

European Groups Weigh In on SMI, Diabetes

BY MIRIAM E. TUCKER

VIENNA — A new joint position statement from three European medical organizations is aimed at reducing cardiovascular disease risk and improving diabetes care in people with severe mental illness, as well as improving their overall health and well-being.

The statement is from the European Psychiatric Association and supported by the European Association for the Study of Diabetes (EASD) and the European Society of Cardiology (www.em-consulte.com/article/223719). It was discussed at a press briefing held during the EASD's annual meeting.

People with severe mental illnesses (SMI), including schizophrenia, depression, and bipolar disorder, have worse physical health and reduced life expectancy compared with the general population. Data suggest that they die years prematurely. It's also much harder for these individuals to access health care services, statement co-author Dr. Richard Holt said at the briefing.



People with SMI are more likely to be overweight, to smoke, and to have diabetes, hypertension, and dyslipidemia. Antipsychotics also can induce weight gain and worsen other metabolic cardiovascular disease (CVD) risk factors.

"The problem is that as well as the devastating effects of SMI, people with bipolar disorder and schizophrenia die on average 10-20 years earlier than the general population," said Dr. Holt, of the department of endocrinology and metabolism at the University of Southampton (England) Because of the reduced access to physical health care services, the rate of screening for diabetes and CVD is significantly lower than that in the general population. In fact, while about 20% of diabetes in the general population is undiagnosed, that rate is about 70% among people with mental illness. People with mental illness also have high rates of untreated dyslipidemia and hypertension, he noted.

With this new statement, "We have an opportunity here of bringing together psychiatry and physical health services—in both primary care and secondary care—to try

to address this problem, to increase the amount of screening for CV risk factors, to identify individuals at high risk, and to then come together with a strategy to treat them."

"In putting together this statement, the three organizations have developed pragmatic guidelines," he said. "Clearly, this is a collaborative effort."

The document, for which the lead author was Dr. Marc De Hert of University Psychiatric Centre, Catholic University, Leuven Campus Kortenberg, Belgium, urges coordinated CVD risk assessment and management for this population, and names psychiatrists as often being the best placed to lead the health care team that ideally includes shared care arrangements between general and specialist health care services.

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DR. HOLT

risk level. Weight should be closely monitored in patients taking psychotropic medications, the document advises.

Psychiatric centers and diabetes centers should cooperate in the care of patients with SMI and diabetes. A diabetes nurse-educator also should be involved in the care of those on insulin. The document also outlines management of blood lipids and blood pressure, along with smoking cessation counseling.

The choice of psychotropic medications should take into account the potential effects of the agent on CVD risk factors, particularly in overweight or obese patients. A dilemma may arise with clozapine, which is recommended by many guidelines as the antipsychotic of choice for patients with refractory schizophrenia, but it is also associated with the highest risk of weight gain and related CVD risk factors, the document says.

In the United States, a similar set of recommendations from the American Psychiatric Association, the American Diabetes Association, the American Association of Clinical Endocrinologists, and the North American Associa-

tion for the Study of Obesity was issued in 2004 (Diabetes Care 2004;27:596-61). In addition, the National Association of State Mental Health Program Directors (NASMHPD) issued similar recommendations in 2006 and 2008 that are available at www.nasmhpd.org. The NASMHPD guidelines also focus on the establishment of systems of care for people with SMI at the national and state levels.

In an interview, Dr. Joe Parks, lead author of the NASMHPD papers, said the problem in the United States is that it's often not clear who is responsible for ensuring that evidence-based standards of care are provided.

"Are the recommendations the responsibility of the individual health care provider? Or the local health care organizations such as hospitals and clinics? Or the payers such as private insurers and Medicaid? Because of this lack of accountability, implementation has been fragmented and spotty," said Dr. Parks, medical director for the Missouri Department of Mental Health, Jefferson City.

Some U.S. states have made progress. The New York State Department of Mental Health, for example, has implemented tracking of obesity and blood pressure in its state-operated hospitals and clinics. In Missouri, the Department of Mental Health has just begun to require and fund annual screening and some interventions for obesity, blood pressure, diabetes, high cholesterol, and dyslipidemia in its programs serving people with mental illness for both Medicaid covered individuals and the uninsured.

Several private insurers encourage and attempt to incentivize clinics and individual providers to follow these recommendations, but Dr. Parks said he is unaware of any that actually require compliance.

"I don't know of any health care entity anywhere that delivers on all of either the American or European recommendations," Dr. Parks said. "If we want to see widespread adoption of these kind of evidence-based standards of care, then the payers need to require it in their contracts, pay more when evidence-based standards of care are followed, and pay less when they are not. Within our current system if you really want something to happen routinely and systematically throughout the health care delivery system, there must be either a legal requirement or financial incentives. Everything else is just wishful thinking." ■

Screening for Restless Legs Syndrome Warranted in IBS

BY PATRICE WENDLING

CHICAGO — Screening patients with irritable bowel syndrome for restless legs syndrome may lead to greater identification of RLS and improved treatment for both conditions.

In a single, community-based gastroenterology center, 29% of 90 patients with irritable bowel syndrome (IBS) based on Rome III criteria were also diagnosed with RLS. The prevalence of RLS in the general population is 1%-10%.

All patients with both IBS and RLS had alterations in the initiation and maintenance of sleep, lead author Dr. P. Patrick Basu and his associates reported in a poster at a meeting on neurogastroenterology and motility. Involuntary jerks and wakefulness during more than 30% of sleep time occurred in 75% and 63% of patients, respectively. The mean age of the cohort was 33 years; 60 were female, 38 were Hispanic, 26 white, 24 Asian, and 2 black.

Of the 26 patients with RLS, 62% had diarrhea-predominant IBS, 4% had con-

stipation-predominant IBS, and 33% had mixed IBS, suggesting the specific pathophysiology of diarrhea-predominant IBS may contribute to or relate to RLS. Previous research has identified a link between small intestinal bacterial overgrowth, which may contribute to IBS, and several sensory disorders including fibromyalgia, interstitial cystitis, and RLS.

"Diagnosis of simultaneous IBS and RLS may provide enhanced therapeutic efficacy for these patients, as some medications [that is,] rifaximin, may provide relief for both conditions," wrote Dr. Basu, director of gastroenterology, North Shore-Long Island Jewish Health System at Forest Hills, N.Y., and his associates.

Although the data were not included in the poster, 19 of the 26 IBS patients with RLS were treated with the antibiotic rifaximin, with 9 reporting relief of their RLS symptoms, Dr. Basu said in an interview. The diagnosis of RLS was made using a standard questionnaire formulated by the International Restless Legs Syndrome Study Group and was

confirmed by polysomnography.

Dr. Basu's decision to use rifaximin was prompted by an independent study in 13 patients with IBS and a positive lactulose breath test, an indicator of small intestinal bacterial overgrowth, in which rifaximin 1,200 mg/day for 10 days was associated with at least an 80% improvement from baseline in RLS symptoms in 10 patients and a "great" or "moderate" global GI symptom improvement in 11 patients (Dig. Dis. Sci. 2008;53:1252-6). Five of the 10 patients followed long term (mean 139 days) maintained complete resolution of their RLS symptoms.

Dr. Basu uses rifaximin plus probiotics in his own practice for patients with both RLS and IBS, and is planning to evaluate its efficacy at doses up to 1,400 mg/day in combination with probiotics in 75 IBS patients with RLS. Further investigations to determine the underlying mechanisms in IBS and RLS are needed to address the causality and possible concomitant nature of both disorders, he said.

Two studies from Washington Univer-

sity School of Medicine, St. Louis, examined whether RLS is associated with celiac disease and Crohn's disease, because all three conditions are associated with iron deficiency. The incidence of RLS was 35% in 85 patients with celiac disease (Dig. Dis. Sci. 2009 Sept. 3 [Epub ahead of print] and 43% in 272 consecutive patients with Crohn's disease (Inflammatory Bowel Dis. 2009 July 2 [doi: 10.1002/ibd.21001]). The rate of iron deficiency was significantly higher in celiac patients with active RLS than in those with no RLS, but there was no difference between Crohn's patients with and without RLS with respect to current iron deficiency.

Dr. Basu noted that screening IBS patients for RLS may allow greater identification and subsequent treatment of RLS, which is thought to be underdiagnosed, even in the general population.

Dr. Basu and associates reported no conflicts of interest. Support for preparation of the poster was provided by Salix Pharmaceuticals, which markets rifaximin as Xifaxan. ■