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CASE REPORT

Bulimia Nervosa and Alcohol Dependence

A Case Report of a Patient Enrolled in a Randomized Controlled Clinical Trial

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Abstract–*Bulimia nervosa and alcohol use disorders frequently co-occur. A review of the literature, however, reveals a paucity of information on treatment of patients with these comorbid conditions. We present a case report of a 34-year-old Caucasian female with a 20-year history of bulimia nervosa with co-occurring alcohol dependence, who participated in a randomized placebo-controlled medication augmentation trial for bulimia nervosa. The patient served as a pilot subject who met the exclusionary criterion of alcohol dependence, but received all the assessment and intervention procedures of the clinical trial for bulimia nervosa. Despite double-blind random assignment to a placebo condition, the patient's symptoms of bulimia nervosa substantially improved over the course of the 5-week efficacy trial. We hypothesize that this improvement was due to concurrent abstinence from alcohol rather than a placebo effect.* © *1999 Elsevier Science Inc. All rights reserved.*

Keywords–bulimia nervosa; alcohol dependence; clinical trial; abstinence.

INTRODUCTION

EATING DISORDERS AND alcohol use disorders frequently co-occur in clinical samples (Holderness, Brooks-Gunn, & Warren, 1994; Katz, 1992). High rates of alcohol use disorders have been observed in patients with eating disorders (e.g., Bulik, 1987; Mitchell, Hatsukami, Eckert, & Pyle, 1985), and high rates of eating disorders have been documented in patients with alcohol use disorders (e.g., Grilo, Levy, Becker, Edell, & McGlashan, 1995; Higuchi, Suzuki, Yamada, Parrish, & Kono, 1993; Taylor, Peveler, Hibbert, & Fairburn, 1993). Although the specific nature of the association between eating and alcohol use disorders remains somewhat ambiguous (Bulik, Sullivan, Carter, & Joyce, 1997; Katz, 1992; Krahn, 1991; Wilson, 1993), the pragmatic clinical issues posed by patients with both disorders represents a well-known challenge. For instance, patients with co-occurring eating and alcohol use disorders are psychiatrically more complicated in terms of additional psychiatric and personality disturbances than those without the co-occurrence (Bulik et al., 1997; Grilo, Becker, Levy, Walker, Edell, & McGlashan, 1995; Lacey, 1993; Suzuki, Higuchi, Yamada, Mizutani, & Kono, 1993) and may be at heightened risk for medical morbidity and mortality (Catterson, Pryor, Burke, & Morgan, 1997).

Clinicians often encounter the very perplexing phenomenon of co-occurring bulimia nervosa and alcohol use disorders in their practice. Although common clinical practice is to recommend abstinence from alcohol use (Mitchell, Specker, & Edmonson, 1997; Wilson, 1993), we found no reports in the literature describing the clini-

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cal outcomes of this conventional clinical wisdom for bulimia nervosa. Due to the idiosyncrasies of efficacy studies, clinical research has not provided sufficient guidance for how to help patients with these co-occurring conditions (Grilo, Devlin, Fahy, & Yanovski, 1997). Options include treating the alcoholism first, the eating disorder first, or a dual-diagnosis approach in which both problems are treated concurrently. Indeed, clinical research is lagging behind clinical practice. Thus, decisions are made on clinical grounds because there is insufficient empirical data available to guide treatment decisions.

Excluding patients with disorders of alcohol or drug use from controlled clinical efficacy trials is a nearly universal practice among eating disorder researchers. Similarly, clinical trials for alcoholism rarely include measures to assess for changes in eating disorder pathology, even if present. A recent workshop sponsored by the National Institutes of Health highlighted research priorities for the field of eating disorders (Grilo et al., 1997). One area of consensus was for clinical researchers to examine treatment interventions for patients with "comorbid" conditions, such as co-occurring alcohol use disorders.

METHOD

A case study of a 34-year old, Caucasian, married, professional female with a 20-year history of co-occurring bulimia nervosa and alcohol dependence was conducted. The patient responded to an advertisement recruiting participants for a clinical trial for the treatment of bulimia nervosa. This trial was a randomized, placebo-controlled study to test a pharmacologic augmentation strategy for individuals with bulimia nervosa and symptoms nonresponsive to treatment with fluoxetine. The patient was included as a pilot subject and the treatment was adapted to address the co-occurring alcohol dependence.

The initial evaluation included a clinical interview during which the Structured Clinical Interview for *DSM-IV* Axis I Disorders (SCID-I; First, Spitzer, Gibbon, & Williams, 1994) was administered to determine diagnosis. In addition, the patient completed a battery of psychometrically well-established measures chosen to assess the core and associated psychopathology of bulimia nervosa. Results of the semi-structured diagnostic interview (First et al., 1994), a clinical interview, and the self-report measures converged to suggest that the patient met *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (*DSM-IV;* American Psychiatric Association, 1994) criteria for both bulimia nervosa (purging type) and alcohol dependence.

At the time of presentation, the patient was on a pharmacotherapy regimen of high-dose fluoxetine (i.e., 100 mg) for 2 years with only partial improvement in bulimia nervosa symptoms. The use of high-dose fluoxetine for bulimia nervosa is currently regarded as the first-line pharmacotherapy of choice for bulimia nervosa (Fluoxetine Bulimia Nervosa Collaborative Study Group, 1992), with a median reduction of 67% in binge-eating and 56% in vomiting. Despite the patient's partial improvement, she still met diagnostic criteria for bulimia nervosa at the time of evaluation. During the 5 years prior to the current high-dose fluoxetine regimen, the patient had received trials with tricyclic antidepressants followed by trials with selective serotonin reuptake inhibitors (SSRIs), including sertraline and fluoxetine. These monotherapy trials were followed by two augmentation trials (fluoxetine plus imipramine and fluoxetine plus nortriptyline). Although a sequential approach to pharmacotherapy has received empirical support (Mitchell, Pyle, Eckert, Hatsukami, Pomeroy, & Zimmerman, 1989), this particular patient reported only partial benefit from the various medication trials.

The co-occurring alcohol dependence rendered the patient ineligible for the clinical efficacy trial. However, for reasons detailed elsewhere (Grilo et al., 1997) the patient was included as a pilot participant. A psychoeducational intervention was implemented to address the patient's alcohol dependence. This intervention was added to the 3-week baseline period prior to beginning the 5-week efficacy trial. The intervention involved a detailed discussion with the patient regarding the outcome of the initial assessment and emphasized the severity of the alcohol dependence and bulimia nervosa, and included information about the medical risks associated with the combination of alcohol and high-dose antidepressant medication use. Information was also provided regarding the potential associations between alcohol use, negative mood, and eating dyscontrol (Cristensten, 1993; Krahn, 1991; Wilson, 1993).

The 5-week clinical efficacy trial was designed to test a pharmacologic augmentation strategy for fluoxetine-resistant patients with bulimia nervosa. During the trial, the patient remained on 100 mg of fluoxetine. The patient was randomly assigned, in double-blind fashion, to the placebo augmentation condition. Weekly visits during the 5-week trial were held to assess compliance and monitor side effects. In addition, daily self-monitoring records were reviewed at each visit to assess eating disorder behaviors.

At baseline, the patient reported an average (and fairly constant) rate of two to three binge-and-purge episodes per week. In addition, the patient reported averaging approximately four to seven skipped meals per week, and excessive exercise (up to 11 times per week). The frequency of these symptomatic behaviors had been relatively constant for a period of 2 years during high-dose fluoxetine treatment (both monotherapy fluoxetine and with the two trials of combined medications). Prior to that, the patient reported a fairly steady pattern of extreme bulimia nervosa symptoms (i.e., range of 7 to 12 binge/purge episodes per week), over a period of approximately 18 years. Although these findings suggest partial improvement, the patient reported considerable distress and concern regarding her continued symptomatology.