

Expert Sees Possible Link Between Strep, Anorexia

Rarely, group A β -Hemolytic streptococcal infection can lead to sudden onset of psychiatric symptoms.

BY KATE JOHNSON
Montreal Bureau

MONTREAL — Streptococcal pharyngitis may be a very occasional trigger for anorexia nervosa and other neuropsychiatric conditions and should be investigated in patients with sudden onset of psychiatric symptoms, Mae S. Sokol, M.D., said at an international conference sponsored by the Academy for Eating Disorders.

Identification of this cause of anorexia nervosa would not change treatment of the condition, but it would alert patients and physicians to the need for more aggressive prevention and treatment of future strep infections, said Dr. Sokol of Creighton University in Omaha, Neb.

Dr. Sokol explained that group A β -hemolytic streptococci (GABHS) have been linked with several illnesses known collectively as PANDAS (pediatric autoimmune neuropsychiatric disorder associated with streptococcus).

In addition to anorexia, the PANDAS

classification includes obsessive-compulsive disorder (OCD) and tic disorders such as Tourette's syndrome.

It is well recognized that rheumatic fever and Sydenham's chorea are streptococcus-triggered autoimmune attacks on cardiac cells and cerebral neurons, respectively. It also is believed that PANDAS might be caused by similar attacks on basal ganglia cells, noted Dr. Sokol, who is also director of the eating disorders program at Children's Hospital in Omaha.

"We hypothesize that the immune system may look at the basal ganglia cells in the brain and mistakenly attack those cells, which may cause patients to have abnormal thoughts about food and weight," she said in an interview at the conference.

Why this damage to basal ganglia cells

The immune system may mistakenly attack the basal ganglia cells in the brain, 'which may cause patients to have abnormal thoughts about food and weight.'

manifests sometimes as anorexia and other times as OCD, Tourette's, or infantile autism is not known, Dr. Sokol said.

"Since the basal ganglia are also involved with emotion, we think this area of the brain may be affected slightly differently with each condition. Another theory is that maybe we are seeing the same thing in children with PANDAS anorexia and children with PANDAS OCD—only in the PANDAS anorexia, the obsessions are about food and weight, whereas in PANDAS OCD they are about other things. What's common in all these patients is a sense of

perfectionism after they become ill," she said.

She presented her study of 21 children and adolescents with possible PANDAS anorexia. The subjects met some or all of the following criteria:

- ▶ Presence of anorexia meeting DSM-IV criteria.
- ▶ Prepubertal onset of anorexia. This

was present in 10 of the 21 participants. Participants ranged in age from 10.5 to 18 years at enrollment, with symptom onset at 9.7-16 years.

▶ Acute onset/exacerbation of their anorexia symptoms. This occurred in 19 of the 21 participants.

▶ Association with GABHS infection: anorexia onset or exacerbation within 1 day to 6 months of strep infection. This occurred in all participants.

▶ Increased psychiatric symptoms, not exclusively during the strep illness. Present in all participants.

▶ Concomitant neurologic abnormalities, such as choreiform movements, motor hyperactivity, or adventitious movements. This occurred in two participants but has been reported more frequently in PANDAS OCD.

Dr. Sokol said physicians who suspect PANDAS anorexia should make an effort to confirm laboratory strep tests, although at this stage treatment recommendations would be no different for this group.

However, identification of an infection-triggered anorexia could alert physicians and patients to the need for more aggressive prevention strategies, she said. ■

Depression Common in Eating Disorders, Complicates Tx

BY KERRI WACHTER
Senior Writer

BALTIMORE — Depression frequently co-occurs with eating disorders, making treatment challenging, Graham W. Redgrave, M.D., said at a symposium on mood disorders sponsored by Johns Hopkins University.

"There are high rates of concurrent major depressive disorder in anorexia," said Dr. Redgrave of the Johns Hopkins University in Baltimore. Among patients with the restricting type of anorexia, 15%-50% also have major depressive disorder (MDD). The rates among patients with the binge-eating/purging type of anorexia are even higher at 46%-80%. The rates are higher still when these patients are asked whether they have ever had depression.

Numbers like these suggest that anorexia might simply be a behavioral manifestation of an underlying mood disorder. However, controlled family studies have provided good evidence that these disorders are different and independent, Dr. Redgrave said.

One reason so much overlap exists between anorexia and MDD is that starvation produces a host of psychiatric conditions in the body, such as mood lability, irritability, anxiety, apathy, obsessiveness, poor concentration, social withdrawal, and decreased libido.

Patients with anorexia aren't the only ones suffering from comorbid depression. Among patients with bulimia, 30%-60% have concurrent MDD and 50%-65% have had a lifetime occurrence of depression.

In patients with bulimia, starvation

magnifies feelings of guilt, shame, and hopelessness, Dr. Redgrave said. Increased frequency in the binge and purge cycles decreases the ability to concentrate, because the fear of being overweight increases in importance.

Depression also is high among patients with binge-eating disorder, with 36%-60% of these patients also having MDD. In addition, 48% of obese women who binge also have MDD, compared with only 26% of obese women who do not binge. "It's not just the obesity. There's something about the psychopathology of depression and the binge eating that seems to be related," Dr. Redgrave said.

Treatment of patients with eating disorders and depression can be a challenge because "when you are treating an eating disorder, you are asking your patient to give up something that is very rewarding." Patients can recognize that what they're doing is problematic but have a hard time giving it up, Dr. Redgrave said at the symposium, also sponsored by the Depression and Related Affective Disorders Association.

Treatment for an eating disorder focuses on behaviors and then on thoughts and feelings. Underlying connections and associations are addressed only when the patient is stabilized.

Pharmacotherapy is primarily an adjunctive treatment for patients with anorexia. Antidepressants are of modest but important benefit in bulimia nervosa, Dr. Redgrave said. Fluoxetine at high doses is especially useful, though most antidepressants can be useful in this population. Bupropion is contraindicated because of the risk of seizures. ■

Refeeding Syndrome Risk Hard To Predict 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 immediately signal the body to switch off compensatory mechanisms, thus unmasking 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 have severe or even fatal consequences, he said.

Although there are few predictive factors to identify patients most at risk,

they tend to be those who are the most underweight and have low prealbumin levels. But these predictors should not be relied on too heavily, Dr. Bermudez said.

"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, phosphorous 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, phosphorous, magnesium, and liver and renal function. "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. ■