LETTERS TO THE EDITORS

Misuse of sibutramine and bulimia nervosa: a dangerous combination

Rev Bras Psiquiatr. 2018;40:343
Brazilian Journal of Psychiatry
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Although sibutramine was withdrawn from the U.S. and European markets,[1] it is still widely prescribed in many countries, such as Brazil, and is available worldwide as an over-the-counter drug.[2,3] There are many descriptions of the psychiatric side effects of sibutramine[2-4]; however, there is scant information about sibutramine misuse as a compensatory behavior in bulimia nervosa (BN) and its potential consequences. In this letter, we report a case of a patient with BN who misused sibutramine and developed severe, recurrent psychotic symptoms.

A 51-year-old single woman with a diagnosis of BN (assessed by the Structured Clinical Interview for DSM-IV, Patient Version [SCID-P], adapted for DSM-5 criteria) was referred to our Eating Disorders Unit for treatment about 5 years ago. She reported feeling fat since adolescence, when she started dieting. About 30 years before referral, she developed severe binge-eating episodes and, to compensate and control them and to avoid weight gain, started taking amphetamines without a prescription. Twenty years later, the patient sought medical advice in order to lose weight (at the time, her BMI was normal or occasionally borderline overweight). Sibutramine 10 mg/day was prescribed in substitution of the amphetamines, but she increased the sibutramine dosage progressively to 180 mg/day.

Three years ago, the patient developed psychotic symptoms. She had persecutory delusions involving her neighbors, whose voices she could hear even when they were not around; she also had tactile hallucinations, including "pins-and-needles" and recurrent feelings that someone had touched her genitals, which resulted in orgasms in embarrassing situations. Considering the severity of her condition, she was weaned off sibutramine in an inpatient psychiatric unit and risperidone up to 4 mg/day was prescribed. The psychotic symptoms remitted quickly. However, a few months later, the patient started to take sibutramine again; the psychotic symptoms reappeared, and became more severe with increasing doses of the drug. Since then, the patient has alternated periods of psychotic symptoms during the course of sibutramine usage with periods in which she discontinues sibutramine and psychosis remits, but the binge-eating episodes and her body-shape dissatisfaction increase.

Currently, the patient is being treated with cognitive-behavioral therapy, nutritional counseling, and topiramate 800 mg/day plus quetiapine 100 mg/day. With this approach she has achieved longer periods of sibutramine abstinence, remission of psychotic symptoms, fewer bulimic episodes, and less weight fluctuations. However, she still has problems with her eating patterns and body image.

This case brings an important and rarely discussed issue to the fore: the dangerous combination between sibutramine and BN. It suggests that patients with BN may occasionally take high doses of sibutramine as a compensatory behavior, which can place them at added risk of developing neuropsychiatric adverse effects (considered rare when the medication is used properly). We highlight two critical points for clinical practice: 1) it is important to consider sibutramine misuse when patients with eating disorders present with atypical psychiatric symptoms; and 2) as many bulimic individuals are overweight or obese, and since weight loss is the main motivation for them to seek for medical care,[5] it is important to actively investigate eating patterns, body image complaints, and engagement in compensatory behaviors before prescribing sibutramine.

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Submitted Oct 25 2017, accepted Jan 29 2018.

Disclosure

The authors report no conflicts of interest.

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