AN EARLY APPROACH TO NERVOUS ANOREXIA

ENDOCRINOLOGIST, PSYCHIATRIST AND NUTRITIONIST: A COMPLEX GAME

Ambulatorio di Nutrizione Clinica
U.O.C. Oncologia Medica
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Conferenza di consenso
Disturbi del Comportamento Alimentare (DCA)
egli adolescenti e nei giovani adulti
Istituto Superiore di Sanità
Roma, 24-25 ottobre 2012

THE SINGLE ONE PROFESSIONAL SPECIALITY IS NOT RECOMMENDED

LINEE GUIDA
PER LA DIAGNOSI ED IL TRATTAMENTO
DEI DISTURBI DEL COMPORTAMENTO ALIMENTARE
ENOCRINOLOGIST, PSYCHIATRIST AND NUTRITIONIST: A COMPLEX GAME

Conferenza di consenso

Disturbi del Comportamento Alimentare (DCA) negli adolescenti e nei giovani adulti

WHICH IS THE BEST DIAGNOSIS-THERAPY-REHABILITATION WAY FOR PEOPLE WITH EATING DISORDERS IN TERMS OF APPROPRIATENES AND EFFICACY? WHICH ARE THE PROFESSIONAL FIGURES TO BE INVOLVED?

RECOMMENDATIONS

The diagnosis-therapy-rehabilitation way of patients affected by ED (eating disorders) includes the following aspects:
1) psychological and psychopathological
2) clinical-nutrition
3) metabolic
4) clinical
5) social and environmental
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RECOMMENDATIONS

The diagnosis-therapy-rehabilitation way must guarantee:
- active involvement of patients and/or parents and relatives
- specific management according to the age and the kind of disease,
  considering the psychotherapy, psychiatry and children neuropsychiatry,
  internal medicine, pediatry and nutrition aspects
- availability of people with specific experience with ED
- treatment of possible comorbidities and general consequences of the
disease, according to specific well-trained specialists
An integrated and age-specific multidimensional, interdisciplinary, multiprofessional evaluation is recommended from the first approach.

A constant communication among professionals is essential when the treatment is offered by a interdisciplinary team in a ambulatory setting.
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EXAMPLES OF THE NEED OF DIFFERENT PROFESSIONAL COMPETENCES AND INTEGRATED MULTIDISCIPLINARY
The current study compared the test meal intake by patients with AN at low weight and after weight restoration with that by control subjects. It found that inpatients with AN consumed significantly less of a test meal than did control subjects at both time points.

Patients with AN show a persistent disturbance in eating behavior, despite the restoration of body weight and significant improvements in eating-disordered and psychological symptoms.

The continued vulnerability during the period after inpatient hospitalization is exemplified by significant relapse rates among patients with AN.

Liking compared with wanting for high- and low-calorie foods in anorexia nervosa: aberrant food reward even after weight restoration

AN-W = weight-restored anorexia nervosa  AN-R = recovered anorexia nervosa

We conclude that anorexic girls with depression are at higher risk of low BMD than those without depression.

Konstantynowicz J et al, J Clin Endocrinol Metab, 90: 296-301, 2005
Disordered eating behaviors in type 1 diabetic patients

Avoid rigid control in susceptible patients

Consider psychological factors in patients with poor metabolic control

Use a validate questionnaire in subjects with high risk of DEB or ED

The different components of the therapy (psychiatric, psychterapeutic, nutritional and internistic) have to be differentiated on the basis of the phases of the disease:

- **Acute**

- **After the recovery of the weight**

- **Chronic**

The clinical way having as the only objective the achievement of the abstinence from the food symptom (binge eating, feeding restriction, purging, physical exercise) is not recommended.

Nutritional aspects and cognitive behavioral deficiency have always to be taken into account in the treatment.
Nutritional evaluation is one of the main elements to establish the therapeutic setting and it has to be managed by clinical nutritionists.

It is very important that nutritional rehabilitation is preceded by a rigorous nutritional evaluation, considering the history of body weight and BMI, malnutrition indexes (albuminemia, ecc.) and instrumental examinations addressed to evaluate body cell mass and hydration (by bioimpedance) and resting metabolism (indirect calorimetry).
The evaluation of the feeding behavior are needed:

- quantity and quality of the meal structure

- description of the feeding habits (with specific attention to previous events: emotional state, hunger, ecc)

- investigation concerning the use of:
  a) dysfunctional behaviors (strict diet, excessive physical activity, binge eating),
  b) conducted compensation (self-induced vomiting, laxatives, diuretics ecc),
  c) obsession for the food and the body shape,
  d) fasting,
  e) insufficient assumption of liquids
Refeeding of severely malnourished patients represents two very complex and conflicting tasks: 
1) to avoid refeeding syndrome caused by a too fast correction of malnutrition; 
2) to avoid underfeeding caused by a too cautious rate of refeeding.

Gentile MG, Nutrients, 4: 1293-1303, 2012
Psychotherapy should be supplied by specialized professionals in ED, taking into account the age of the patients.

Different kinds of psychotropies used in the ambulatory treatment, such as cognitive-analytical therapy, cognitive-behavior therapy, interpersonal psychotherapy, focal psychodynamic therapy, and familial interventions addressed to the eating disorders have been shown to be efficient.

The choice of the kind of psychotherapy should take into account the preferences of the patient and, when appropriate, of the parents.

The therapy based on the family (FBT) can be more appropriate than other kind of psychologic treatments in inducing a short-term symptomatic improvement in adolescent patients with a short span of disease. The therapy contemplates that parents have an active role in the refeeding of the sons.
A Randomized Controlled Trial of Adjunctive Family Therapy and Treatment as Usual Following Inpatient Treatment for Anorexia Nervosa Adolescents

Godart N et al, Plos One, 2012
Anorexia nervosa

SUMMARY POINTS

Anorexia nervosa has the highest rate of mortality of any psychiatric disorder.
It is best to make a positive diagnosis of psychologically driven weight loss, rather than reach
a diagnosis by exclusion.
Short term structured treatments—such as cognitive behaviour therapy—are not effective,
and longer term therapies that incorporate motivational enhancement techniques are
recommended.
Focused family work is effective in adolescents and young adults; counselling can involve the
family as a whole or the patient and their family can be treated separately.
To date, no effective drugs are available to treat anorexia.

TIPS FOR NON-SPECIALISTS

• Recovery takes years rather than weeks or months, and patients must accept that they should attain
a normal weight—refeeding alone may lead to relapse.
• Trends should be monitored by weighing, which needs to be managed skillfully so it does not become a
battleground.
• No cut off weight or body mass index exists because many other factors influence risk.
• Substance misuse—including alcohol, deliberate overdoses, or misuse of prescribed insulin—greatly
increases risk.
• Weight fluctuations and binge-purge methods (rather than pure restriction) increase risk.
• Depression, anxiety, and family arguments are probably secondary to the disorder, not underlying
causes, so the anorexia should be treated first.
• Medication has little benefit in anorexia and the risk of dangerous side effects is high in malnourished
patients.
• Try to involve the family—encourage calm firmness and assertive care.

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PSYCHOPHARMACOLOGICAL TREATMENT

The drugs should not be used as the only treatment for the patients affected by ED.

We have few evidences concerning the utility of a specific psychopharmacological treatment on the main components of ED.

The psychopharmacology may well be useful in the treatment of psychiatric comorbidities.
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WHICH IS THE ORGANIZATION MODEL FOR ED THAT GUARANTEES THE BEST RESULTS IN TERMS OF APPROPRIATENESS AND OF EFFICACY OF THE DIAGNOSIS-THERAPY-REHABILITATION INTERVENTIONS
RECCOMENDATIONS

On the basis of specific need, the therapy-rehabilitation project of the patient affected by ED should be organized on different kind of services:

- **first level**: General practitioner and family pediatrician

- **second level**: Specialistic ambulatory services in interdisciplinary network, including psychological-psychiatric/child neuropsychiatric and internistic-metabolic-nutritional areas

- **third level**: day hospital/day service, semiresidential structures

- **fourth level**: residential intensive rehabilitation or psychiatric and/or child neuropsychiatric therapy and rehabilitation communities

- **fifth level**: common and urgent admissions
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RECOMMENDATIONS

. **fourth level**: residential intensive rehabilitation or psychiatric and/or child neuropsychiatric therapy and rehabilitation communities

. **fifth level**: common and urgent admissions

The 4th and 5th levels are not necessarily one behind the other

It is important to evaluate with attention the possible need to alienate the adolescent or the pre-adolescent from the family
**LINEE GUIDA**

PER LA DIAGNOSI ED IL TRATTAMENTO

DEI DISTURBI DEL COMPORTAMENTO ALIMENTARE

<table>
<thead>
<tr>
<th>BREVE TERMINE (1-8 settimane)</th>
<th>MEDIO TERMINE (3-6 mesi)</th>
<th>LUNGO TERMINE (6-12 mesi)</th>
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<tbody>
<tr>
<td><strong>AN</strong></td>
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<tr>
<td>arresto perdita di peso corporeo;</td>
<td>recupero del peso corporeo;</td>
<td>recupero del “set point”;</td>
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<td>interruzione del digiuno/assestamento;</td>
<td>riequilibrio pattern nutrizionale;</td>
<td>normalizzazione</td>
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<td>interruzione del semidigiuno;</td>
<td>ripristino percezioni sensoriali di fame e sazietà.</td>
<td>composizione corporea;</td>
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<td>interruzione uso diuretici/lassativi/iperattività;</td>
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<td>adeguato pattern alimentare</td>
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<tr>
<td>interruzione condotte dispomaniche.</td>
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<td>(aumento variabilità</td>
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<td>tipologia cibi assunti e loro quantità).</td>
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<td>OBIETTIVE</td>
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<tr>
<td><strong>MEDICI</strong></td>
<td>Stabilizzazione delle condizioni cliniche e dei parametri vitali; Gestione della comobilità psichiatrica.</td>
<td></td>
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<td><strong>PSICOLOGICI</strong></td>
<td>Lavoro sulla motivazione con il fine di acquisire una consapevolezza di malattia con l’aumento della collaborazione al trattamento.</td>
<td>Ristrutturazione cognitiva; Aumento della consapevolezza di malattia e aumento capacità insight; Attenuazione distorsioni cognitive e disturbo percezione immagine corporea (riconoscimento e disidentificazione DAI sintomi); Miglioramento relazioni familiari</td>
</tr>
<tr>
<td><strong>NUTRIZIONALI</strong></td>
<td>Recupero di un comportamento alimentare che porti il paziente verso il recupero di un peso naturale; riduzione degli episodi di controllo/discontrollo alimentare (restrizione/abbuffate) e le condotte compensatorie (vomito autoindotto, iperattività, uso di lassativi e diuretici)</td>
<td>Consolidamento della autonomia nella gestione del pasto e dei comportamenti disfunzionali; Miglioramento della alterazione dell’immagine corporea e delle dispercezioni.</td>
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PER LA DIAGNOSI ED IL TRATTAMENTO DEI DISTURBI DEL COMPORTAMENTO ALIMENTARE
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