presented. Also, limitations of CBT for BED are discussed, making emphasis in the case of weight decrease, which can be achieved by joining to the treatment strictly behavioral strategies and medication. Conclusions: It is possible to conclude that it exists enough evidence of CBT effectiveness for the treatment of BED; and also to suggest its implementation in Mexican Populations, characterized by a high prevalence of obesity. (PsycINFO Database Record (c) 2010 APA, all rights reserved) (journal abstract)

1599. Hay PP, Bacaltchuk J, Stefano S, Kashyap P. Psychological treatments for bulimia nervosa and binging. Cochrane database of systematic reviews (Online) 2009;(4):CD000562.

Ref ID: 2181

Abstract: BACKGROUND: A specific manual-based form of cognitive behavioural therapy (CBT) has been developed for the treatment of bulimia nervosa (CBT-BN) and other common related syndromes such as binge eating disorder. Other psychotherapies and modifications of CBT are also used. OBJECTIVES: To evaluate the efficacy of CBT, CBT-BN and other psychotherapies in the treatment of adults with bulimia nervosa or related syndromes of recurrent binge eating. SEARCH STRATEGY: Handsearch of The International Journal of Eating Disorders since first issue; database searches of MEDLINE, EXTRAMED, EMBASE, PsycInfo, CURRENT CONTENTS, LILACS, SCISEARCH, CENTRAL and the The Cochrane Collaboration Depression, Anxiety & Neurosis Controlled Trials Register; citation list searching and personal approaches to authors were used. Search date June 2007. SELECTION CRITERIA: Randomised controlled trials of psychotherapy for adults with bulimia nervosa, binge eating disorder and/or eating disorder not otherwise specified (EDNOS) of a bulimic type which applied a standardised outcome methodology and had less than 50% drop-out rate. DATA COLLECTION AND ANALYSIS: Data were analysed using the Review Manager software program. Relative risks were calculated for binary outcome data. Standardised mean differences were calculated for continuous variable outcome data. A random effects model was applied. MAIN RESULTS: 48 studies (n = 3054 participants) were included. The review supported the efficacy of CBT and particularly CBT-BN in the treatment of people with bulimia nervosa and also (but less strongly due to the small number of trials) related eating disorder syndromes.Other psychotherapies were also efficacious, particularly interpersonal psychotherapy in the longer-term. Self-help approaches that used highly struc-

tured CBT treatment manuals were promising. Exposure and Response Prevention did not enhance the efficacy of CBT.Psychotherapy alone is unlikely to reduce or change body weight in people with bulimia nervosa or similar eating disorders. AUTHORS' CONCLUSIONS: There is a small body of evidence for the efficacy of CBT in bulimia nervosa and similar syndromes, but the quality of trials is very variable and sample sizes are often small. More and larger trials are needed, particularly for binge eating disorder and other EDNOS syndromes. There is a need to develop more efficacious therapies for those with both a weight and an eating disorder

2036. Kotova E. A meta-analysis of Interpersonal Psychotherapy. Dissertation Abstracts International: Section B: The Sciences and Engineering Vol 66(5-B),2005, pp 2828 2005;(5-B):2005, pp.

Ref ID: 4498

Abstract: A meta-analysis was conducted for studies of short-term Interpersonal Psychotherapy (IPT) to estimate its efficacy at post-treatment and at follow up. Overall, the collective sample of patients in the studies consisted mostly of non-psychotic, non-bipolar, non-suicidal, physically healthy adult women with mixed ethnic background diagnosed with depression or eating disorders and treated as outpatients. The efficacy of IPT when compared with no treatment was estimated to be in the range of .60 to .73 effect sizes, dependent on the type of outcome measures chosen by the original researchers. In comparison with minimum treatment (mostly educational interventions or placebo), IPT was found to have effect sizes in the range of .37 to .48. These results confirm that IPT is an efficacious treatment for and that the magnitude of its efficacy approaches what has been commonly reported for other bona fide therapies. In terms of relative efficacy, the current meta-analysis confirmed that when compared with another established psychological treatment, IPT is not convincingly superior or inferior. The largest effect sizes estimated were .23 for the relative efficacy of IPT for the treatment of depression and -.17 for its relative efficacy in the treatment of eating disorders (mostly Bulimia Nervosa and Binge Eating Disorder). It was concluded that these effect sizes do not represent significant difference. Their 95% confidence intervals contained zero, which means that they could be attributed to chance. No strong evidence was found that IPT is superior or inferior when compared with medication. This conclusion is similar to conclusions about Cognitive-Behavioral Therapy compared with antidepressants. Slight superiority of medication over IPT, as estimated by effect size of -.15 was reported when only measures of depression were considered. The combination of IPT and medication was also not found to be superior than each treatment alone. Finally, IPT was found to retain its efficacy at follow up. This conclusion was strongest when eating disorders were considered. Homogeneity among effect sizes in each grouping of studies for analysis precluded identifying moderating effects on the efficacy of IPT. It was concluded that overall, studies reported uniform results.

3402. Shapiro JR, Berkman ND, Brownley KA, Sedway JA, Lohr KN, Bulik CM. Bulimia nervosa treatment: a systematic review of randomized controlled trials. International

Journal of Eating Disorders 2007;40(4):321-36.

Ref ID: 784

Abstract: OBJECTIVE: The RTI International-University of North Carolina at Chapel Hill Evidence-based Practice Center systematically reviewed evidence on efficacy of treatment for bulimia nervosa (BN), harms associated with treatments, factors associated with treatment efficacy, and differential outcome by sociodemographic characteristics. METHOD: We searched six major databases published from 1980 to September 2005 in all languages against a priori inclusion/exclusion criteria; we focused on eating, psychiatric or psychological, and biomarker outcomes. RESULTS: Forty-seven studies of medication only, behavioral interventions only, and medication plus behavioral interventions for adults or adolescents met our inclusion criteria. Fluoxetine (60 mg/day) decreases the core symptoms of binge eating and purging and associated psychological features in the short term. Cognitive behavioral therapy reduces core behavioral and psychological features in the short and long term. CONCLUSION: Evidence for medication or behavioral treatment for BN is strong, for self-help is weak; for harms related to medication is strong but either weak or nonexistent for other interventions; and evidence for differential outcome by sociodemographic factors is nonexistent. Attention to sample size, standardization of outcome measures, attrition, and reporting of abstinence from target behaviors are required. Longer follow-up intervals, innovative treatments, and attention to sociodemographic factors would enhance the literature. [References: 62]

3540. St.Amant K. A systematic review of the treatment for anorexia nervosa in adolescents: The search for evidence-based practice. Dissertation Abstracts International: Section B: The Sciences and Engineering Vol 68(12-B),2008, pp 8414 2008;(12-B):2008, pp.

Ref ID: 4106

Abstract: The purpose of this study was to determine evidence-based practice for the psychotherapeutic treatment of anorexia nervosa in adolescents. Psychological databases were consulted for treatment literature published between 1996 and 2006 to ensure literature currency. The research reviewed included randomized controlled trials, clinical observation/case studies, qualitative research, systematic case studies, and meta-analyses. The treatment literature was analyzed to determine treatment efficacy and clinical utility to aid in the establishment of evidence-based practice for the treatment of anorexia nervosa in adolescents. Specific psychotherapeutic treatment approaches are discussed and presented with empirical research when available. Results of the comprehensive review and analysis indicate that a number of psychotherapeutic approaches have sufficient evidence base for use with the anorectic adolescent population. A list of treatment recommendations for clinicians working with anorectic adolescents is provided. Finally, the implications of utilizing evidence-based practice are discussed and future research considerations are presented. (PsycINFO Database Record (c) 2010 APA, all rights reserved)

3778. Thompson-Brenner H, Glass S, Westen D. A multidimensional meta-analysis of psychotherapy for bulimia nervosa. Clinical Psychology: Science and Practice

2003;10(3):269-87.

Ref ID: 3590

Abstract: We report a multidimensional meta-analysis of psychotherapy trials for bulimia nervosa published between 1980 and 2000, including multiple variables in addition to effect size such as inclusion and exclusion, recovery, and sustained recovery rates. The data point to four conclusions. First, psychotherapy leads to large improvements from baseline. Approximately 40% of patients who complete treatment recover completely, although 60% maintain clinically significant posttreatment symptoms. Second, individual therapy shows substantially better effects than group therapy for the therapies tested. Third, additional approaches or treatment parameters (e.g., number of sessions) need to be tested for the substantial number of patients who enter treatment and do not recover. Finally, the utility of meta-analyses can be augmented by including a wider range of outcome metrics, such as recovery rates and posttreatment symptom levels. copyright 2003 American Psychological Association D12

3784. Thompson-Brenner HJ. Implications for the treatment of bulimia nervosa: A meta-analysis of efficacy trials and a naturalistic study of treatment in the community. Dissertation Abstracts International: Section B: The Sciences and Engineering Vol 63(10-B), Apr 2003, pp 4928 2003;(10-B):Apr.

Ref ID: 4777

Abstract: Prior meta-analyses of the clinical trials of treatments for Bulimia Nervosa have concluded that short-term cognitive-behavioral therapy (CBT) is the treatment of choice for all patients. This dissertation first presents a multidimensional meta-analysis of the same clinical trial data previously analyzed, using additional variables bearing on generalizability and outcome. The data suggest that short-term treatments do result in substantial improvement: However, almost forty percent of the patients who applied for treatment were excluded from the clinical trials; over half of the patients who entered treatment did not recover; and the average patient who completed treatment showed high symptom levels at the post-treatment timepoint. The selection procedure for inclusion in these studies raises questions about representativeness and generalizability of these clinical samples, while the outcome results raise questions about the efficacy of short-term CBT as tested in clinical trials. To assess treatment techniques and outcomes in a less selected sample, this dissertation next presents original data from a naturalistic study of treatment of patients with bulimic symptoms in the community. The clinician-report data suggest that treatments in the community (unconstrained by the limitations of clinical trials) are of much longer duration than the treatments provided in the manuals for clinical trials, and address a much more varied population. Comorbid axis I and axis II diagnoses were extremely common in the naturalistic sample, and it appeared that at least forty percent of the patients with bulimic symptoms treated in the community would have been excluded from clinical trials under four common exclusion criteria. The data suggested that there were three subtypes of bulimia represented in the sample: a High Functioning/Perfectionistic subtype; a Dysregulated/Undercontrolled subtype;

and a Constricted/Overcontrolled subtype. These subtypes showed different patterns of comorbidity and different treatment outcomes. The Dysregulated patients had the most comorbidity, the longest treatments, and the least successful outcomes. In addition, the therapists reported using different therapeutic techniques with the different subgroups: both self-declared CBT and Psychodynamic therapists used more Psychodynamic interventions with the Dysregulated patients. Both CBT and Psychodynamic approaches appeared to have specific effects on treatment outcome: the use of CBT was correlated with shorter overall therapies and shorter times to improvement in eating symptoms, while the use of Psychodynamic psychotherapy was correlated with more overall improvement (particularly among the Constricted and Dysregulated subgroups). The two studies taken together imply that previous claims on behalf of short-term CBT as the treatment of choice are in need of clarification. (PsycINFO Database Record (c) 2010 APA, all rights reserved)

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220. Bacaltchuk J, Hay P. Antidepressants versus placebo for people with bulimia nervosa. COCHRANE DATABASE SYST REV 2003;(4):CD003391.

Ref ID: 1774

Abstract: BACKGROUND: Bulimia Nervosa (BN) represents an important public health problem and is related to serious morbidity and even mortality. This review attempted to systematically evaluate the use of antidepressant medications compared with placebo for the treatment of bulimia nervosa. OBJECTIVES: The primary objective of this review was to determine whether using antidepressant medications was clinically effective for the treatment of bulimia nervosa. The secondary objectives were:(i) to examine whether there was a differential effect for the various classes/types of antidepressants with regard to effectiveness and tolerability(ii) to test the hypothesis that the effect of antidepressants on bulimic symptoms was independent of its effect on depressive symptoms SEARCH STRATEGY: (1) electronic searches of MEDLINE (1966 to December 2002), EMBASE (1980-December 2002), PsycINFO (to December 2002), LILACS & SCISEARCH (to 2002)(2) the Cochrane Register of Controlled Trials and the Cochrane Depression, Anxiety and Neurosis Group Register - ongoing(3) inspection of the references of all identified trials(4) contact with the pharmaceutical companies and the principal investigator of included trials(5) inspection of the International Journal of Eating Disorders - ongoing SELECTION CRITERIA: Inclusion criteria: every randomised, placebo-controlled trial in which antidepressant medications were compared to placebo to reduce the symptoms of bulimia nervosa in patients of any age or gender.Quality criteria: reports were considered adequate if they were classified as A or B according to the Cochrane Manual. The Jadad scale, with a cut off of 2 points, was applied to check the validity of the above referred criterion but was not used as an inclusion criterion. DATA COLLECTION AND ANALYSIS: Data were extracted independently by two

reviewers for each included trial. Dichotomous data were evaluated by the relative risk with 95% confidence intervals (CI) around this measure, based on the random effects model; continuous data were evaluated by the standardised mean difference with the 95% CI. NNT was calculated using the inverse of the absolute risk reduction. MAIN RESULTS: Currently the review includes 19 trials comparing antidepressants with placebo: 6 trials with TCAs (imipramine, desipramine and amitriptyline), 5 with SSRIs (fluoxetine), 5 with MAOIs (phenelzine, isocarboxazid, moclobemide and brofaromine) and 3 with other classes of drugs (mianserin, trazodone and bupropion). Similar results were obtained in terms of efficacy for these different groups of drugs. The pooled RR for remission of binge episodes was 0.87 (95% CI 0.81-0.93; p<0,001) favouring drugs. The NNT for a mean treatment duration of 8 weeks, taking the non-remission rate in the placebo controls of 92% as a measure of the baseline risk was 9 (95% CI 6 - 16). The RR for clinical improvement, defined as a reduction of 50% or more in binge episodes was 0.63 (95% CI 0.55-0.74) and the NNT for a mean treatment duration of 9 weeks was 4 (95% CI 3 - 6), with a non-improvement rate of 67% in the placebo group. Patients treated with antidepressants were more likely to interrupt prematurely the treatment due to adverse events. Patients treated with TCAs dropped out due to any cause more frequently that patients treated with placebo. The opposite was found for those treated with fluoxetine, suggesting it may be a more acceptable treatment. Independence between antidepressant and anti-bulimic effects could not be evaluated due to incomplete published data. REVIEWER'S CONCLUSIONS: The use of a single antidepressant agent was clinically effective for the treatment of bulimia nervosa when compared to placebo, with an overall greater remission rate but a higher rate of dropouts. No differential effect regarding efficacy and tolerability among the various classes of antidepressants could be demonstrated. [References: 70]

620. Carter WP, Hudson JI, Lalonde JK, Pindyck L, McElroy SL, Pope J. Pharmacologic treatment of binge eating disorder. International Journal of Eating Disorders 2003;34(SUPPL.):S74-S88.
Ref ID: 3645
Abstract: Objective: To review the findings from pharmacologic trials of binge eating disorder (BED) and to provide guidelines for pharmacologic treatment. Methods: The literature was searched for studies of pharmacologic treatment of BED and related conditions, such as nonpurging bulimia nervosa. Results: Placebo-controlled studies of desipramine, fluvoxamine, fluoxetine, sertraline, citalopram, dexfenfluramine, sibutramine, and topiramate have demonstrated the efficacy of these agents in the treatment of BED. An open trial of venlafaxine has offered preliminary evidence for the efficacy of this medication. Guidelines for pharmacologic management of BED are provided. Conclusions: The literature offers support for the use of agents from three categories of medication (antidepressants, appetite suppressants, and anticonvulsants) in the treatment of BED. copyright 2003 by Wiley Periodicals, Inc

706. Claudino AM, Hay P, Lima MS, Bacaltchuk J, Schmidt U, Treasure J. Antidepressants for anorexia nervosa. COCHRANE DATABASE SYST REV

2006;(1):CD004365.

Ref ID: 1185

Abstract: BACKGROUND: Anorexia Nervosa (AN) is an illness characterised by extreme concern about body weight and shape, severe self-imposed weight loss, and endocrine dysfunction. In spite of its high mortality, morbidity and chronicity, there are few intervention studies on the subject. OBJECTIVES: The aim of this review was to evaluate the efficacy and acceptability of antidepressant drugs in the treatment of acute AN. SEARCH STRATEGY: The strategy comprised of database searches of the Cochrane Collaboration Depression, Anxiety and Neurosis Controlled Trials Register, MEDLINE (1966 to April 28th, 2005), EMBASE (1980 to week 36, 2004), PsycINFO (1969 to August week 5, 2004), handsearching the International Journal of Eating Disorders and searching the reference lists of all papers selected. Personal letters were sent to researchers in the field requesting information on unpublished or in-progress trials. SELECTION CRITERIA: All randomised controlled trials of antidepressant treatment for AN patients, as defined by the Diagnostic and Statistical Manual, fourth edition (DSM-IV) or similar international criteria, were selected. DATA COLLECTION AND ANALYSIS: Quality ratings were made giving consideration to the strong relationship between allocation concealment and potential for bias in the results; studies meeting criteria A and B were included. Trials were excluded if non-completion rates were above 50%. The standardised mean difference and relative risk were used for continuous data and dichotomous data comparisons, respectively. Whenever possible, analyses were performed according to intention-to-treat principles. Heterogeneity was tested with the I-squared statistic. Weight change was the primary outcome. Secondary outcomes were severity of eating disorder, depression and anxiety symptoms, and global clinical state. Acceptability of treatment was evaluated by considering non-completion rates. MAIN RESULTS: Only seven studies were included. Major methodological limitations such as small trial size and large confidence intervals decreased the power of the studies to detect differences between treatments, and meta-analysis of data was not possible for the majority of outcomes. Four placebo-controlled trials did not find evidence that antidepressants improved weight gain, eating disorder or associated psychopathology. Isolated findings, favouring amineptine and nortriptyline, emerged from the antidepressant versus antidepressant comparisons, but cannot be conceived as evidence of efficacy of a specific drug or class of antidepressant in light of the findings from the placebo comparisons. Non-completion rates were similar between the compared groups. AUTHORS' CONCLUSIONS: A lack of quality information precludes us from drawing definite conclusions or recommendations on the use of antidepressants in acute AN. Future studies testing safer and more tolerable antidepressants in larger, well designed trials are needed to provide guidance for clinical practice. [References: 129]

787. Court A, Mulder C, Hetrick SE, Purcell R, McGorry PD. What is the scientific evidence for the use of antipsychotic medication in anorexia nervosa? EAT DISORD 2008;16(3):217-23.

Ref ID: 2421

Abstract: This systematic review assesses the effectiveness of antipsychotic medication for improving core psychopathology and behavioral symptoms of anorexia nervosa. The Cochrane Depression, Anxiety and Neurosis Group Trials Register, reference lists of retrieved studies and conference abstracts were searched. Four randomized controlled trials comparing typical or atypical antipsychotic medication to other interventions were included. Clinical heterogeneity precluded meta-analysis. Overall, there is insufficient evidence to either support or refute the use of antipsychotic medication in anorexia nervosa. Further trials may be justified but should be designed with a clear theoretical framework to guide use of antipsychotic medication

790. Couturier J, Lock J. Psychopharmacology update: A review of medication use for children and adolescents with eating disorders. Journal of the Canadian Academy of Child and Adolescent Psychiatry 2007;16(4):173-6.

Ref ID: 2451

Abstract: Objective: This paper aims to review the research literature on the use of medication for eating disorders in children and adolescents. Method: The literature was reviewed on the pharmacotherapy of anorexia nervosa (AN), bulimia nervosa (BN) and eating disorder not otherwise specified (EDNOS). The PubMed database was searched for all articles on medication use in the child and adolescent population using the terms medication, antipsychotic, antidepressant, child, adolescent, eating disorders, anorexia nervosa and bulimia nervosa. Results: Very little literature exists on the use of medication for the treatment of eating disorders in children and adolescents. There is one retrospective study on the use of SSRIs and some case reports on atypical antipsychotics for children and adolescents with AN, and one small open trial on SSRIs for adolescent BN. Conclusions: Evidence-based pharmacological treatment for children and adolescents with eating disorders is not yet possible due to the limited number of studies available, It appears that olanzapine and other atypical antipsychotics may prove to be promising for AN at low body weights. It remains uncertain whether SSRIs are helpful in preventing relapse in AN. For children and adolescents with BN, the first line pharmacological option is fluoxetine given the large evidence base of this drug with the adult population and a small open trial of adolescents with BN

1032. Dunican KC, DelDotto D. The role of olanzapine in the treatment of anorexia nervosa. Annals of Pharmacotherapy 2007;41(1):111-5.

Ref ID: 2654

Abstract: OBJECTIVE: To evaluate the role of olanzapine in the treatment of anorexia nervosa. DATA SOURCES: Literature was obtained through searches of MEDLINE (1966-December 2006), EMBASE (1980-4th Quarter 2006), and PsycINFO (1985-December 2006) and a bibliographic review of published articles. Key terms used in the searches included anorexia nervosa, antipsychotics, eating disorders, olanzapine, and Zyprexa. STUDY SELECTION AND DATA EXTRACTION: All English language articles that were identified from the search were evaluated. All primary literature was included in the review. DATA SYNTHESIS: In several case

reports and most clinical trials, patients with anorexia nervosa successfully gained weight while being treated with olanzapine. Moreover, many patients treated with olanzapine achieved a healthy body weight. Case reports and trials identified additional benefits of olanzapine, including reduction in delusional thinking; improvement in body image, sleep, depressive symptoms, adherence to treatment, and eating-disorder symptoms; and decreased agitation and premeal anxiety. CONCLUSIONS: Preliminary evidence supports the use of olanzapine for treatment of anorexia nervosa by demonstrating that olanzapine 2.5-15 mg daily promotes weight gain and has positive effects on associated psychological symptoms. Limitations of the reported data include small sample size, low completion rate in clinical trials, and open-label trial design. Although olanzapine appears to have a potential role in the treatment of anorexia nervosa that has been unresponsive to other therapy, randomized, placebo-controlled studies with larger sample sizes are necessary to establish its role in therapy

1958. Kim SS. Role of fluoxetine in anorexia nervosa. Annals of Pharmacotherapy 2003;37(6):890-2.
Ref ID: 1865
Abstract: OBJECTIVE: To evaluate the efficacy of fluoxetine in the treatment of anorexia nervosa. DATA SOURCES: Literature obtained through searching MEDLINE (1966-January 2003). DATA SYNTHESIS: Studies conducted on the efficacy of fluoxetine in treating anorexia nervosa have conflicting results. Study design and methodology should be carefully evaluated. CONCLUSIONS: Fluoxetine played a role in the reduction of symptoms of obsessive-compulsive disorder and depression in anorexic patients. While psychotherapy, nutritional therapy, and behavioral therapy should be the mainstays of treatment, fluoxetine should be considered as an option to prevent relapse or to treat associated symptoms of anorexia nervosa following adequate weight restoration as a part of maintenance therapy and not as a primary or acute therapy. Although fluoxetine appears to be promising for the treatment of patients with anorexia nervosa, further studies need to be performed with a larger sample size and/or better design. [References: 16]

3081. Reas DL, Grilo CM. Review and meta-analysis of pharmacotherapy for binge-eating disorder. Obesity 2008;16(9):2024-38.
Ref ID: 330
Abstract: This study evaluated available controlled treatment studies to determine utility of pharmacotherapy for binge-eating disorder (BED). The authors identified randomized placebo-controlled trials testing pharmacotherapy-only treatments and controlled trials testing pharmacotherapy with psychotherapy treatments. Meta-analysis was performed on placebo-controlled trials with data for attrition, remission, and weight loss. Qualitative review was performed on remaining controlled treatment literature. A total of 33 studies were considered of which 14 studies with a total of 1,279 patients were included in the meta-analysis of pharmacotherapy-only treatment and 8 studies with a total of 683 patients were included in the qualitative review of pharmacotherapy combined with psychotherapy interventions. No evidence sug-

gested significant differences between medication and placebo for attrition. Evidence suggested that pharmacological treatments have a clinically significant advantage over placebo for achieving short-term remission from binge eating (48.7% vs. 28.5%) and for weight loss, although weight losses are not substantial. No data exist to allow evaluation of longer-term effects of pharmacotherapy-only treatment for BED. Combining medications with psychotherapy interventions failed to significantly enhance binge outcomes, although specific medications (orlistat, topiramate) enhanced weight losses achieved with cognitive behavioral therapy and behavioral weight loss. In summary, BED patients can be advised that certain pharmacotherapies may enhance likelihood of stopping binge eating short term, but that longer-term effects are unknown. Although some weight loss may occur, it is unlikely to be substantial with available medications. Combining medications with cognitive or behavioral treatments is unlikely to enhance binge outcomes, but specific medications (orlistat, topiramate) may enhance weight losses, albeit modestly

3201. Rossi A, Barraco A, Donda P. Fluoxetine: A review on evidence based medicine. Annals of General Hospital Psychiatry Vol 3 Feb 2004, ArtID 2 2004;ArtID.
Ref ID: 4636
Abstract: Background: Fluoxetine was the first molecule of a new generation of antidepressants, the Selective Serotonin Re-uptake Inhibitors (SSRIs). It is recurrently the paradigm for the development of any new therapy in the treatment of depression. Many controlled studies and meta-analyses were performed on Fluoxetine, to improve the understanding of its real impact in the psychiatric area. The main objective of this review is to assess the quality and the results reported in the meta-analyses published on Fluoxetine. Methods: Published articles on Medline, Embase and Cochrane databases reporting meta-analyses were used as data sources for this review. Articles found in the searches were reviewed by 2 independent authors, to assess if these were original meta-analyses. Only data belonging to the most recent and comprehensive meta-analytic studies were included in this review. Results: Data, based on a group of 9087 patients, who were included in 87 different randomized clinical trials, confirms that fluoxetine is safe and effective in the treatment of depression from the first week of therapy. Fluoxetine's main advantage over previously available antidepressants (TCAs) was its favorable safety profile, that reduced the incidence of early drop-outs and improved patient's compliance, associated with a comparable efficacy on depressive symptoms. In these patients, Fluoxetine has proven to be more effective than placebo from the first week of therapy. Fluoxetine has shown to be safe and effective in the elderly population, as well as during pregnancy. Furthermore, it was not associated with an increased risk of suicide in the overall evaluation of controlled clinical trials. The meta-analysis available on the use of Fluoxetine in the treatment of bulimia nervosa shows that the drug is as effective as other agents with fewer patients dropping out of treatment. Fluoxetine has demonstrated to be as effective as chlomipramine in the treatment of Obsessive-Compulsive-Disorder (OCD). Conclusion: Fluoxetine can be considered a drug successfully used in several diseases for its favorable safety/efficacy ratio. As the re-

sponse rate of mentally ill patients is strictly related to each patient's personal characteristics, any new drug in this area, will have to be developed under these considerations. (PsycINFO Database Record (c) 2010 APA, all rights reserved) (journal abstract)

3555. Stefano SC, Bacaltchuk J, Blay SL, Appolinario JC. Antidepressants in short-term treatment of binge eating disorder: Systematic review and meta-analysis. Eating Behaviors 2008;9(2):129-36.
Ref ID: 2469
Abstract: Objective: To evaluate the effects of antidepressant interventions for patients with Binge Eating Disorder (BED). Method: A systematic review and meta-analysis of available randomized controlled trials including a quality appraisal was conducted. Six databases: PUBMED, EMBASE, PSYINFO, LILACS, The Cochrane Collaboration Controlled Trials Register and The Cochrane Depression, Anxiety and Neurosis Group Database of Trials were searched using an electronic search strategy. Articles published during the period from January 1994 to December 2005 were included. Results: From the 3357 articles initially identified, 19 full manuscripts were selected and analyzed and 7 studies fulfilled the inclusion criteria and were included in the final analysis. Data from the meta-analysis revealed that binge-eating remission rates were higher in patients receiving antidepressants when compared with placebo. No difference in body weight has been found as measured by short-term change in body mass index. Most studies were short-term trials (median duration: 8 weeks). The only 16-week duration study did not show superiority of antidepressants over placebo. Conclusion: Available data are not sufficient to formally recommend antidepressants as a single first line therapy for both short-term remission of binge-eating episodes and weight reduction in patients with BED. BED is a chronic condition and very short-term studies (8 weeks) may be of limited value.

3738. Tata AL, Kockler DR. Topiramate for binge-eating disorder associated with obesity. Annals of Pharmacotherapy 2006;40(11):1993-7.
Ref ID: 981
Abstract: OBJECTIVE: To review the use of topiramate for the treatment of binge-eating disorder (BED) associated with obesity. DATA SOURCES: MEDLINE (1966-July 2006) and the Cochrane Database (2006, issue 3) were used to conduct an English-language literature search. Key search terms included eating disorder, binge-eating, and topiramate. Bibliographies of identified articles were examined for additional references. DATA SYNTHESIS: BED is characterized by excessive food intake with lack of control during eating episodes, but without subsequent compensatory weight loss mechanisms, and is often associated with obesity and psychiatric disorders. Evidence suggests that topiramate may have mood-stabilizing properties and cause decreased appetite and weight. One case series, 1 case report, 2 open-label studies, and 1 placebo-controlled trial have described the use of topiramate for BED associated with obesity. Doses ranging from 50 to 1400 mg/day were stated to be effective in these reports. Adverse reactions included paresthesias, cognitive im-

pairment, somnolence, and gastrointestinal distress. Although these adverse effects were transient, they may interfere with patients' tolerability of topiramate therapy. CONCLUSIONS: Albeit limited, evidence suggests that topiramate may be a viable short- and long-term treatment alternative for BED associated with obesity for patients with limited options. Further controlled trials are necessary to establish topiramate's place in therapy, optimal dosing, and length of treatment for this eating disorder. [References: 29]

4177. Woods TM, Eichner SF, Franks AS. Weight Gain Mitigation with Topiramate in Mood Disorders. Annals of Pharmacotherapy 2004;38(5):887-91.
Ref ID: 3528
Abstract: OBJECTIVE: To review the evidence of weight loss with use of topiramate in patients with mood disorders. DATA SOURCES: Literature search included MEDLINE (1966-December 2003), International Pharmaceutical Abstracts (1970-December 2003), and EMBASE (1980-December 2003). Search terms included topiramate, weight loss, adverse effect, mood disorders, bipolar disorder. DATA SYNTHESIS: Weight gain is a common adverse effect of many agents used to treat mood disorders. Topiramate has been evaiuated in the management of some mood disorders, and weight loss may be a beneficial side effect in these patients. Case reports, letters to the editor, prospective investigations, and retrospective observational studies were reviewed to identify evidence of weight loss with topiramate use in patients with mood disorders. CONCLUSIONS: Current evidence suggests an association between topiramate and weight loss. Based on the limited data, controlled studies need to be conducted to define the role of topiramate in patients with mood disorders who would also benefit from weight reduction

3314. Scarpellini P, Perugi G. Use of zonisamide in psychiatry. Italian Journal of Psychopathology 2008;14(3):316-23.
Ref ID: 2051
Abstract: Objective: Antiepileptic drugs (AE) such as valproate and carbamazepine are today widely used in psychiatry. Recently, lamotrigine has been approved for the prevention of depressive recurrences in bipolar disorder. Some of the new AEs such as oxcarbazepine, gabapentin, topiramate, levetiracetam, pregabalin and zonisamide have been reported to be effective in the treatment of several resistant mood, anxiety, impulse control, substance use, eating and personality disorders. In the present article we systematically review the available literature on the use of zonisamide in psychiatry. Method: Medline, Embase, PsychInfo databases were searched for existing studies of zonisamide in mental, mood, anxiety, and eating disorders. Inquiry to Eisai pharmaceuticals and manual search on significant book chapters and reviews on the same topic were also performed. Results: Zonisamide shows an anticonvulsant action in patients with partial, generalized and combined seizures. The mechanism of action is not completely known, but zonisamide stabilizes neuronal cell activity and suppresses neuronal hypersynchronization. This mechanism could also be responsible for the antianxiety, antimanic, antidepressant and anti-impulsive action of the drug. Most clinical studies on zonisamide are open,

non-randomized, and involve small samples; therefore the results should still be considered preliminary (Tab.I). With these limitations, the data reported seem to indicate efficacy of the drug as adjunctive treatment of various treatment-resistant patients with bipolar and eating disorders, and obesity. Zonisamide is well tolerated; however drop-out tares are high; most frequently reported side effects include somnolence, depression, and cognitive disturbances. Conclusion: The available information on zonisamide in different mental disorders should be considered preliminary. Although reported results are encouraging, further controlled research in larger samples is necessary

Medikamentell i kombinasjon med annen behandling (6)

363. Berkman ND, Bulik CM, Brownley KA, Lohr KN, Sedway JA, Rooks A, et al. Management of eating disorders. Evidence Report/Technology Assessment 2006;(135):1-166.
Ref ID: 927
Abstract: OBJECTIVES: The RTI International-University of North Carolina at Chapel Hill Evidence-based Practice Center (RTI-UNC EPC) systematically reviewed evidence on efficacy of treatment for anorexia nervosa (AN), bulimia nervosa (BN), and binge eating disorder (BED), harms associated with treatments, factors associated with the treatment efficacy and with outcomes of these conditions, and whether treatment and outcomes for these conditions differ by sociodemographic characteristics. DATA SOURCES: We searched MEDLINE, the Cumulative Index to Nursing and Applied Health (CINAHL), PSYCHINFO, the Educational Resources Information Center (ERIC), the National Agricultural Library (AGRICOLA), and Cochrane Collaboration libraries. REVIEW METHODS: We reviewed each study against a priori inclusion/exclusion criteria. For included articles, a primary reviewer abstracted data directly into evidence tables; a second senior reviewer confirmed accuracy. We included studies published from 1980 to September 2005, in all languages. Studies had to involve populations diagnosed primarily with AN, BN, or BED and report on eating, psychiatric or psychological, or biomarker outcomes. RESULTS: We report on 30 treatment studies for AN, 47 for BN, 25 for BED, and 34 outcome studies for AN, 13 for BN, 7 addressing both AN and BN, and 3 for BED. The AN literature on medications was sparse and inconclusive. Some forms of family therapy are efficacious in treating adolescents. Cognitive behavioral therapy (CBT) may reduce relapse risk for adults after weight restoration. For BN, fluoxetine (60 mg/day) reduces core bulimic symptoms (binge eating and purging) and associated psychological features in the short term. Individual or group CBT decreases core behavioral symptoms and psychological features in both the short and long term. How best to treat individuals who do not respond to CBT or fluoxetine remains unknown. In BED, individual or group CBT reduces binge eating and improves abstinence rates for up to 4 months after treatment; however, CBT is not associated with weight loss. Medi-

cations may play a role in treating BED patients. Further research addressing how best to achieve both abstinence from binge eating and weight loss in overweight patients is needed. Higher levels of depression and compulsivity were associated with poorer outcomes in AN; higher mortality was associated with concurrent alcohol and substance use disorders. Only depression was consistently associated with poorer outcomes in BN; BN was not associated with an increased risk of death. Because of sparse data, we could reach no conclusions concerning BED outcomes. No or only weak evidence addresses treatment or outcomes difference for these disorders. CONCLUSIONS: The literature regarding treatment efficacy and outcomes for AN, BN, and BED is of highly variable quality. In future studies, researchers must attend to issues of statistical power, research design, standardized outcome measures, and sophistication and appropriateness of statistical methodology. [References: 401]

379. Beumont P, Hay P, Beumont R. Summary Australian and New Zealand clinical practice guideline for the management of anorexia nervosa (2003). Australasian Psychiatry 2003;11(2):129-33.
Ref ID: 3774
Abstract: Objective: To provide a summary of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) Clinical Practice Guideline for the Management of Anorexia Nervosa (AN). Conclusions: Anorexia nervosa affects only a small proportion of the Australian and New Zealand population but it is important because it is a serious and potentially life-threatening illness. Sufferers often struggle with AN for many years, if not for life, and the damage done to their minds and bodies may be irreversible. Anorexia nervosa is characterized by a deliberate loss of weight and refusal to eat. Overactivity is common. Approximately 50% of patients also use unhealthy purging and vomiting behaviours to lose weight. There are two main areas of physical interest: the undernutrition and malnutrition of the illness and the various detrimental weight-losing behaviours themselves. Basic psychopathology ranges from an over-valued idea of high salience concerning body shape through to total preoccupation and eventually to firmly held ideas that resemble delusions. Comorbid features are frequent, especially depression and obsessionality. It is inadvisable in clinical practice to apply too strict a definition of AN because to do so excludes patients in the early stage of the illness in whom prompt intervention is most likely to be effective. The best treatment appears to be multidimensional/multidisciplinary care, using a range of settings as required. Obviously, the medical manifestations of the illness need to be addressed and any physical harm halted and reversed. It is difficult to draw conclusions about the efficacy of further treatments. There is a paucity of clinical trials, and their quality is poor. Furthermore, the stimuli for developing AN are varied, and the psychotherapy options to address these problems need to be tailored to suit the individual patient. Because there is no known 'chemical imbalance' that causes the illness, no one drug offers relief. There is a high rate of relapse, and some patients are unable to recover fully. Because AN is a psychiatric illness, a psychiatrist should always be involved in its treatment. All psychiatrists should be capable of assuming this responsibility. Because cognitive behavioural methods are gen-

erally accepted as the best mode of therapy, a clinical psychologist should also be involved in treatment. Because medical manifestations are important, someone competent in general medicine should always be consulted. The optimal approach is multidisciplinary or at least multiskilled, with important contributions from psychologists, general practitioners, psychiatric nurses, paediatricians, dietitians and social workers

380. Beumont P, Hay P, Beumont D, Birmingham L, Derham H, Jordan A, et al. Australian and New Zealand clinical practice guidelines for the treatment of anorexia nervosa. Australian and New Zealand Journal of Psychiatry 2004;38(9):659-70.
Ref ID: 1586
Abstract: BACKGROUND: The Royal Australian and New Zealand College of Psychiatrists is co-ordinating the development of clinical practice guidelines (CPGs) in psychiatry, funded under the National Mental Health Strategy (Australia) and the New Zealand Ministry of Health. This CPG covers anorexia nervosa (AN). METHOD: The CGP team consulted with scientists, clinicians, carers and consumer groups in meetings of over 200 participants and conducted a systematic review of meta-analyses, randomized controlled trials and other studies. TREATMENT RECOMMENDATIONS: It is extremely difficult to draw general conclusions about the efficacy of specific treatment options for AN. There are few controlled clinical trials and their quality is generally poor. These guidelines necessarily rely largely upon expert opinion and uncontrolled trials. A multidimensional approach is recommended. Medical manifestations of the illness need to be addressed and any physical harm halted and reversed. Weight restoration is essential in treatment, but insufficient evidence is available for any single approach. A lenient approach is likely to be more acceptable to patients than a punitive one and less likely to impair self-esteem. Dealing with the psychiatric problems is not simple and much controversy remains. For patients with less severe AN who do not require in-patient treatment, out-patient or day-patient treatment may be suitable, but this decision will depend on availability of such services. Family therapy is a valuable part of treatment, particularly for children and adolescents, but no particular approach emerges as superior to any other. Dietary advice should be included in all treatment programs. Cognitive behaviour therapy or other psychotherapies are likely to be helpful. Antidepressants have a role in patients with depressive symptoms and olanzapine may be useful in attenuating hyperactivity

512. Brownley KA, Berkman ND, Sedway JA, Lohr KN, Bulik CM. Binge eating disorder treatment: a systematic review of randomized controlled trials. International Journal of Eating Disorders 2007;40(4):337-48.
Ref ID: 783
Abstract: OBJECTIVE: The Research Triangle Institute-University of North Carolina Evidence Based Practice Center (RTI-EPC) systematically reviewed evidence on efficacy of treatment for binge eating disorder (BED), harms associated with treatments, factors associated with treatment efficacy, and differential outcome by sociodemographic characteristics. METHOD: We searched six major databases for stud-

ies on the treatment of BED published from 1980 to September, 2005, in all languages against a priori inclusion/exclusion criteria and focused on eating, psychiatric or psychological, or biomarker outcomes. RESULTS: Twenty-six studies, including medication-only, medication plus behavioral intervention, and behavioral intervention only designs, met inclusion criteria. The strength of the evidence for medication and behavioral interventions was moderate, for self-help and other interventions was weak, for treatment-related harms was strong, for factors associated with efficacy of treatment was weak, and for differential outcome by sociodemographic factors was nonexistent. Individual or group CBT reduces binge eating and improves abstinence rates for up to 4 months after treatment but does not lead to weight loss. Medications may play a role in treating BED patients. CONCLUSION: The literature regarding treatment efficacy for BED is variable. Future directions include the identification of optimal interventions that are associated with both sustained abstinence from binge eating and permanent weight loss. [References: 32]

1592. Hay Phillipa PJ, Claudino AM, Kaio MH. Antidepressants versus psychological treatments and their combination for bulimia nervosa. Cochrane Database of Systematic Reviews: Reviews. I: Cochrane Database of Systematic Reviews 2001 Issue 4. Chichester (UK): John Wiley & Sons, Ltd; 2001.
Ref ID: 5072
Abstract: BACKGROUND: Psychotherapeutic approaches, mainly cognitive behavior therapy, and antidepressant medication are the two treatment modalities that have received most support in controlled outcome studies of bulimia nervosa. OBJECTIVES: The primary objective was to conduct a systematic review of all RCTs comparing antidepressants with psychological approaches or comparing their combination with each single approach for the treatment of bulimia nervosa. SEARCH STRATEGY: (1) electronic searches of MEDLINE (1966 to December 2000), EMBASE (1980-December 2000) , PsycLIT (to December 2000), LILACS & SCISEARCH (to 1999) (2) the Cochrane Register of Controlled Trials and the Cochrane Depression, Anxiety and Neurosis Group Register - ongoing (3) handsearches of the references of all identified trials (4) contact with the pharmaceutical companies and the principal investigator of each included trial (5) handsearch of the International Journal of Eating Disorders - ongoing SELECTION CRITERIA: Inclusion criteria: every randomized controlled trial in which antidepressants were compared with psychological treatments or the combination of antidepressants with psychological approaches was compared to each treatment alone, to reduce the symptoms of bulimia nervosa in patients of any age or gender. Quality criteria: reports were considered adequate if they were classified as A or B according to the Cochrane Manual. DATA COLLECTION AND ANALYSIS: Data were extracted independently by two reviewers for each included trial. The main outcome for efficacy was full remission of bulimic symptoms, defined as 100% reduction in binge or purge episodes from baseline to endpoint. Dichotomous data was evaluated by the relative risks and 95% confidence intervals around this measure, based on the random effects model; continuous data was evaluated by the average difference and the 95% confidence interval.

Number needed to treat (NNT) and number needed to harm (NNH) were calculated using the inverse of the absolute risk reduction. MAIN RESULTS: Five trials were included in comparison one (antidepressants versus psychological treatments), five in comparison two (antidepressants versus the combination) and seven in comparison three (psychological treatments versus the combination). Remission rates were 20% for single antidepressants compared to 39% for single psychotherapy (DerSimonian-Laird Relative Risk = 1.28; 95% Confidence Interval = 0.98;1.67). Dropout rates were higher for antidepressants than for psychotherapy (DerSimonian-Laird Relative Risk = 2.18; 95% Confidence Interval = 1.09;4.35). The NNH for a mean treatment duration of 17.5 weeks was 4 (95% confidence interval = 3;11). Comparison two found remission rates of 42% for the combination versus 23% for antidepressants (DerSimonian-Laird Relative Risk = 1.38; 95% Confidence Interval = 0.98;1.93). Comparison three showed a 36% pooled remission rate for psychological approaches compared to 49% for the combination (DerSimonian-Laird Relative Risk = 1.21; 95% Confidence Interval = 1.02;1.45). The NNT for a mean treatment duration of 15 weeks was 8 (95% Confidence Interval = 4;320). Dropout rates were higher for the combination compared to single psychological treatments (DerSimonian-Laird Relative Risk = 0.57; 95% Confidence Interval = 0.38;0.88). The NNH was 7 (95% Confidence Interval = 4;21). AUTHORS' CONCLUSIONS: Using a more conservative statistical approach, combination treatments were superior to single psychotherapy. This was the only statistically significant difference between treatments. The number of trials might be insufficient to show the statistical significance of a 19% absolute risk reduction in efficacy favouring psychotherapy or combination treatments over single antidepressants. Psychotherapy appeared to be more acceptable to subjects. When antidepressants were combined with psychological treatments, acceptability of the latter was significantly reduced. ANTIDEPRESSANTS AND PSYCHOLOGICAL TREATMENTS, ALONE OR COMBINED, FOR BULIMIA NERVOSA: Psychotherapeutic approaches, mainly cognitive behavior therapy, and antidepressant medication are the two treatment modalities that have received most support in controlled outcome studies of bulimia nervosa. Using a more conservative statistical approach, combination treatments were superior to single psychotherapy. This was the only statistically significant difference between treatments. The number of trials might be insufficient to show the statistical significance of a 19% absolute risk reduction in efficacy favouring psychotherapy or combination treatments over single antidepressants. Psychotherapy appeared to be more acceptable to subjects. When antidepressants were combined with psychological treatments, acceptability of the latter was significantly reduced

2679. National Institute for Clinical Excellence. Eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders (DARE structured abstract). London: National Institute for Clinical Excellence; 2004. 2004:35.

Ref ID: 6390

Abstract: Authors' conclusions

Anorexia nervosa - Most people with anorexia nervosa should be managed on an outpatient basis with psychological treatment provided by a service that is competent in giving that treatment and assessing the physical risk of people with eating disorders. - People with anorexia nervosa requiring inpatient treatment should be admitted to a setting that can provide the skilled implementation of refeeding with careful physical monitoring (particularly in the first few days of refeeding) in combination with psychosocial interventions. - Family interventions that directly address the eating disorder should be offered to children and adolescents with anorexia nervosa.

Bulimia nervosa - As a possible first step, patients with bulimia nervosa should be encouraged to follow an evidence-based self-help programme. - As an alternative or additional first step to using an evidence-based self-help programme, adults with bulimia nervosa may be offered a trial of an antidepressant drug. - Cognitive behaviour therapy for bulimia nervosa (CBT-BN), a specifically adapted form of CBT, should be offered to adults with bulimia nervosa. The course of treatment should be for 16 to 20 sessions over 4 to 5 months. - Adolescents with bulimia nervosa may be treated with CBT-BN, adapted as needed to suit their age, circumstances and level of development, and including the family as appropriate.

Atypical eating disorders - In the absence of evidence to guide the management of atypical eating disorders (eating disorders not otherwise specified) other than binge eating disorder, it is recommended that the clinician considers following the guidance on the treatment of the eating problem that most closely resembles the individual patients eating disorder. - Cognitive behaviour therapy for binge eating disorder (CBT-BED), a specifically adapted form of CBT, should be offered to adults with binge eating disorder.

For all eating disorders - Family members including siblings should normally be included in the treatment of children and adolescents with eating disorders. Interventions may include sharing of information, advice on behavioural management and facilitating communication.

Poliklinisk behandling (4)

1593. Hay P, Bacaltchuk J, Claudino A, Ben-Tovim D, Yong PY. Individual psychotherapy in the outpatient treatment of adults with anorexia nervosa. COCHRANE DATABASE SYST REV 2003;(4):CD003909.
Ref ID: 1773
Abstract: BACKGROUND: Anorexia nervosa is a disorder of high morbidity and significant mortality. It is commonest in young adult women, in whom the incidence may be increasing. The focus of treatment has moved to an outpatient setting and a number of differing psychotherapies are presently used in treatment. OBJECTIVES:

The aim of the present review was to evaluate the evidence from randomised controlled trials for the efficacy of outpatient psychotherapies used in the treatment of older adolescents and adults with anorexia nervosa SEARCH STRATEGY: The strategy comprised database searches of MEDLINE, EXTRAMED, EMBASE,PSYCLIT, CURRENT CONTENTS, Cochrane Collaboration Controlled Trials Register and the Depression and Anxiety Neuroses Cochrane Group (CCDAN), a hand-search of The International Journal of Eating Disorders, and he reference lists of all papers selected. Personal letters were sent to identified notable researchers published in the area, requesting information on trials that are unpublished or in progress. SELECTION CRITERIA: All randomised controlled trials of adult individual outpatient therapy for anorexia nervosa as defined by the DSM-IV or similar international criterion. Quality ratings were made according to the CCDAN criteria and in addition, whether the trial had examined treatment integrity. DATA COLLECTION AND ANALYSIS: A range of outcome variables were selected, including physical state, severity of eating disorder attitudes and beliefs, interpersonal function, and general psychiatric symptom severity. Continuous outcome data comparisons were made with the standardized mean difference statistic, and binary outcome comparisons made with the relative risk statistic. Reliability of data extraction and quality ratings were made with the kappa statistic. Sensitivity analyses to evaluate the effects of trial quality and subgroup analyses to explore specific questions of treatment effects from different settings, frequency and duration of therapies were planned. MAIN RESULTS: Six small trials only, two of which included children or adolescents, were identified from the search and aggregation of data was not possible. Bias was possible due particularly to lack of blinding of outcome assessments. The results in two trials suggested that 'treatment as usual' or similar may be less efficacious than a specific psychotherapy. No specific treatment was consistently superior to any other specific approach. Dietary advice as a control arm had a 100% non-completion rate in one trial. REVIEWER'S CONCLUSIONS: No specific approach can be recommended from this review. It is unclear why 'treatment as usual' performed so poorly or why dietary advice alone appeared so unacceptable as the reasons for non-completion were not reported. There is an urgent need for large well-designed trials in his area. [References: 84]

1920. Keel PK, Brown TA. Update on course and outcome in eating disorders. International Journal of Eating Disorders 2010;43(3):195-204.

Ref ID: 2256

Abstract: Objective: To review recent studies describing eating disorder course and outcome. Method: Electronic and manual searches were conducted to identify relevant articles published since 2004. Results: Twenty-six articles were identied. For anorexia nervosa (AN), most patients ascertained through outpatient settings achieved remission by 5-year follow-up. Inpatient treatment predicted poor prognosis as inpatient samples demonstrated lower remission rates. Outcome differed between bulimia nervosa (BN) and eating disorders not otherwise specified (EDNOS), including binge eating disorder (BED), for shorter follow-up durations; however, out-

comes appeared similar between BN and related EDNOS by 5-year follow-up. Greater psychiatric comorbidity emerged as a significant predictor of poor prognosis in BN, whereas few prognostic indicators were identified for BED or other EDNOS. Discussion: Results support optimism for most patients with eating disorders. However, more effective treatments are needed for adult AN inpatients and approximately 30% of patients with BN and related EDNOS who remain ill 10-20 years following presentation. copyright 2010 by Wiley Periodicals, Inc

4000. Wallier J, Vibert S, Berthoz S, Huas C, Hubert T, Godart N. Dropout from inpatient treatment for anorexia nervosa: critical review of the literature. International Journal of Eating Disorders 2009;42(7):636-47.
Ref ID: 128
Abstract: OBJECTIVE: High dropout rates from inpatient treatment for Anorexia Nervosa (AN) pose a serious obstacle to successful treatment. Because dropping out of inpatient treatment may have a negative impact on outcome, it is important to understand why dropout occurs so that treatment can be targeted toward keeping patients in care. We therefore conducted a critical literature review of studies on dropout from inpatient treatment for AN. METHOD: Searches of Medline and PsycINFO revealed nine articles on this subject. Two were excluded because they did not differentiate AN from other eating disorders in analyses. RESULTS: Results were scarce and conflicting, with methodological issues complicating comparisons. Weight on admission, AN subtype, eating disorder symptoms, greater psychiatric difficulty in general, and the absence of depression were related to dropout in multivariate analyses. DISCUSSION: Authors should use a common definition of dropout and continue research on the identified predictors as well as potential predictors such as impulsivity and family factors. [References: 31]

914. de ZM, Zipfel S, Herzog W, Herpertz-Dahlmann B, Konrad K, Hebebrand J, et al. EDNET - eating disorders diagnostic and treatment network. Psychotherapie, Psychosomatik, Medizinische Psychologie 2009;59(3-4):110-6.
Ref ID: 237
Abstract: The paper gives an overview of the 4 randomized-controlled multi-center psychotherapy studies and the associated studies of the Eating Disorders Diagnostic and Treatment Network (EDNET). The multi-center trials include an outpatient treatment trial for AN comparing focal psychodynamic psychotherapy, cognitive-behavioral therapy, and treatment as usual, a trial comparing in- and day-patient treatment in adolescents with AN, and two internet-based relapse prevention trials for patients with AN and with BN after discharge from inpatient treatment. Associated studies are grouped around these core proposals covering neuropsychology, structural as well as functional neuroimaging, genetics, endocrinology, and moderators and mediators of treatment outcome. [References: 49]

Selvhjelp (3)

3554. Stefano SC, Bacaltchuk J, Blay SL, Hay P. Self-help treatments for disorders of recurrent binge eating: a systematic review. Acta Psychiatrica Scandinavica 2006;113(6):452-9.
Ref ID: 1130
Abstract: OBJECTIVE: To evaluate self-help interventions for patients with binge eating disorder (BED) and bulimia nervosa (BN), tested in randomized controlled trials, and compared with waiting list or any other type of control group. METHODS: A systematic review including quality appraisal was conducted of randomized controlled trials, using self-help techniques in patients with BED and/or BN. Six databases were searched during the period between January 1994 and June 2004. RESULTS: A total of 2686 articles were identified, 1701 abstracts were evaluated in detail and, nine studies fulfilled the inclusion criteria for this review. All studies indicated that patients treated with active interventions had a reduced number of binge eating episodes at end of treatment. CONCLUSION: The results support self-help interventions but shall be interpreted with caution. Because of the small number of studies using self-help techniques for BED and BN, further larger randomized, multi-center controlled studies that apply standardized inclusion criteria, evaluation instruments and self-help materials, are needed. [References: 51]

2904. Perkins SJ, Murphy R, Schmidt U, Williams C. Self-help and guided self-help for eating disorders. COCHRANE DATABASE SYST REV 2006;3:CD004191.
Ref ID: 1055
Abstract: BACKGROUND: Anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED) and eating disorder not otherwise specified (EDNOS) are common and disabling disorders. Many patients experience difficulties accessing specialist psychological treatments. Pure self-help (PSH: self-help material only) or guided self-help (GSH: self-help material with therapist guidance), may bridge this gap. OBJECTIVES: Main objective:Evaluate evidence from randomised controlled trials (RCTs) / controlled clinical trials (CCTs) for the efficacy of PSH/GSH with respect to eating disorder symptoms, compared with waiting list or placebo/attention control, other psychological or pharmacological treatments (or combinations/augmentations) in people with eating disorders. Secondary objective:Evaluate evidence for the efficacy of PSH/GSH regarding comorbid symptomatology and costs. SEARCH STRATEGY: CCDANCTR-Studies and CCDANCTR-References were searched in November 2005, other electronic databases were searched, relevant journals and grey literature were checked, and personal approaches were made to authors. SELECTION CRITERIA: Published/unpublished RCTs/CCTs evaluating PSH/GSH for any eating disorder. DATA COLLECTION AND ANALYSIS: Data was extracted using a customized spreadsheet. Relative Risks (RR) were calculated from dichotomous data and weighted/standardized mean differences (WMD/SMD) from continuous data, using a random effects model. MAIN RESULTS: Twelve RCTs and three CCTs were identified, all focusing on BN, BED, EDNOS or

combinations of these, in adults, using manual-based PSH/GSH across various settings. Primary comparisons:At end of treatment, PSH/GSH did not significantly differ from waiting list in abstinence from bingeing (RR 0.72, 95% CI 0.47 to 1.09), or purging (RR 0.86, 95% CI 0.68 to 1.08), although these treatments produced greater improvement on other eating disorder symptoms, psychiatric symptomatology and interpersonal functioning but not depression. Compared to other formal psychological therapies, PSH/GSH did not differ significantly at end of treatment or follow-up in improvement on bingeing and purging (RR 0.99, 95% CI 0.75 to 1.31), other eating disorder symptoms, level of interpersonal functioning or depression. There were no significant differences in treatment dropout. Secondary comparisons:One small study in BED found that cognitive-behavioural GSH compared to a non-specific control treatment produced significantly greater improvements in abstinence from bingeing and other eating disorder symptoms. Studies comparing PSH with GSH found no significant differences between treatment groups at end of treatment or follow-up. Comparison between different types of PSH/GSH found significant differences on eating disorder symptoms but not on bingeing/purging abstinence rates. AUTHORS' CONCLUSIONS: PSH/GSH may have some utility as a first step in treatment and may have potential as an alternative to formal therapist-delivered psychological therapy. Future research should focus on producing large well-conducted studies of self-help treatments in eating disorders including health economic evaluations, different types and modes of delivering self-help (e.g. computerised versus manual-based) and different populations and settings. [References: 62]

2155. Leach LS, Christensen H. A systematic review of telephone-based interventions for mental disorders. Journal of Telemedicine and Telecare 2006;12(3):122-9.
Ref ID: 1139
Abstract: To assess the effectiveness of telephone-based interventions for mental illness, a systematic search of the literature was conducted using the databases PsycINFO and PubMed, and the search engine Google Scholar. The search identified 14 studies evaluating telephone-based interventions in the areas of depression (n = 6), anxiety (n = 3), eating disorders (n = 3), substance use (n = 1) and schizophrenia (n = 1). Although these studies provide evidence that telephone interventions can be effective, the few studies conducted, small sample sizes and lack of randomized controlled trial methodology prevent firm conclusions from being drawn. The articles reviewed suggest that an effective telephone intervention includes clearly structured therapy sessions and homework tasks. However, further evidence using large-scale, randomized controlled trials must be obtained in order to inform government and telephone counselling agencies about the efficacy of telephone interventions. [References: 24]

Vedlegg 3 – Bestilling (PICO) og foreløpig treff etter scoping søk

Participants, Interventions, Comparisons and Outcomes (PICO)

1 Familieterapi

P: Mennesker med spiseforstyrrelser, som har fått en diagnose på anoreksi (DSM-IV) eller overspisningslidelse (DSM-IV diagnostic criteria).

I: Familieterapi, strukturert behandlingsopplegg.

C: Her har vi ingen standard behandling å sammenlikne med, og ønsker egentlig de enkelte systematiserte behandlingstiltak som finnes (om noen?) sammenliknet innbyrdes.

O: Vekt, symptomer på psykologiske og fysisk bedring av helsetilstand, akseptabilitet, sunt kosthold, tilbakefall, klinisk forverring av tilstanden, holdninger til vekt og kropp, dødsfall, medisinske komplikasjoner, psykososiale faktorer, vekttap, overaktivitet, oppkasting, bulimi og BMI.

Fisher CA, Rushford N, Hetrick SE. Family therapy for anorexia nervosa (Protocol). *Cochrane Database of Systematic Reviews* 2004

National Institute for Clinical Excellence: Eating Disorders: Core Interventions in the Treatment and Management of Anorexia Nervosa, Bulimia Nervosa and Related Eating Disorders: Clinical Guideline 9. London, National Institute for Clinical Excellence, 2004.

American Psychiatric Association (APA). Practice guideline for the treatment of patients with eating disorders. 3rd ed. Washington (DC): American Psychiatric Association (APA); 2006 Jun. 128 p.

2 Kognitiv terapi

P: Mennesker med spiseforstyrrelser, som har fått en diagnose på anoreksi (DSM-IV) eller overspisningslidelse (DSM-IV diagnostic criteria).

I: Kognitiv terapi, kognitiv atferdsterapi, eller kognitiv atferdsterapi tilrettelagt for spiseforstyrrelser f.eks cognitive behaviour therapy enhanced for eating disorder (CBT-E).

C: Her har vi ingen standard behandling å sammenlikne med, og ønsker egentlig de enkelte systematiserte behandlingstiltak som finnes (om noen?) sammenliknet innbyrdes.

O: Vekt, symptomer på psykologiske og fysisk bedring av helsetilstand, akseptabilitet, sunt kosthold, tilbakefall, klinisk forverring av tilstanden, holdninger til vekt og kropp, dødsfall, medisinske komplikasjoner, psykososiale faktorer, vekttap, overaktivitet, oppkasting, bulimi og BMI.

Hay PPJ, Bacaltchuk J, Stefano S, Kashyap P. Psychological treatments for bulimia nervosa and binging. *Cochrane Database of Systematic Reviews* 2009, Issue 4.

3 Medikamentell behandling

P: Mennesker med spiseforstyrrelser, som har fått en diagnose på anoreksi (DSM-IV) eller overspisningslidelse (DSM-IV diagnostic criteria).

I: Medikamentell behandling med kombinasjon av psykososiale tiltak.

C: Treatment as usual (TAU).

O: Vekt, symptomer på psykologiske og fysisk bedring av helsetilstand, akseptabilitet, sunt kosthold, tilbakefall, klinisk forverring av tilstanden, holdninger til vekt og kropp, dødsfall, medisinske komplikasjoner, psykososiale faktorer, vekttap, overaktivitet, oppkasting, bulimi og BMI.

Bacaltchuk J, Hay PPJ, Trefiglio R. Antidepressants versus psychological treatments and their combination for bulimia nervosa. *Cochrane Database of Systematic Reviews* 2001

Bacaltchuk J, Hay PPJ. Antidepressants versus placebo for people with bulimia nervosa. *Cochrane Database of Systematic Reviews* 2003

Claudino AM, Silva de Lima M, Hay PPJ, Bacaltchuk J, Schmidt UUS, Treasure J. Antidepressants for anorexia nervosa. *Cochrane Database of Systematic Reviews* 2006,

4 Poliklinisk behandling

P: Mennesker med spiseforstyrrelser, som har fått en diagnose på anoreksi (DSM-IV) eller overspisningslidelse (DSM-IV diagnostic criteria).

I: I Norsk sammenheng er det viktig å se om det finnes god forskning om behandlingsintensitet og utfall ved poliklinisk behandling.

C: Ordinær behandling, annen behandling, tilleggsbehandling, venteliste, placebo, sykehus vs poliklinisk behandling.

O: Vekt, symptomer på psykologiske og fysisk bedring av helsetilstand, akseptabilitet, sunt kosthold, tilbakefall, klinisk forverring av tilstanden, holdninger til vekt og kropp, dødsfall, medisinske komplikasjoner, psykososiale faktorer, vekttap, overaktivitet, oppkasting, bulimi og BMI.

Meads C, Gold L, Burls A, Jobanputra P. *In-patient versus out-patient care for eating disorders*. University of Birmingham, Department of Public Health and Epidemiology, 1999:58.

Hay PPJ, Bacaltchuk J, Byrnes RT, Claudino AM, Ekmejian AA, Yong PY. Individual psychotherapy in the outpatient treatment of adults with anorexia nervosa. *Cochrane Database of Systematic Reviews* 2003, oppdatert i 2008.

5 Selvhjelpsgrupper

P: Mennesker med spiseforstyrrelser, som har fått en diagnose på anoreksi (DSM-IV) eller overspisningslidelse (DSM-IV diagnostic criteria).

I: Selvhjelpsgrupper for personer med spiseforstyrrelser.

C: Treatment as usual (TAU)

O: Vekt, symptomer på psykologiske og fysisk bedring av helsetilstand, akseptabilitet, sunt kosthold, tilbakefall, klinisk forverring av tilstanden, holdninger til vekt og kropp, dødsfall, medisinske komplikasjoner, psykososiale faktorer, vekttap, overaktivitet, oppkasting, bulimi og BMI.

Perkins SSJ, Murphy RRM, Schmidt UUS, Williams C. Self-help and guided self-help for eating disorders. *Cochrane Database of Systematic Reviews* 2006