

Psychiatric Issues Can Loom Large in HIV

BY SHARON WORCESTER
Southeast Bureau

NEW ORLEANS — The neurologic and psychiatric aspects of HIV should be treated at least as aggressively as the impact of the disease on the liver, lungs, and heart, Dr. Marshall Forstein said at the American Psychiatric Association's Institute on Psychiatric Services.

HIV invades the brain beginning at the time of seroconversion, and can progress in the central nervous system independently of the peripheral progression of the disease, resulting in neurologic effects that can adversely affect the course of illness, adherence to treatment, secondary transmission, and survival, Dr. Forstein, of the department of psychiatry at Harvard Medical School, Boston.

Central nervous system (CNS) dysfunction can occur as a result of the effects of HIV on metabolic and endocrine dysfunction. Hypoxia, anemia, hypothyroidism, adrenal insufficiency, and hypogonadism are more common in those who have HIV, for example.

Such dysfunction also can occur as a result of various treatments, such as antivirals, antimicrobials, and herbal medicines, and can range from subclinical cognitive impairment to mild neurocognitive disorder to HIV-related dementia, he noted, adding that effective HIV treatment can help, but long-standing adverse effects can occur as a result of subcortical and cortical insult in those who go untreated.

Furthermore, the effects can be aggravated by psychiatric disorders, substance abuse, sleep deprivation, and pain—all of which are common in HIV patients, and thus may contribute greatly to the cognitive problems.

Antiretroviral treatment can help improve neurocognitive function, as can psychostimulants, but it is important to remember that the CNS can be a sanctuary for the virus in the brain. Therefore, it is also important to maintain "a sense of disconnect between what's going on in the periphery and what's going on in the nervous system," he said.

For example, findings in HIV, as well as in other diseases such as hepatitis C, suggest that infections of the brain may

stimulate inflammatory processes that adversely affect cognition. Bolstering this suggestion are recent findings of a relationship between HIV treatment and a halo effect in the CNS, reducing the consequences of inflammatory processes in the brain regardless of the progression or resistance of the virus in the periphery, Dr. Forstein said.

In addition, viral load does not appear to be linked with cognitive changes; some patients who have a low viral load have extensive cognitive impairment, and some who have a high viral load have no cognitive impairment.

"It may be a question of how much inflammation is in the brain itself," he said.

As for psychiatric issues, many HIV patients experience depression, anxiety, and other psychiatric conditions. Mood disorders are the most common psychiatric complaint in those who have HIV, with studies suggesting that up to 60% have depression, half are substance abusers, and up to 25% have an anxiety disorder. Several factors are considered probable risk factors for depression in HIV (see box), such as a history of or family history of a mood disorder, and alcohol or drug use.

It may be that those at increased risk of HIV are also at increased risk of mood disorders, but in some cases the disorders can also be secondary to the disease, treatments, and/or physical manifestations of the disease, such as lipodystrophy, which can be a telltale sign of HIV infection.

Suicide also is a risk in HIV patients, and that risk is elevated across the trajectory of the disease; surviving into middle and older years has been associated with increased risk, and in the era of antiretroviral therapy, such survival is more common. However, few studies have evaluated suicide risk in this period.

Other psychiatric disorders common in HIV patients include adjustment disorders and psychotic disorders. Somatic problems, such as sleep and pain disorders; fatigue; and sexual dysfunction also occur frequently, and like mood and other psychiatric disorders, should be addressed in these patients. ■

Medications Used to Treat HIV May Alter Absorption of Others

BY SHARON WORCESTER
Southeast Bureau

NEW ORLEANS — For neurologic and psychiatric issues in HIV patients, several factors should be considered, Dr. Marshall Forstein said at the American Psychiatric Association's Institute on Psychiatric Services.

Psychopharmacology should be used carefully, and patients should be monitored for CNS effects.

In addition, drug-drug interactions should be considered. It is important to keep in mind, for example, that HIV medications may alter absorption of other medications and that induction/inhibition of CP450 may alter drug levels, Dr. Forstein noted.

Common treatments for depression in HIV include selective serotonin reuptake inhibitors, serotonin norepinephrine reuptake inhibitors, novel antidepressants, tricyclic antidepressants, psychostimulants, and hormonal treatments.

The start-low/go-slow approach often taken with elderly patients should be applied here as well.

Comorbid substance abuse should be monitored; several dangerous interactions can occur between HIV treatments and recreational drugs, said Dr. Forstein, who

is with the department of psychiatry at the Harvard School of Medicine, Boston.

As for psychotherapy, several common themes among HIV patients have emerged and should be addressed, including:

- ▶ Loss.
- ▶ Anger.
- ▶ Control (decision making).
- ▶ Death and dying.
- ▶ Impact of HIV on partners and children.
- ▶ Fear.
- ▶ Disclosure.
- ▶ Sexuality.
- ▶ Spirituality.
- ▶ Guilt and regret.
- ▶ Self-criticism and self-esteem issues.
- ▶ Stigma and discrimination.
- ▶ Suicide, including physician-assisted suicide.

Importantly, several effective strategies are available for the management of mood disorders and psychiatric complications in HIV patients, Dr. Forstein said.

One study showed that about half of depressed HIV patients were not treated with antidepressants, and those not treated had 50% lower survival than those who were treated.

All HIV patients who have mood disorders or other psychiatric symptoms should be offered aggressive and timely treatment, he concluded. ■

Patient Awareness Is Key to Night-Eating Diagnosis

BY KATE JOHNSON
Montreal Bureau

MONTREAL — When night eating becomes pathological, with harmful effects on sleep and body weight, it is important to differentiate between sleep-related eating disorder and night-eating syndrome, said Dr. Jonathan Fleming, a psychiatrist at the University of British Columbia, Vancouver.

One key difference is that awareness of the awakenings and eating is seen in night-eating syndrome, but not in sleep-related eating disorder, he said at the annual conference of the Canadian Psychiatric Association. Another difference is that sleep-related eating disorder (SRED) is characterized by bizarre eating behavior, which can put the patient in danger.

"A recent patient of mine was found by his wife with the Christmas turkey, which was frozen, trying to carve it with a butter knife," Dr. Fleming said. "People eat very unusual things—like raw meat—that they would not normally eat in the daytime. They can get up and drive in a confused state, and go pick up food from the store. Or they can cut or burn themselves trying to prepare something."

Night-eating syndrome (NES) is considered largely an affective illness, but sleep-related eating disorder tends to be associated with sleep disorders—making the treatment of these conditions quite different, Dr. Fleming said.

"The major thought is that NES may be a variant of affective illness with an admixture of a circadian disorder, whereas SRED is particularly associated with sleep apnea and periodic limb movement disorder," he said.

NES was first described in 1955, in patients seeking weight loss treatment. It occurs in about 1.5% of the population but is particularly prevalent in obese (6%-14%) and morbidly obese (42%) patients. It is characterized by evening hyperphagia, morning anorexia, initial insomnia, and awakenings throughout the night, with clear recall of being hungry and snacking.

There are no randomized controlled trials of treatments, but it is not surprising that case reports suggest chronobiotics (melatonin), antidepressants, appetite suppressants, and even light therapy have all been effective, he said. In contrast, night eating is involuntary and largely unremembered in SRED, and morning anorexia is often characterized by nausea resulting from the unusual foods or toxic substances consumed overnight. Because the underlying etiology is sleep disorder, this is where treatment of SRED is directed, Dr. Fleming said.

Dr. Fleming said he advises use of the parasomnia protocol for SRED patients, which can be remembered with the mnemonic SIS: **S**ecure the bedroom and home environment; avoid **i**ntoxicant use; and keep the sleep **s**chedule constant. ■

Probable Risk Factors for Depression

- ▶ Personal history of a mood disorder.
- ▶ Personal or family history of alcoholism, substance use, suicide attempt, and/or anxiety disorders.
- ▶ Current alcohol or drug use.
- ▶ Inadequate social support system.
- ▶ Nondisclosure of HIV-positive status.
- ▶ Multiple losses.
- ▶ Disease progression.
- ▶ Treatment failure, and in some cases—treatment success (for exam-

ple, when a patient expects to die but is treated successfully and then fears constantly that the treatment will subsequently fail and he or she will be faced with preparing again for death).

In addition, women are twice as likely as men to develop depression, regardless of HIV status, and women with HIV and depression are twice as likely to die as are women without signs or symptoms of depression, Dr. Forstein noted.