

Bipolar Disorder, Medical Comorbidities Linked

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PITTSBURGH — Patients with bipolar disorder have an unexpectedly high prevalence of medical comorbidities, based on findings from a study of 175 patients.

These 175 patients, with an average age of 35, had a high prevalence of gastrointestinal, musculoskeletal, genitourinary, and other medical comorbidities, Ellen Frank, Ph.D., said at the Sixth International Conference on Bipolar Disorder.

The rates were “very high for such a young population. It stunned us,” said Dr. Frank, professor of psychiatry and psychology at the University of Pittsburgh, which sponsored the conference.

If physicians focus only on the psychiatric symptoms of patients with bipolar disorder, they “do their patients a disservice because they also have a lot of medical illness ... associated with poor psychiatric outcomes,” she told this newspaper.

The Pittsburgh Study of Maintenance

Therapies in Bipolar Disorders was designed to assess the efficacy of a psychosocial therapy as an adjunct to pharmacotherapy. But as part of the study, the participants underwent a thorough medical work-up at baseline.

The initial assessment found large numbers of patients with an active medical illness. For example, 59 of the 175 patients (34%) had active gastrointestinal disease; a total of 97 (55%) had a history of gastrointestinal disease, but the condition was not active in all patients.

Active musculoskeletal or joint disease was found in 56 patients (32%), and a total of 131 (75%) had a history of this comorbidity. A substantial fraction also had active genitourinary disease (43 patients, 25%), headaches or migraines (42 patients, 24%), asthma or respiratory disease (41 patients, 23%), and cardiovascular disease (32 patients, 18%). In addition, 58 patients (33%) were obese.

One analysis of the findings compared the efficacy of maintenance treatment in pa-

tients with four or more active comorbidities with those with fewer comorbidities. The analysis showed that, during 2 years of follow-up, patients with four or more active comorbidities were about twice as likely to have a recurrence of bipolar symptoms as were patients with fewer comorbidities, reported Dr. Frank, who is also director of the depression and manic-depression prevention program at the Western Psychiatric Institute and Clinic in Pittsburgh.

In the subgroup of patients with a high number of active, medical comorbidities, intensive clinical management was the superior maintenance therapy. The second psychosocial treatment tested—interpersonal and social rhythm therapy—was more effective for patients with fewer medical comorbidities. The high prevalence of medical comorbidities seen in this study leads to two additional messages on how to best manage patients: First, “some treatments for bipolar disorder may exacerbate med-

ical symptoms,” Dr. Frank said. “We need to be careful when treating patients who are at risk” for obesity, cardiovascular disease, and other conditions. “Many bipolar disorder drugs have cardiac effects, so physicians have to be aware of these risk factors.”

Also, because bipolar patients are frequently depressed, they often find it hard to adhere to a healthy diet and exercise. Patients with bipolar disorder must be given tools for improving their physical health-related behavior, Dr. Frank said. ■

Number of Bipolar Patients In Study With Active Comorbidities

Gastrointestinal disease	59
Obesity	58
Musculoskeletal/joint disease	56
Genitourinary disease	43
Headache/migraine	42
Asthma/respiratory disease	41
Cardiovascular disease	32

Refeeding Syndrome Looms for Patients With Eating Disorders

BY KATE JOHNSON
Montreal Bureau

MONTREAL — Refeeding syndrome is a potential problem for all eating-disordered patients who are reintroducing fluids and food, but it is difficult to predict which patients are at greatest risk, Ovidio Bermudez, M.D., said at an international conference sponsored by the Academy for Eating Disorders.

“There is something about the reintroduction of nutrients to someone who has suffered a significant nutritional insult that can cause severe metabolic imbalances, resulting in cardiovascular, pulmonary, neurological, hepatic, and even bone marrow dysfunction,” he said in an interview.

Once the body has adjusted to a state of malnourishment, refeeding will signal the body to switch off its compensatory mechanisms, thus unmasking many nutritional deficiencies, said Dr. Bermudez, medical director of the eating disorders program at Laureate Psychiatric Clinic and Hospital in Tulsa, Okla. The result is electrolyte and fluid imbalances, glucose intolerance, liver dysfunction, and thiamine deficiency.

“All patients who are refeed will develop some degree of refeeding syndrome, but there is great variability in terms of the severity of the readjustment. Most patients fare well without any apparent clinical challenges, some patients have a moderate challenge, and a few patients have very severe or even fatal consequences,” he said.

Although there are few predictive factors to identify patients most at risk for refeeding syndrome, they tend to be those who are the most underweight (less than 70% of their ideal body

weight) and have low prealbumin levels. But these predictors should not be relied on too heavily, Dr. Bermudez warned. “The idea that a person who has had only a moderate metabolic insult is not going to develop some of these problems would be a false reassurance. The best approach we should have as physicians is to know the literature and know the group of patients at highest risk,” but to be alert for any trouble, he said.

By screening for problems prior to refeeding and then monitoring patients carefully during the refeeding, Dr. Bermudez noted, most serious consequences can be avoided.

He recommended that a comprehensive metabolic panel (including liver and renal function tests), calcium, phosphorus and magnesium levels, CBC, and a prealbumin test should be performed prior to refeeding. Any vitamin and trace mineral deficiencies, as well as electrolyte and glucose imbalances, should also be corrected at that time. During refeeding, fluids and caloric intake should be increased gradually by 200-250 kcal every 2-3 days, and weight gain should not exceed 2-3 pounds per week, Dr. Bermudez said. Initially, patients should have their vital signs, weight, and fluid intake and output monitored daily, with weekly assessments of CBC, electrolytes and glucose, calcium, phosphorus, magnesium, and liver and renal function, he said.

“How long to do this is not quite clear. In our setting, it is usually 2-3 weeks, but in others it can be up to 6 weeks,” he said. “Sometimes patients are ambulatory, but I think the sicker patients should be refeed in the hospital. Then you can relax the surveillance and be more guided by symptoms.” ■

Eating Disorders a Challenge As Patients Become Adults

BY KATE JOHNSON
Montreal Bureau

MONTREAL — When young patients with eating disorders transfer from the pediatric to the adult care setting, they literally take their lives into their own hands—which sometimes leaves their families and health care professionals empty handed.

Parents and the health care team play a central decision-making role in the pediatric setting, but the adult system transfers full responsibility to the patient. Some adolescents are ready for this new empowerment. For others, the freedom to refuse treatment or to exclude family members can create many bumps along the road, noted experts at an international conference sponsored by the Academy for Eating Disorders.

“Everyone’s fear is that the child will enter the adult system, get less attention, and eventually die,” said D. Blake Woodside, M.D., director of the inpatient eating disorders program at Toronto General Hospital. Indeed, the harsh reality is that, unlike pediatric programs, most adult eating disorder programs have no resources and often no legal jurisdiction to treat involuntary patients, he said.

But although many patients drift away from treatment at this time, the natural course of anorexia nervosa (AN), is such that the risk of death during this middle phase of the illness tends to be low, he said.

“There is a period of instability and risk of death in the early phase of the disease [around puberty] and the late phase after fifteen or more years, but through the middle phase it stabilizes and there are few deaths,” he said. “We have had hundreds of patients who have had a Body Mass Index of 14 for years. Sure, they are very sick, but they probably will not die.”

Many adolescents with eating disorders do

not recognize or acknowledge their need to continue treatment as adults, said Debra K. Katzman, M.D., of the department of pediatrics at the University of Toronto’s Hospital for Sick Children. In a recent survey of adolescents under age 18 with AN, only 14% anticipated that they would need treatment in the adult system and only 33% said they would participate in such a transfer.

She said it is useful for parents and pediatric caregivers to remember that aggressive treatment early in the course of the illness can have a positive outcome on child and adolescent growth and development and eventual long-term outcome.

“What we struggle with as pediatricians is the worry, knowing that we can make a significant impact on the patient’s growth and development if we intervene. But once these patients are adults, intervention is less likely to make significant change.”

Dr. Katzman recommends that the transition from pediatric to adult care should be an extended and gradual one, starting as early as age 10. “The transition may take years. It’s a process through which patients and their families are empowered to become active participants in their own care.”

The first step is actually a step back on the part of parents, said Leora Pinhas, M.D., psychiatric director of the eating disorders program at the University of Toronto’s Hospital for Sick Children. Although the adolescent may be 18 years old, many teens with eating disorders are developmentally delayed—which makes this process particularly difficult. “We try to encourage them to accept help from those who have their best interests at heart,” she said.

But family dynamics can be very fragile, added Dr. Woodside. “If parents are sufficiently anxious and can’t back off, the patient can cut off contact with them completely,” he explained. ■