**Cochrane Database of Systematic Reviews**

1. AU: Padwal Raj S

**TI: Long-term pharmacotherapy for obesity and overweight**

YR: 2003

AB: Background: Obesity is a highly and increasingly prevalent chronic condition for which drugs are commonly prescribed to improve health.Objectives: To assess the long-term effects of approved anti-obesity medications in clinical trials of at least one-year duration.Search methods: MEDLINE, EMBASE, The Cochrane Library, the Current Science Meta-register of Controlled Trials and reference lists were searched. Drug manufacturers and two obesity experts were contacted.Selection criteria: Double-blind, randomised placebo-controlled trials of approved anti-obesity agents that 1) included patients over 18 years, 2) used an intention-to-treat analysis, and 3) had follow-up of one year or more. Both weight loss and weight maintenance trials were included. Abstracts, pseudo-randomised trials, head-to-head trials and open-label studies were excluded.Data collection and analysis: Two reviewers independently assessed all potentially relevant reports for inclusion and methodological quality. Data were extracted using double data entry. The primary outcome measure was weight loss.Main results: Sixteen orlistat (n = 10,631), 10 sibutramine (n = 2623) and four rimonabant trials (n = 6365) met inclusion criteria. Attrition rates averaged 30% to 40%. Compared to placebo, orlistat reduced weight by 2.9 kg (95% confidence interval (CI) 2.5 to 3.2 kg), sibutramine by 4.2 kg (95% CI 3.6 to 4.7 kg), and rimonabant by 4.7 kg (95% CI 4.1 to 5.3 kg). Patients on active drug therapy were significantly more likely to achieve 5% and 10% weight loss thresholds. Placebo-controlled weight losses were consistently lower in patients with diabetes. Orlistat reduced diabetes incidence, improved total cholesterol, LDL-cholesterol, blood pressure, and glycaemic control in patients with diabetes but increased rates of gastrointestinal side effects and slightly lowered HDL levels. Sibutramine improved HDL and triglyceride levels but raised blood pressure and pulse rate. Rimonabant improved HDL-cholesterol, triglyceride and blood pressure levels and glycaemic control in patients with diabetes but increased the risk of mood disorders.Authors' conclusions: Orlistat, sibutramine and rimonabant have been studied in trials of one year or longer. Internal validity of studies was limited by high attrition rates. All three antiobesity agents are modestly effective in reducing weight and have differing effects on cardiovascular risk and adverse effects profiles. Longer and more methodologically rigorous studies of anti-obesity drugs that are powered to examine endpoints such as mortality and cardiovascular morbidity are required.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004094.pub2/abstract

2. AU: Fernandes Marcos AP

**TI: Intragastric balloon for obesity**

YR: 2007

AB: Background: Obesity is one of the major public health problems of modern society. Intragastric balloon (IGB) treatment for obesity has been developed as a temporary aid. Its primary objective is the treatment of obese people, who have had unsatisfactory results in their clinical treatment for obesity, despite of being cared for by a multidisciplinary team, and super obese patients with a higher surgical risk. However, the effects of different IGB procedures compared with conventional treatments and with each other are uncertain.Objectives: To assess the effects of intragastric balloon in people with obesity.Search methods: Studies were obtained from computerised searches of MEDLINE, EMBASE, LILACS, The Cochrane Library and other electronic databases. Furthermore, reference lists of relevant articles and hand searches of selected journals were performed. Experts in the field were contacted.Selection criteria: Randomised and quasi-randomised controlled trials fulfilling the inclusion criteria were used. Short term weight loss is common, so studies were included if they reported measurements after a minimum of four weeks follow-up.Data collection and analysis: Data were extracted by one reviewer and checked independently by two reviewers. Two reviewers independently assessed the quality of trials.Main results: Nine randomised controlled trials involving 395 patients were included. Six out of nine studies had a follow-up of less than one year, the longest study duration was 24 months. Only a third of the analysed studies revealed a low risk of bias. No information was available on quality of life, all-cause mortality and morbidity. Compared with conventional management, IGB did not show convincing evidence of a greater weight loss. On the other hand, complications of intragastric balloon placement occurred, however few of a serious nature. The relative risks for minor complications like gastric ulcers and erosions were significantly raised.Authors' conclusions: Evidence from this review is limited for decision making, since there was large heterogeneity in IGB trials, regarding both methodological and clinical aspects. However, a co-adjuvant factor described by some authors in the loss and maintenance of weight has been the motivation and the encouragement to changing eating habits following a well-organized diet and a program of behavioural modification. The IGB alone and the technique of positioning appear to be safe. Despite the evidence for little additional benefit of the intragastric balloon in the loss of weight, its cost should be considered against a program of eating and behavioural modification.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004931.pub2/abstract

3. AU: Waters Elizabeth

**TI: Interventions for preventing obesity in children**

YR: 2011

AB: Background: Prevention of childhood obesity is an international public health priority given the significant impact of obesity on acute and chronic diseases, general health, development and well-being. The international evidence base for strategies that governments, communities and families can implement to prevent obesity, and promote health, has been accumulating but remains unclear.Objectives: This review primarily aims to update the previous Cochrane review of childhood obesity prevention research and determine the effectiveness of evaluated interventions intended to prevent obesity in children, assessed by change in Body Mass Index (BMI). Secondary aims were to examine the characteristics of the programs and strategies to answer the questions "What works for whom, why and for what cost?"Search methods: The searches were re-run in CENTRAL, MEDLINE, EMBASE, PsychINFO and CINAHL in March 2010 and searched relevant websites. Non-English language papers were included and experts were contacted.Selection criteria: The review includes data from childhood obesity prevention studies that used a controlled study design (with or without randomisation). Studies were included if they evaluated interventions, policies or programs in place for twelve weeks or more. If studies were randomised at a cluster level, 6 clusters were required.Data collection and analysis: Two review authors independently extracted data and assessed the risk of bias of included studies.  Data was extracted on intervention implementation, cost, equity and outcomes. Outcome measures were grouped according to whether they measured adiposity, physical activity (PA)-related behaviours or diet-related behaviours.  Adverse outcomes were recorded. A meta-analysis was conducted using available BMI or standardised BMI (zBMI) score data with subgroup analysis by age group (0-5, 6-12, 13-18 years, corresponding to stages of developmental and childhood settings).Main results: This review includes 55 studies (an additional 36 studies found for this update). The majority of studies targeted children aged 6-12 years.  The meta-analysis included 37 studies of 27,946 children and demonstrated that programmes were effective at reducing adiposity, although not all individual interventions were effective, and there was a high level of observed heterogeneity (I2=82%).  Overall, children in the intervention group had a standardised mean difference in adiposity (measured as BMI or zBMI) of -0.15kg/m2 (95% confidence interval (CI): -0.21 to -0.09).  Intervention effects by age subgroups were -0.26kg/m2 (95% CI:-0.53 to 0.00) (0-5 years), -0.15kg/m2 (95% CI -0.23 to -0.08) (6-12 years), and -0.09kg/m2 (95% CI -0.20 to 0.03) (13-18 years). Heterogeneity was apparent in all three age groups and could not explained by randomisation status or the type, duration or setting of the intervention.  Only eight studies reported on adverse effects and no evidence of adverse outcomes such as unhealthy dieting practices, increased prevalence of underweight or body image sensitivities was found.  Interventions did not appear to increase health inequalities although this was examined in fewer studies.Authors' conclusions: We found strong evidence to support beneficial effects of child obesity prevention programmes on BMI, particularly for programmes targeted to children aged six to 12 years. However, given the unexplained heterogeneity and the likelihood of small study bias, these findings must be interpreted cautiously. A broad range of programme components were used in these studies and whilst it is not possible to distinguish which of these components contributed most to the beneficial effects observed, our synthesis indicates the following to be promising policies and strategies:·         school curriculum that includes healthy eating, physical activity and body image·         increased sessions for physical activity and the development of fundamental movement skills throughout the school week·         improvements in nutritional quality of the food supply in schools·         environments and cultural practices that support children eating healthier foods and being active throughout each day·         support for teachers and other staff to implement health promotion strategies and activities (e.g. professional development, capacity building activities)·         parent support and home activities that encourage children to be more active, eat more nutritious foods and spend less time in screen based activitiesHowever, study and evaluation designs need to be strengthened, and reporting extended to capture process and implementation factors, outcomes in relation to measures of equity, longer term outcomes, potential harms and costs.Childhood obesity prevention research must now move towards identifying how effective intervention components can be embedded within health, education and care systems and achieve long term sustainable impacts.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD001871.pub3/abstract

4. AU: Wieland L. Susan

**TI: Interactive computer-based interventions for weight loss or weight maintenance in overweight or** obese people

YR: 2012

AB: Background: The World Health Organization (WHO) estimates that the number of obese or overweight individuals worldwide will increase to 1.5 billion by 2015. Chronic diseases associated with overweight or obesity include diabetes, heart disease, hypertension and stroke.Objectives: To assess the effects of interactive computer-based interventions for weight loss or weight maintenance in overweight or obese people.Search methods: We searched several electronic databases, including CENTRAL, MEDLINE, EMBASE, CINAHL, LILACS and PsycINFO, through 25 May 2011. We also searched clinical trials registries to identify studies. We scanned reference lists of included studies and relevant systematic reviews.Selection criteria: Studies were included if they were randomized controlled trials or quasi-randomized controlled trials that evaluated interactive computer-based weight loss or weight maintenance programs in adults with overweight or obesity. We excluded trials if the duration of the intervention was less than four weeks or the loss to follow-up was greater than 20% overall.Data collection and analysis: Two authors independently extracted study data and assessed risk of bias. Where interventions, control conditions, outcomes and time frames were similar between studies, we combined study data using meta-analysis.Main results: We included 14 weight loss studies with a total of 2537 participants, and four weight maintenance studies with a total of 1603 participants. Treatment duration was between four weeks and 30 months. At six months, computer-based interventions led to greater weight loss than minimal interventions (mean difference (MD) -1.5 kg; 95% confidence interval (CI) -2.1 to -0.9; two trials) but less weight loss than in-person treatment (MD 2.1 kg; 95% CI 0.8 to 3.4; one trial). At six months, computer-based interventions were superior to a minimal control intervention in limiting weight regain (MD -0.7 kg; 95% CI -1.2 to -0.2; two trials), but not superior to infrequent in-person treatment (MD 0.5 kg; 95% -0.5 to 1.6; two trials). We did not observe consistent differences in dietary or physical activity behaviors between intervention and control groups in either weight loss or weight maintenance trials. Three weight loss studies estimated the costs of computer-based interventions compared to usual care, however two of the studies were 11 and 28 years old, and recent advances in technology render these estimates unlikely to be applicable to current or future interventions, while the third study was conducted in active duty military personnel, and it is unclear whether the costs are relevant to other settings. One weight loss study reported the cost-effectiveness ratio for a weekly in-person weight loss intervention relative to a computer-based intervention as USD 7177 (EUR 5678) per life year gained (80% CI USD 3055 to USD 60,291 (EUR 2417 to EUR 47,702)). It is unclear whether this could be extrapolated to other studies. No data were identified on adverse events, morbidity, complications or health-related quality of life.Authors' conclusions: Compared to no intervention or minimal interventions (pamphlets, usual care), interactive computer-based interventions are an effective intervention for weight loss and weight maintenance. Compared to in-person interventions, interactive computer-based interventions result in smaller weight losses and lower levels of weight maintenance. The amount of additional weight loss, however, is relatively small and of brief duration, making the clinical significance of these differences unclear.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007675.pub2/abstract

5. AU: Shaw Kelly A

**TI: Exercise for overweight or obesity**

YR: 2006

AB: Background: Clinical trials have shown that exercise in adults with overweight or obesity can reduce bodyweight. There has been no quantitative systematic review of this in The Cochrane Library.Objectives: To assess exercise as a means of achieving weight loss in people with overweight or obesity, using randomised controlled clinical trials.Search methods: Studies were obtained from computerised searches of multiple electronic bibliographic databases.Selection criteria: Studies were included if they were randomised controlled trials that examined body weight change using one or more physical activity intervention in adults with overweight or obesity at baseline and loss to follow-up of participants of less than 15%.Data collection and analysis: Two authors independently assessed trial quality and extracted data.Main results: The 43 studies included 3476 participants. Although significant heterogeneity in some of the main effects' analyses limited ability to pool effect sizes across some studies, a number of pooled effect sizes were calculated. When compared with no treatment, exercise resulted in small weight losses across studies. Exercise combined with diet resulted in a greater weight reduction than diet alone (WMD - 1.0 kg; 95% confidence interval (CI) -1.3 to -0.7). Increasing exercise intensity increased the magnitude of weight loss (WMD - 1.5 kg; 95% CI -2.3 to -0.7). There were significant differences in other outcome measures such as serum lipids, blood pressure and fasting plasma glucose. Exercise as a sole weight loss intervention resulted in significant reductions in diastolic blood pressure (WMD - 2 mmHg; 95% CI -4 to -1), triglycerides (WMD - 0.2 mmol/L; 95% CI -0.3 to -0.1) and fasting glucose (WMD - 0.2 mmol/L; 95% CI -0.3 to -0.1). Higher intensity exercise resulted in greater reduction in fasting serum glucose than lower intensity exercise (WMD - 0.3 mmol/L; 95% CI -0.5 to -0.2). No data were identified on adverse events, quality of life, morbidity, costs or on mortality.Authors' conclusions: The results of this review support the use of exercise as a weight loss intervention, particularly when combined with dietary change. Exercise is associated with improved cardiovascular disease risk factors even if no weight is lost.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003817.pub3/abstract

6. AU: Summerbell Carolyn D

**TI: Advice on low-fat diets for obesity**

YR: 2008

AB: Background: Overweight and obesity are global health problems contributing to an ever increasing noncommunicable disease burden. Calorie restriction can achieve short-term weight loss but the weight loss has not been shown to be sustainable in the long-term. An alternative approach to calorie restriction is to lower the fat content of the diet. However, the long-term effects of fat-restricted diets on weight loss have not been established.Objectives: To assess the effects of advice on low-fat diets as a means of achieving sustained weight loss, using all available randomised clinical trials. This review focused primarily on participants who were overweight or clinically obese and were dieting for the purpose of weight reduction. Since we were particularly interested in the ability of participants to sustain weight loss over a longer period of time, we focused on studies of 'free living' men and women who were given dietary advice rather than provision of food or money to purchase food.Search methods: We searched the Cochrane Controlled Trials Register (Cochrane Library Issue 2, 2001), MEDLINE (up to February 2002), and EMBASE (up to February 2002). We also searched the Science Citation Index (up to January 2001) and bibliographies of studies identified. Date of latest search: February 2002.Selection criteria: Trials were included if they fulfilled the following criteria: 1) they were randomised controlled clinical trials of low-fat diets versus other weight-reducing diets, 2) the primary purpose of the study was weight loss, 3) participants were followed for at least six months, 4) the study participants were adults (18 years or older) who were overweight or obese (BMI >25 kg/m2) at baseline. Studies including pregnant women or patients with serious medical conditions were excluded. Two people independently applied the inclusion criteria to the studies identified. Disagreement was resolved by discussion or by intervention of a third party.Data collection and analysis: Data were extracted by three independent reviewers and meta-analysis performed using a random effects model. Weighted mean differences of weight loss were calculated for treatment and control groups at 6, 12 and 18 months.Main results: Four studies were included at the six month follow-up, five studies at the 12 month follow-up and three studies at the 18 month follow-up. There was no significant difference in weight loss between the two groups at six months (WMD 1.7 kg, 95% CI -1.4 to 4.8 kg). The weighted sum of weight loss in the low fat group was -5.08 kg (95% CI -5.9 to -4.3 kg) and in the control group was -6.5 kg, (95% CI -7.3 to -5.7 kg). There was no significant difference in weight loss between the two groups at 12 months (WMD 1.1 kg, 95% CI -1.6 to 3.8 kg). The weighted sum of weight loss in the low fat group was -2.3 kg (95% CI -3.2 to -1.4 kg) and in the control group was -3.4 kg (95% CI -4.2 to -2.6 kg). There was no significant difference in weight loss between the two groups at 18 months (WMD 3.7 kg, 95% CI - 1.8 to 9.2). The weighted sum of weight loss in the control group was -2.3 kg (95% CI -3.5 to -1.2 kg) and in the low fat group there was a weight gain of 0.1 kg (95% CI -0.8 to 1 kg). There was significant heterogeneity in the results for weight loss at six months and 12 months.Apart from one study which showed a slight but statistically significant difference in total cholesterol in the low fat group at one year follow-up, there were no significant differences between the dietary groups for other outcome measures such as serum lipids, blood pressure and fasting plasma glucose. Studies measuring other factors such as perceived wellness and quality of life reported conflicting results.Authors' conclusions: The review suggests that fat-restricted diets are no better than calorie restricted diets in achieving long term weight loss in overweight or obese people. Overall, participants lost slightly more weight on the control diets but this was not significantly different from the weight loss achieved through dietary fat restriction and was so small as to be clinically insignificant.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003640.pub2/abstract

7. AU: Tuah Nik AA

**TI: Transtheoretical model for dietary and physical exercise modification in weight loss management for overweight and obese adults**

YR: 2011

AB: Background: Obesity is a global public health threat. The transtheoretical model stages of change (TTM SOC) model has long been considered a useful interventional approach in lifestyle modification programmes, but its effectiveness in producing sustainable weight loss in overweight and obese individuals has been found to vary considerably. Objectives: To assess the effectiveness of dietary and physical activity interventions based on the transtheoretical model, to produce sustainable weight loss in overweight and obese adults.Search methods: Studies were obtained from searches of multiple electronic bibliographic databases. Date of last search for The Cochrane Library was issue 10, 2010, for MEDLINE Dezember 2010, for EMBASE January 2011 and for PSYCHINFO Januar 2011.Selection criteria: Trials were included if they fulfilled the following criteria: randomised controlled clinical trials using TTM SOC as a model, theoretical framework or guideline in designing lifestyle modification strategies, mainly dietary and physical exercise versus a comparison intervention of usual care; one of the outcome measures of the study was weight loss; and participants were overweight or obese adults.Data collection and analysis: Two researchers independently applied the inclusion criteria to the identified studies and assessed risk of bias. Disagreement was resolved by discussion or by intervention of a third party. Descriptive analysis was conducted for the review.Main results: A total of five studies met the inclusion criteria and a total of 3910 participants were evaluated. The total number of participants randomised to intervention groups was 1834 and 2076 were randomised to control groups. Overall risk of bias was high. The trials varied in length of intervention from six weeks to 24 months, with a  median length of nine months. The intervention was found to have limited impact on weight loss (about 2 kg or less). There was no conclusive evidence for sustainable weight loss. However, TTM SOC and a combination of physical activity, diet and other interventions tended to produce significant outcomes (particularly change in physical activity and dietary intake). TTM SOC was used inconsistently as a theoretical framework for intervention in the trials. Death and weight gain are the two adverse events reported by the included trials. None of the trials reported health-related quality of life, morbidity, and costs as outcomes.Authors' conclusions: TTM SOC and a combination of physical activity, diet and other interventions resulted in minimal weight loss, and there was no conclusive evidence for sustainable weight loss. The impact of TTM SOC as theoretical framework in weight loss management may depend on how it is used as a framework for intervention and in combination with other strategies like diet and physical activities.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008066.pub2/abstract

8. AU: Fisher Caroline A

**TI: Family therapy for anorexia nervosa**

YR: 2010

KY: Anorexia Nervosa [therapy];Family Therapy [methods];Randomized Controlled Trials as

AB: 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 methods: 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 is insufficient evidence to be able to determine whether family therapy offers any advantage over other types of psychological interventions, or whether one type of family therapy is more effective than another. The field would benefit from a large, well-conducted trial.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004780.pub2/abstract

-1:AU: Perkins Sarah S J AU: Murphy Rebecca RM AU: Schmidt Ulrike US AU: Williams Chris

**TI: Self-help and guided self-help for eating disorders**

YR 2006

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 methods: 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.

US: <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004191.pub2/abstract>

-2:AU: Oude Luttikhuis Hiltje AU: Baur Louise AU: Jansen Hanneke AU: Shrewsbury Vanessa A AU: O'Malley Claire AU: Stolk Ronald P AU: Summerbell Carolyn D

**TI: Interventions for treating obesity in children**

YR: 2009

Background: Child and adolescent obesity is increasingly prevalent, and can be associated with significant short- and long-term health consequences.Objectives: To assess the efficacy of lifestyle, drug and surgical interventions for treating obesity in childhood.Search methods: We searched CENTRAL on The Cochrane Library Issue 2 2008, MEDLINE, EMBASE, CINAHL, PsycINFO, ISI Web of Science, DARE and NHS EED. Searches were undertaken from 1985 to May 2008. References were checked. No language restrictions were applied.Selection criteria: We selected randomised controlled trials (RCTs) of lifestyle (i.e. dietary, physical activity and/or behavioural therapy), drug and surgical interventions for treating obesity in children (mean age under 18 years) with or without the support of family members, with a minimum of six months follow up (three months for actual drug therapy). Interventions that specifically dealt with the treatment of eating disorders or type 2 diabetes, or included participants with a secondary or syndromic cause of obesity were excluded.Data collection and analysis: Two reviewers independently assessed trial quality and extracted data following the Cochrane Handbook. Where necessary authors were contacted for additional information.Main results: We included 64 RCTs (5230 participants). Lifestyle interventions focused on physical activity and sedentary behaviour in 12 studies, diet in 6 studies, and 36 concentrated on behaviorally orientated treatment programs. Three types of drug interventions (metformin, orlistat and sibutramine) were found in 10 studies. No surgical intervention was eligible for inclusion. The studies included varied greatly in intervention design, outcome measurements and methodological quality.Meta-analyses indicated a reduction in overweight at 6 and 12 months follow up in: i) lifestyle interventions involving children; and ii) lifestyle interventions in adolescents with or without the addition of orlistat or sibutramine. A range of adverse effects was noted in drug RCTs.Authors' conclusions: While there is limited quality data to recommend one treatment program to be favoured over another, this review shows that combined behavioural lifestyle interventions compared to standard care or self-help can produce a significant and clinically meaningful reduction in overweight in children and adolescents. In obese adolescents, consideration should be given to the use of either orlistat or sibutramine, as an adjunct to lifestyle interventions, although this approach needs to be carefully weighed up against the potential for adverse effects. Furthermore, high quality research that considers psychosocial determinants for behaviour change, strategies to improve clinician-family interaction, and cost-effective programs for primary and community care is required.

US: <http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD001872.pub2/abstract>

1: Claudino Angélica M AU: Silva de Lima Mauricio AU: Hay Phillipa PJ AU: Bacaltchuk Josué AU: Schmidt Ulrike US AU: Treasure Janet

**TI: Antidepressants for anorexia nervosa**

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 methods: 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.

US: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD004365.pub2/abstract

**2;. Psychological interventionn for Overweight and Obesity**

ShawKA,2009

Overweight and obesity are global health problems which are increasing throughout the industrialised world. If left unchecked, they will continue to contribute to the ever increasing non communicable disease burden.

To assess the effects of psychological interventions for overweight or obesity as a means of achieving sustained weight loss.

Studies were obtained from searches of multiple electronic bibliographic databases.

Trials were included if the fulfilled the following criteria: 1) they were randomised controlled clinical trials of a psychological intervention versus a comparison intervention, 2) one of the outcome measures of the study was weight change measured by any method, 3) participants were followed for at least three months, 4) the study participants were adults (18 years or older) who were overweight or obese (BMI > 25 kg/m2) at baseline.

**Data collection and analysis**

Two people independently applied the inclusion criteria to the studies identified and assessed study quality. Disagreement was resolved by discussion or by intervention of a third party. Meta-analyses were performed using a fixed effect model.

A total of 36 studies met the inclusion criteria and were included in the review. Overall, 3495 participants were evaluated. The majority of studies assessed behavioural and cognitive-behavioural weight reduction strategies. Cognitive therapy, psychotherapy, relaxation therapy and hypnotherapy were assessed in a small number of studies. Behaviour therapy was found to result in significantly greater weight reductions than placebo when assessed as a stand-alone weight loss strategy (WMD -2.5 kg; 95% CI -1.7 to -3.3). When behaviour therapy was combined with a diet / exercise approach and compared with diet / exercise alone, the combined intervention resulted in a greater weight reduction. Studies were heterogeneous however the majority of studies favoured combining behaviour therapy with dietary and exercise interventions to improve weight loss. Increasing the intensity of the behavioural intervention significantly increased the weight reduction (WMD -2.3 kg; 95% CI -1.4 to - 3.3). Cognitive-behaviour therapy, when combined with a diet / exercise intervention, was found to increase weight loss compared with diet / exercise alone (WMD -4.9 kg; 95% CI -7.3 to - 2.4). No data on mortality, morbidity or quality of life were found.

People who are overweight or obese benefit from psychological interventions, particularly behavioural and cognitive-behavioural strategies, to enhance weight reduction. They are predominantly useful when combined with dietary and exercise strategies. The bulk of the evidence supports the use of behavioural and cognitive-behavioural strategies. Other psychological interventions are less rigorously evaluated for their efficacy as weight loss treatments.

**Psychological interventions for overweight or obesity**

Several psychological methods are used to try and help people who are overweight or obese to lose weight. This review found that cognitive behaviour therapy and behaviour therapy significantly improved the success of weight loss for these people. Cognitive therapy was not effective as a weight loss treatment. There was not enough evidence to reach a conclusion about other psychological forms of therapy, such as relaxation therapy and hypnotherapy, however the evidence that is available suggests that these therapies may also be successful in improving weight loss. No data on mortality, morbidity or quality of life were found.

3: Pratt Belinda M AU: Woolfenden Susan

**TI: Interventions for preventing eating disorders in children and adolescents**

YR: 2002

Background: Eating disorders represent an extremely difficult, time-consuming and costly condition to treat. Being young, female, and dieting are some of the few identified risk factors that have been reliably linked to the development of eating disorders. There is currently limited evidence in the published literature to suggest that any particular type of program is effective in preventing eating disorders and there has been concern that some interventions have the potential to cause harm.Objectives: To determine if eating disorder prevention programs for children and adolescents are effective in: (1) promoting healthy eating attitudes and behaviours; (2) promoting protective psychological factors; (3) promoting satisfactory physical health; (4) having a long-term, sustainable, and positive impact on mental and physical health; and, (5) ensuring safety in relation to possible harmful consequences on mental or physical health.Search methods: Relevant trials are identified through searching the Cochrane Controlled Trial Register (CCTR) and relevant biomedical and social science databases, as well as reference lists from articles identified through the search strategy and contact with experts in the field.Selection criteria: Randomised controlled trials (RCTs) with a major focus on eating disorder prevention programs for children and adolescents, where there is no known DSM-IV diagnosis of an eating disorder, are eligible for inclusion in the review. Trials must include a control group and at least one objective outcome measure (e.g., BMI) or a standardised psychological measure used with the intervention and control group, pre- and post-intervention.Data collection and analysis: A total of 1016 titles have been identified through the search to date. Twenty-two studies were located that reported use of a randomised controlled trial methodology and were critically appraised by two independent reviewers. Twelve studies met the selection criteria outlined above.Main results: Combined data from two eating disorder prevention programs based on a media literacy and advocacy approach indicate a reduction in the internalisation or acceptance of societal ideals relating to appearance at a 3- to 6-month follow-up (Kusel 1999; Neumark\* 2000) [SMD -0.28, -0.51 to -0.05, 95% CI]. There is insufficient evidence to support the effect of five programs designed to address eating attitudes and behaviours and other adolescent issues in the general community or those classified as being at high risk for eating disorder (Buddeberg\* 1998; Dalle Grave 2001; Killen 1993; Santonastaso 1999; Zanetti 1999) and insufficient evidence to support the effect of two programs designed to improve self-esteem (O'Dea 2000; Wade 2003). Data from two didactic eating disorder awareness programs could not be pooled for analysis. There is not sufficient evidence to suggest that harm resulted from any of the prevention programs included in the review.Authors' conclusions: The one significant pooled effect in the current review does not allow for any firm conclusions to be made about the impact of prevention programs for eating disorders in children and adolescents, although none of the pooled comparisons indicated evidence of harm. The meta-analysis is in the process of being revised to account for the impact of cluster randomised trials.

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4: Hay Phillipa PJ AU: Bacaltchuk Josué AU: Byrnes Roanna T AU: Claudino Angélica M AU: Ekmejian Avedis A AU: Yong Poh Yee

**TI: Individual psychotherapy in the outpatient treatment of adults with anorexia nervosa**

YR: 2003

Background: Anorexia nervosa is a disorder with 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 methods: CCDANCTR-Studies and CCDANCTR-References were searched on 12/2/2008. Further database searches of MEDLINE, EXTRAMED, EMBASE, PSYCLIT, CURRENT CONTENTS were carried out, hand-search of The International Journal of Eating Disorders, and the reference lists of all papers selected. Personal letters were sent to identified notable researchers who had published in the area, requesting information on trials that are unpublished or in progress. The search was updated to December 2005 (MEDLINE and CCDAN registers) and then to Feb 2008 (MEDLINE, SCOPUS, and CCDAN registers).Selection criteria: All randomised controlled trials of adult individual outpatient therapy for anorexia nervosa, as defined by DSM-IV or similar international criteria. Quality assessment was made according to Quality Rating Scale 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 used the standardised mean difference statistic, and binary outcome comparisons used relative risk. Reliability of data extraction and quality assessment 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: Seven 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. One trial found a nonspecific therapy was favoured over two specific psychotherapies.Authors' 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 this area.

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5.: Hay Phillipa PJ AU: Bacaltchuk Josué AU: Stefano Sergio AU: Kashyap Priyanka

**TI: Psychological treatments for bulimia nervosa and binging**

YR: 2009

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 methods: 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 structured 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.

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6: Hay Phillipa PJ AU: Claudino Angélica M AU: Kaio Marcel H

**TI: Antidepressants versus psychological treatments and their combination for bulimia nervosa**

YR: 2001

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 methods: (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 - ongoingSelection 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.

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7: Bacaltchuk Josué AU: Hay Phillipa PJ TI:

**Antidepressants versus placebo for people with bulimia nervosa**

YR: 2003

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 symptomsSearch methods: (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 - ongoingSelection 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.Authors' 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.

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