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Managing weight gain as a side effect of antidepressant therapy

ABSTRACT

Weight gain caused by antidepressant drugs is a major reason for patient noncompliance with treatment and poor treatment outcome. Knowing which drugs are more likely to cause weight gain in the short term and the long term is essential to any discussion with the patient about the risks vs the benefits of antidepressant therapy. Informing the patient up front about the chances of weight gain and what can be done if it occurs helps build a strong physician-patient relationship and promotes good treatment outcomes.

KEY POINTS

Tricyclic antidepressants and irreversible monoamine oxidase inhibitors (MAOIs) are more likely to cause weight gain in both the short term (< 6 months) and the long term (≥ 1 year). Reversible MAOIs are less likely to cause weight gain but are not available in the United States.

Selective serotonin reuptake inhibitors (SSRIs) are not likely to cause weight gain if used for 6 months or less. Opinions vary as to whether they cause weight gain when used for 1 year or longer. Paroxetine may be more likely than other SSRIs to cause weight gain.

For long-term therapy, nefazodone is less likely to cause weight gain than SSRIs and tricyclic compounds.

In general, bupropion is more likely to cause weight loss, and for long-term therapy it is less likely than SSRIs to cause weight gain.

WEIGHT GAIN IS A SERIOUS concern for patients starting or already taking an antidepressant. Weight gain as a side effect of antidepressant therapy¹⁻⁵ in the short term (3 to 6 months) and the long term (1 year or longer) contributes to the reluctance of patients to continue or start treatment.²

Knowing how likely an antidepressant is to cause weight gain (**TABLE 1**) helps the physician select the best drug for the individual patient. Informing the patient about the chances of weight gain and what can be done about it helps build a strong physician-patient relationship and improves the effectiveness of treatment.

MONOAMINE OXIDASE INHIBITORS

Monoamine oxidase inhibitors (MAOIs) inhibit an enzyme involved in the metabolism of biogenic amines (eg, norepinephrine, epinephrine, dopamine, serotonin) and xenobiotic amines (eg, tyramine, ephedrine, phenylephrine). They are effective against depression and anxiety.

MAOIs that bind irreversibly to receptors (eg, phenelzine, isocarboxazid, tranylcypromine) typically cause weight gain, and this is perhaps more common with phenelzine than with isocarboxazid and tranylcypromine.^{2,6-8} Reversible MAOIs are less likely to cause weight gain but are currently unavailable in the United States.²

TRICYCLIC ANTIDEPRESSANTS

Weight gain is a common and well-known adverse effect of short-term and long-term treatment with tricyclic antidepressants,² primarily as a result of excessive appetite. Possible

*The author has indicated that she is on the speakers' bureau of the Pfizer company.

TABLE 1

Effect of antidepressant drugs on body weight

| DRUG | EFFECT ON WEIGHT |
|--|--|
| Monoamine oxidase inhibitors (irreversible type) | Weight gain likely in short term (< 6 months) and long term (\geq 1 year) |
| Tricyclic compounds | Weight gain likely in short term and long term |
| Selective serotonin reuptake inhibitors (SSRIs) other than paroxetine | Weight gain in short term less likely Weight gain in long term possible, but evidence is varied |
| Paroxetine | Weight gain in short and long term more likely than for other SSRIs |
| Nefazodone | Likely to have no effect on weight |
| Bupropion | Likely to cause weight loss |
| Mirtazapine | More likely than placebo to cause weight gain in short term, but less likely than tricyclics |
| Venlafaxine | Likely to have no effect on weight |

mechanisms include blockade of histamine H₁ and serotonin 2C receptors, carbohydrate craving caused by alpha-noradrenergic activity or histamine blockade, changes in the regulation of body fat stores by modulating neurotransmitter systems at the hypothalamic level, and recovery from clinical depression.^{2,5,9,10}

Because tertiary tricyclic antidepressants such as amitriptyline, imipramine, and doxepin are stronger histamine blockers than are secondary tricyclics such as desipramine and nortriptyline, the tertiary tricyclic drugs are more likely to cause weight gain.

In a randomized study of hospitalized depressed patients, Fernstrom and Kupfer¹⁰ reported that treatment with three tricyclic compounds promoted weight gain, with amitriptyline adding more weight than nortriptyline and desipramine. In the same study, most patients treated with zimelidine (a tricyclic antidepressant, not available in the United States) showed no weight gain and often demonstrated weight loss.

A study by Frank et al¹¹ indicated that 13% to 15% of imipramine-treated patients gained 10 or more pounds by week 16 or 33 of treatment. In contrast, at least one study of nursing home residents found no measurable difference in weight outcomes after treatment with tricyclic antidepressants or selective sero-

tonin reuptake inhibitors (SSRIs), or no antidepressant treatment.¹² All drug groups showed mean weight changes of less than 2.1 lb after 6 months of therapy. Whether or not these findings can be generalized to community patients is unclear.

■ SELECTIVE SEROTONIN REUPTAKE INHIBITORS

Weight gain is less likely with SSRIs when they are used for 6 months or less. There are diverse opinions about whether increases in body weight occur in patients using them for 1 year or longer. Paroxetine may be more likely than other SSRIs to cause weight gain during short-term or long-term treatment.

Weight change induced by SSRIs is probably related to alteration in serotonin 2C receptor activity, appetite increase, carbohydrate craving, or recovery from clinical depression.^{8,13,14}

In one large placebo-controlled study,¹⁵ outpatients with depression treated with fluoxetine for 12 weeks lost 0.3 kg on average. Croft et al¹⁶ documented a loss of 0.8 kg with sertraline vs 1.1 kg with bupropion in a placebo-controlled 12-week comparison. On the other hand, Mackle and Kocsis,¹⁷ in a study lasting fewer than 8 weeks, reported a weight gain of

A strong patient-physician alliance is integral to positive outcome

0.5% in patients taking the SSRI citalopram vs 0.9% in those taking placebo. Bouwer and Harvey,¹⁴ in an open-label study without placebo control, reported a rapid appetite increase and an average weight gain of 7.1 kg with citalopram, which is well known to have a marked affinity for histamine H₁ receptors and, therefore, stimulates the appetite.

In nursing home patients, SSRIs are as likely to cause weight gain as they are to cause weight loss, but the magnitude of the effect is generally small.¹² Studies of short-term antidepressant therapy have suggested that weight gain is less likely to occur when SSRIs are used in the short term (3 to 6 months). When weight gain does occur, the rates are comparable with those of placebo.²

Clearly, there is uncertainty about whether unexpected increases in body weight occur during long-term treatment as opposed to short-term treatment with SSRIs.¹⁸ In its revised practice guideline for the treatment of major depressive disorder,¹⁹ the American Psychiatric Association acknowledges that the literature differs as to whether patients taking SSRIs beyond the acute phase experience weight gain as a medication side effect.¹⁹ Six-month placebo-controlled studies have found no significant difference in weight gain with fluoxetine¹⁵ or citalopram.¹⁷ A 12-month study of citalopram reported 4.7% of 541 patients with depression experienced weight gain of greater than 5 kg.²⁰ Another placebo-controlled study of the prophylactic effect of citalopram in unipolar, recurrent depression at 48 to 77 weeks reported no weight gain with citalopram.²¹

Weight gain more likely with long-term paroxetine

Fava et al²² presented data from a 6-month double-blind non-placebo-controlled study of paroxetine, sertraline, and fluoxetine. The rate of emergence of significant weight gain, defined as a 7% or greater increase in body weight, was 25.5% for paroxetine vs 4.2% with sertraline and 6.8% with fluoxetine.

A 24-week double-blind study of paroxetine and sertraline²³ showed significantly more weight gain with paroxetine but failed to report the percentage of patients who exhibited at least a 7% change in weight, the accepted standard of clinical significance.

NEFAZODONE

Nefazodone seems to be less associated with weight gain than other antidepressants in studies of both short-term and long-term therapy. It is a phenylpiperazine with selective serotonin and norepinephrine reuptake inhibition.

A 36-week placebo-controlled study²⁴ reported weight gain associated with nefazodone to be similar to placebo (7.6% vs 8.6%).

Sussman et al²⁵ conducted a pooled analysis of three clinical trials comparing nefazodone with SSRIs and three clinical trials comparing nefazodone with imipramine.^{7,18,25} Using 7% or greater weight change as a measure of clinical significance, results indicated that 4.3% of SSRI-treated patients had lost weight at some point in the acute phase (6 to 8 weeks) vs 1.7% with nefazodone. During longer treatment (16 to 46 weeks), weight gain occurred more often in patients taking an SSRI than in patients taking nefazodone (17.9% vs 8.3%). Patients taking imipramine also had a greater increase in body weight than patients taking nefazodone in both short-term and long-term phases, indicating that nefazodone may be less likely to cause weight gain than both SSRIs and tricyclic antidepressants when used longer than 1 year.

BUPROPION

Bupropion is essentially devoid of antihistaminic effects and is commonly associated with weight loss. This aminoketone weakly blocks postsynaptic serotonin and norepinephrine uptake, in addition to inhibiting presynaptic dopamine reuptake.

A number of studies have compared bupropion with placebo, sertraline, tricyclic antidepressants, or trazodone.^{16,26-29} All showed that bupropion was associated with weight loss (mean 2.5 lb), whereas the other drugs were associated with weight gain. In placebo-controlled studies, depressed outpatients treated for 12 weeks lost, on average, 0.3 kg with fluoxetine,¹⁵ 0.8 kg with sertraline¹⁶ or 1.1 kg with bupropion.¹⁶ In a separate 52-week double-blind placebo-controlled study, Weihs et al²⁹ showed a mean weight loss of 1.2 kg in patients treated with bupropion.

Whether long-term SSRI use leads to weight gain is still unclear

■ MIRTAZAPINE

Through blockade of histamine H₁ and serotonin 2C receptors, mirtazapine is likely to be related to weight gain in both the short term and the long term.¹ A piperazine-azepine compound, it enhances central noradrenergic and serotonergic activity. It is a potent antagonist of H₁, serotonin 2, and serotonin 3, and a moderate antagonist of peripheral alpha-1 adrenergic and muscarinic receptors.

A meta-analysis of four US studies found that patients gained weight during the first 4 weeks of treatment.³⁰

Mirtazapine is more likely to cause weight gain than placebo but may be less likely to cause weight gain than tricyclic antidepressants such as amitriptyline.^{31,32} A comparison of mirtazapine and venlafaxine in the treatment of severely depressed hospitalized patients with melancholic features identified a significant weight gain of 2.0 ± 3.7 kg in the mirtazapine group and a loss of 0.5 ± 2.9 kg in the venlafaxine group.³³

■ VENLAFAXINE

Venlafaxine, a potent inhibitor of serotonin and norepinephrine reuptake, is sometimes prescribed for patients with psychomotor retardation, hypersomnia, or resistance to other antidepressants.³⁴

A short-term study comparing venlafaxine with fluoxetine found no significant weight gain with either agent.³⁵ Thus, like SSRIs and unlike mirtazapine, venlafaxine is less likely to cause weight gain in the short term,³³ although there are not enough data to comment on its long-term effects.

■ RECOMMENDATIONS FOR MANAGEMENT

Many patients prematurely discontinue their medication as a result of increased appetite or

weight gain and may fall back into depression. On the other hand, fighting weight gain once it has occurred can be very difficult, and it is advisable to consider the likelihood and potential consequences of weight gain when choosing an antidepressant.^{36,37}

Educating the patient about the chances of weight gain as a side effect of treatment and its management is best accomplished through a strong patient-physician alliance and is integral to positive outcome.

Preventing weight gain in patients on antidepressants is the ideal strategy. It typically involves caloric restriction and increased caloric expenditure through aerobic exercise.¹ Patients may benefit from a nutritional consultation and participation in a low-cost commercial weight-loss program. Individuals can be asked to record weekly weights, and thus both clinician and patient can be alerted to small increases in weight before the problem becomes too difficult. Maintaining a food diary and behavioral techniques such as increasing meal frequency, smaller meals, or decreasing the pace of eating can help.

Switching to another drug with a lower risk of weight gain is an alternative approach, although this carries a risk of loss of clinical effect.

Addition of another agent such as a stimulant (methylphenidate, amphetamines), an H₂ receptor antagonist (famotidine), triiodothyronine, topiramate, bupropion, or naltrexone may help diminish weight gain.^{1,37} Although none has been tested systematically, low doses have been prescribed along with an antidepressant in an effort to avoid weight gain associated with antidepressant therapy.

In our practice, we have found that adding low-dose bupropion (100 to 150 mg/day) or topiramate (25 to 50 mg/day) may help weight loss when used in addition to diet control and exercise. ■

Treat weight gain with behavior modification, dietary changes, another drug

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