

### Bupropion controversy

I am writing to question publication of “Bupropion: Off-label treatment for cocaine and methamphetamine addiction” (Pearls, CURRENT PSYCHIATRY, July 2010, p. 52). The author recommends use of bupropion during inpatient detoxification and continuing after discharge. The only support given for this recommendation is the unreferenced statement that “some clinicians have found it helpful during the initial treatment.” No actual supporting data are given, either directly or by citing published literature. I believe that this article does a serious disservice to readers by giving a clinical recommendation based solely on the author’s unsubstantiated opinion. No evidence is provided at any level of scientific rigor, whether anecdotal case series or controlled clinical trial. Readers are left unable to judge for themselves the validity of the recommendation.

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### Bupropion for cocaine users

The article by Heidi Magyar, MS, ARNP, “Bupropion: Off-label treatment for cocaine and methamphetamine addiction” (Pearls, CURRENT PSYCHIATRY, July 2010, p. 52) was quite interesting. Over the last 2 decades studies assessing the efficacy of bupropion for cocaine and methamphetamine addiction treatment have had conflicting results, with more negative than positive findings. There have been at least 4 studies since 2006, some of which have found statistically significant results when comparing



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bupropion with placebo in specific subgroups.

A double-blind, randomized, placebo-controlled trial by Shoptaw et al<sup>1</sup> that used bupropion or placebo combined with cognitive-behavioral therapy showed no statistically significant difference. A study of 106 methadone-maintained patients carried out by Poling et al<sup>2</sup> evaluated 4 treatment conditions: contingency management and placebo, contingency management and bupropion, 300 mg/d, voucher control and placebo, and voucher control and bupropion. The contingency management and bupropion group was the only one that showed a significant decrease in cocaine use. Su et al<sup>3</sup> found that in mice prenatal bupropion exposure could enhance cocaine sensitivity.

In the case of methamphetamine treatment, a double-blind placebo-controlled study by Elkashef et al<sup>4</sup> randomized patients to either placebo or bupropion, 300 mg/d. Initial generalized results showed no statistically significant difference, but a mixed model regression analysis

that adjusted for sex, baseline level of methamphetamine use, and severity of depression showed significantly increased abstinence, mainly in male patients and those with low-to-moderate methamphetamine use at baseline.

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### References

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3. Su SW, Cherng CF, Lin YC, et al. Prenatal exposure of bupropion may enhance agitation, anxiety responses, and sensitivity to cocaine effects in adult mice. *Chin J Physiol.* 2007;50(1):1-8.
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### Reconsidering delusions

I appreciate Dr. Henry A. Nasrallah’s refreshing, mind-bending thoughts about delusions in, “Are some nonpsychotic psychiatric disorders actually psychotic?” (From the Editor, CURRENT PSYCHIATRY, November 2010, p. 16-19). I am moved to contemplate delusions in a new way and to try an antipsychotic in select cases. If delusional thinking were like a closed circuit with its associated neurotransmitter pathway and no access to cortical modification, it would make sense to use a “circuit breaker” (such as dopamine inhibitors and anxiolytics) to open up a pathway to cortical modification. Cognitive-behavioral therapy would help with the transition to cortical control.

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