12° Congresso Nazionale AME
6th Joint Meeting with AACE
Update in Endocrinologia Clinica

Bari,
7-10 novembre 2013

AN EARLY APPROACH TO NERVOUS ANOREXIA

ENDOCRINOLOGIST, PSYCHIATRIST AND NUTRITIONIST: A COMPLEX GAME

Ambulatorio di Nutrizione Clinica

U.O.C. Oncologia Medica

Dipartimento Scienze Biomediche e Oncologia Umana

Giovanni De Pergola

7-10 novembre 2013
Bari, Sheraton Nicolaus Hotel & Conference Center

ENDOCRINOLOGIST, PSYCHIATRIST AND NUTRITIONIST: A COMPLEX GAME

Bari,
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Conferenza di consenso

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

Istituto Superiore di Sanità
Roma, 24-25 ottobre 2012

THE SINGLE ONE PROFESSIONAL SPECIALITY IS NOT RECOMMENDED

Regione Umbria

LINEE GUIDA
PER LA **DIAGNOSI** ED IL **TRATTAMENTO**
DEI **DISTURBI** DEL **COMPORTAMENTO ALIMENTARE**

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

WHICH IS THE BEST DIAGNOSIS-THERAPY-REHABILTATION 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)psycological 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

EQUIPE INTEGRATA PER LA GESTIONE DELLA ANORESSIA

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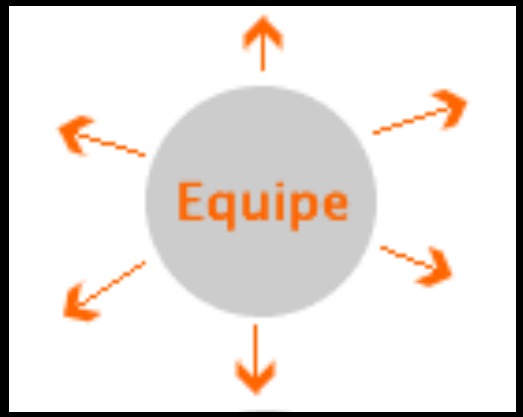
PSYCHIATRIST

NURSE



INTERNIST
(ENDOCRINOLOGIST, ecc)

PHYSIOTERAPIST

NUTRITIONIST
(DIETIST)

PSYCHOLOGIST

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 interdisciplinar team in a ambulatory *setting*

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EXAMPLES OF THE NEED OF DIFFERENT PROFESSIONAL COMPETENCES AND INTEGRATED MULTIDISCIPLINARY

Eating behavior among women with anorexia nervosa

Bari,
7-10 novembre 2013

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

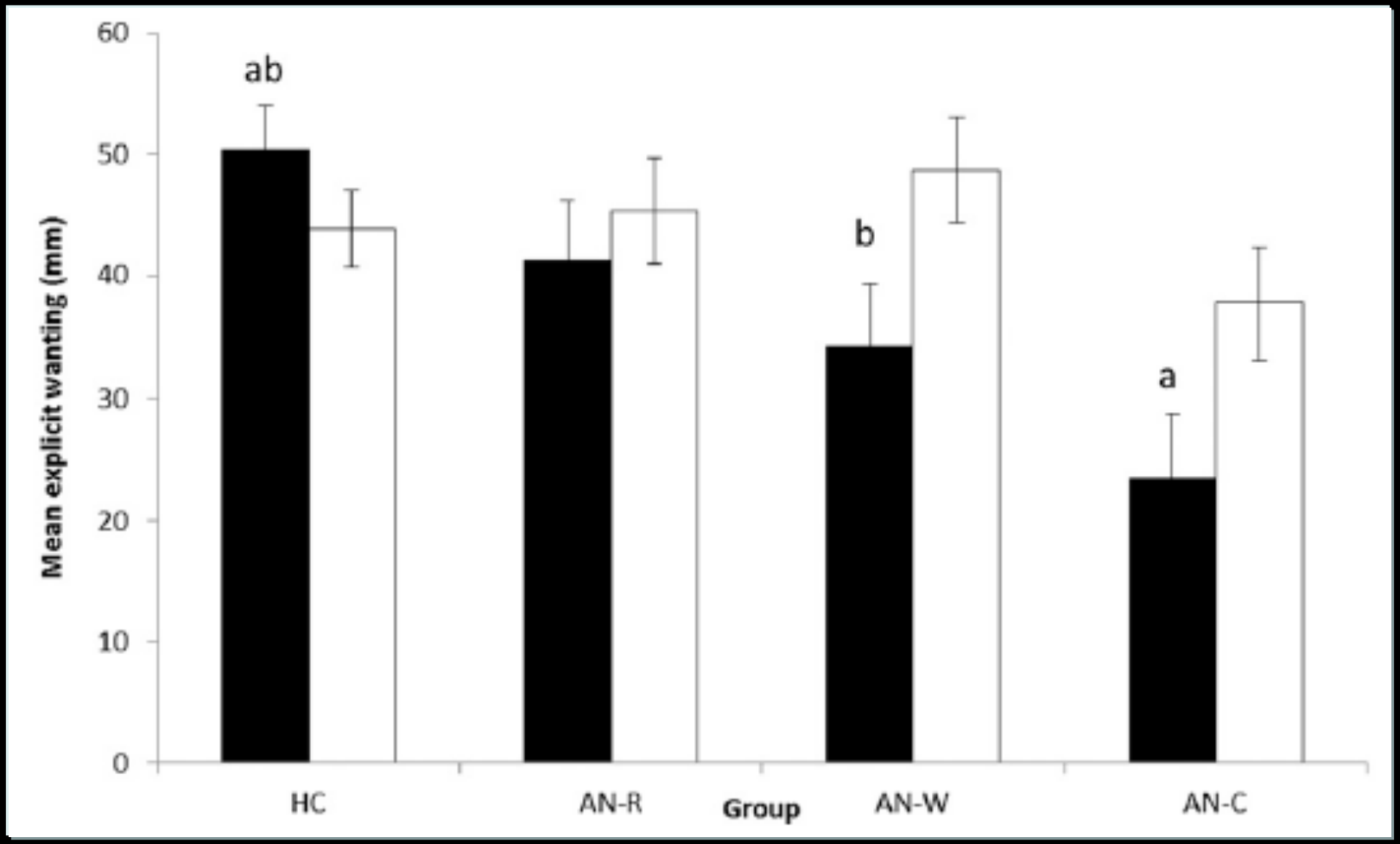
Sysko R et al, *Am J Clin Nutr*, 82: 296-301, 2005

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

Bari,
7-10 novembre 2013

AN-W = weight-restored anorexia nervosa

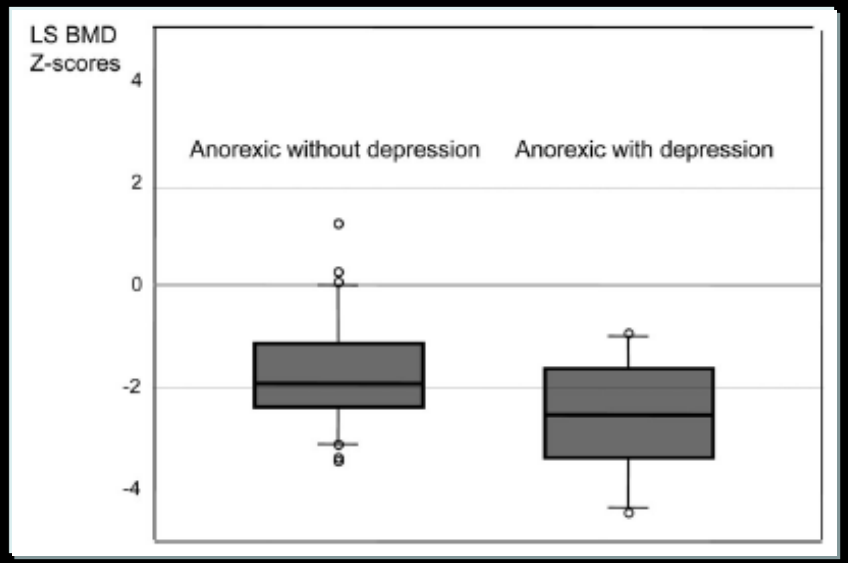
AN-R = recovered anorexia nervosa

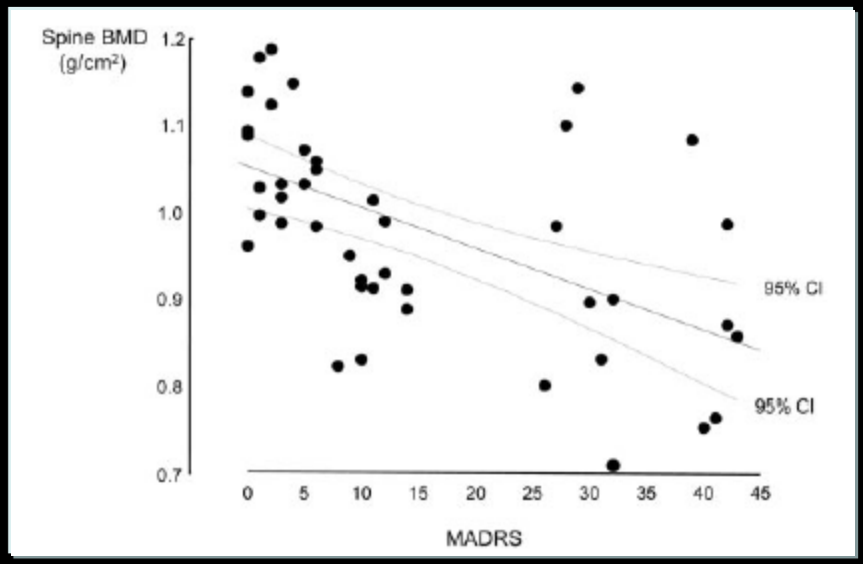


Cowdrey F et al, AJCN, 97: 463-470, 2013

Depression in Anorexia Nervosa: A Risk Factor for Osteoporosis

Bari,
7-10 novembre 2013

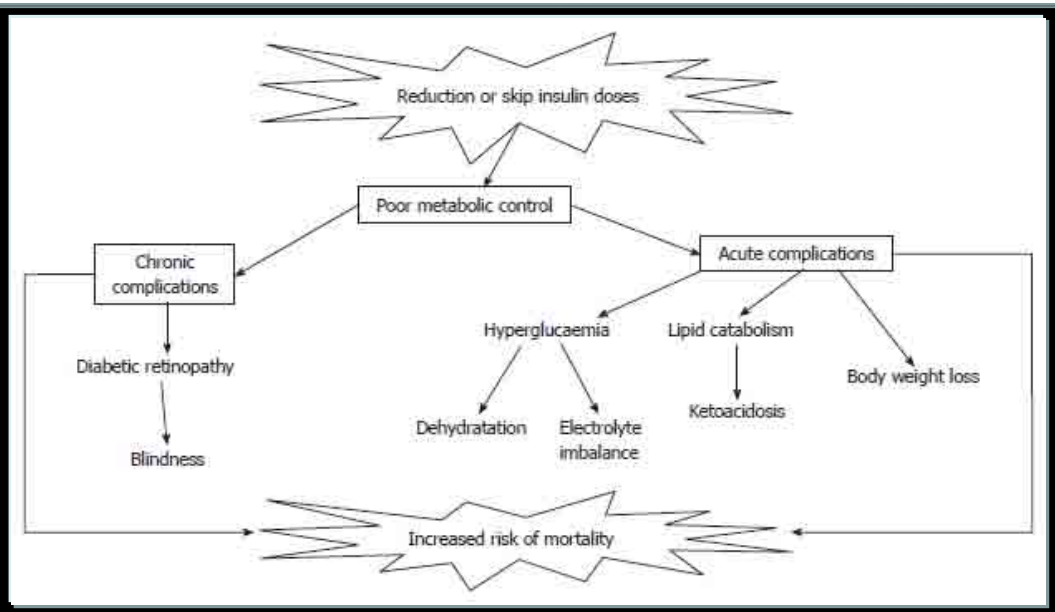


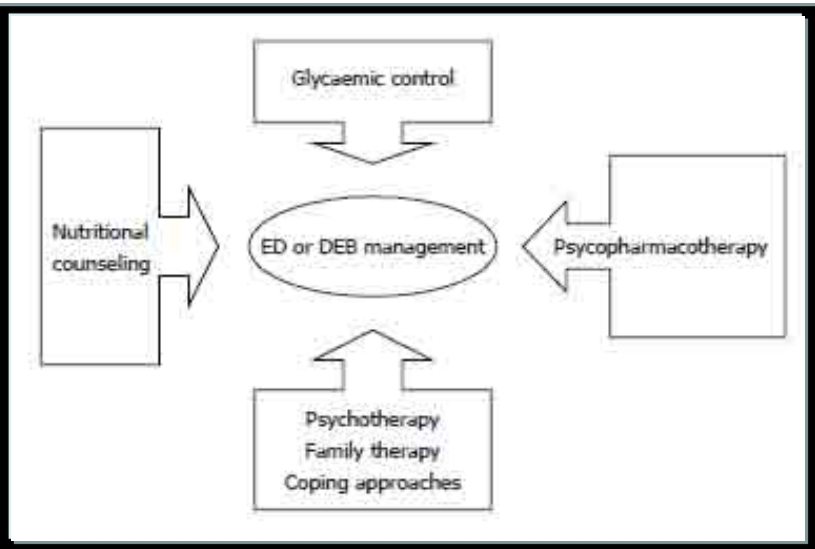


We conclude that anorexic girls with depression are at higher risk of low BMD than those without depression.

Konstantynowicz J et al, *J Clin Endocrinol Metab*, 90: 296-301, 2005

Disordered eating behaviors in type 1 diabetic patients





Larranaga A et al, World J Diabetes, 2: 189-195, 2011

Disordered eating behaviors in type 1 diabetic patients

Table 1 Prevention of eating disorders or disordered eating behaviors in type 1 diabetics

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

Larranaga A et al, World J Diabetes, 2: 189-195, 2011

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THERAPEUTIC WAY AND CHOOSE OF THE SETTING

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

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NUTRITIONAL EVALUTATION AND REHABILITATION

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 (albuminema, ecc.) and instrumental examinations addressed to evaluate body cell mass and hydration (by bioimpedance) and resting metabolism (indirect calorimetry)

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NUTRITIONAL EVALUTATION AND REHABILITATION

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)obession for the food and the body shape,
d)fasting,
e)insufficient assumption of liquids

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The consulting of clinical nutritionits and experts in ED is requested for life-saving measures performed in Departments of Internal Medicine and/or Intensive Therapy (for example: refeeding syndrome)

Enteral Nutrition for Feeding Severely Underfed Patients with Anorexia Nervosa

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

PSYCHOTERAPEUTIC INTERVENTION

Psychoterapy should be supplied by specialized professionals in ED, taking into account the age of the patients

Different kind of psychoterapies used in the ambulatory treatment, such as cognitive-analytical therapy, cognitive-behavior therapy, interpersonal psychoterapy, focal psychodinamic therapy and familial interventions addressed to the eating diseases have been shown to be efficient.

The choise of the kind of psychoterapy shoud 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 tratments 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

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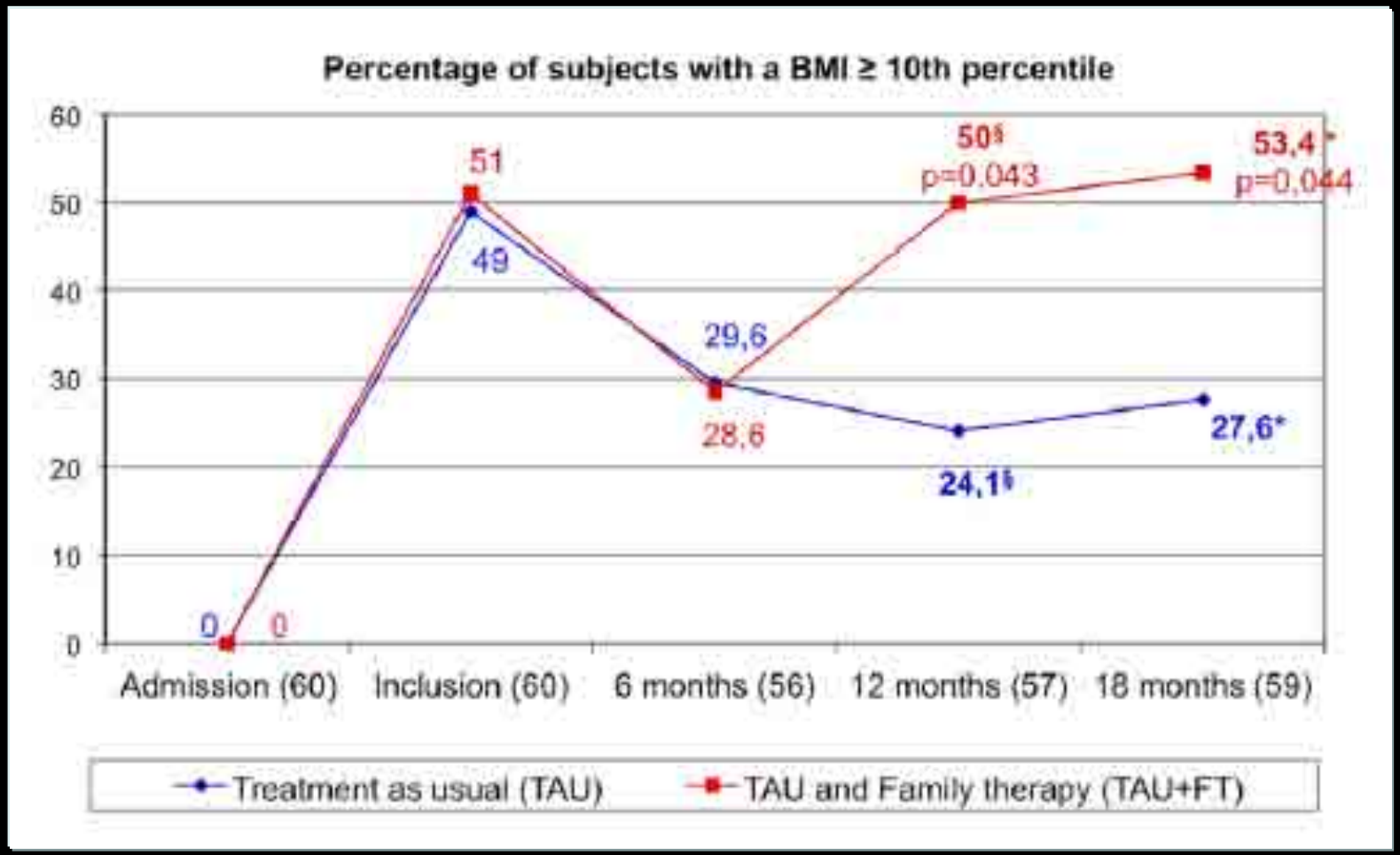

Godart N et al, *Plos One*, 2012

Anorexia nervosa

Bari,
7-10 novembre 2013

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 skilfully 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

Morris J e Twaddle S, BMJ, 334: 894-898, 2007

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 psychopharmacologyc 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-REHABILTATION INTERVENTIONS

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RECCOMENDATIONS

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

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

. **second level** : Specialistic ambulatory services in interdisciplinar network, including psychological-psychiatric/child neuropsichiatric 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

RECCOMENDATIONS

. **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 adolecent or the pre-adolescent from the family

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	BREVE TERMINE (4–8 settimane)	MEDIO TERMINE (3–6 mesi)	LUNGO TERMINE (6–12 mesi)
AN	arresto perdita di peso corporeo; interruzione del digiuno/ assestamento; interruzione del semidigiuno; interruzione uso diuretici/ lassativi/iperattività; interruzione condotte dispomaniche.	recupero del peso corporeo; riequilibrio pattern nutrizionale; ripristino percezioni sensoriali di fame e sazietà.	recupero del "set point"; normalizzazione composizione corporea; adeguato pattern alimentare (aumento variabilità tipologia cibi assunti e loro quantità).

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OBIETTIVI:	BREVE TERMINE	MEDIO TERMINE	LUNGO TERMINE
MEDICI	Stabilizzazione delle condizioni cliniche e dei parametri vitali; Gestione della comobilità psichiatrica.		Stabilizzazione delle condizioni generali; Recupero del peso naturale; Non utilizzazione di sintomi di controllo e discontrollo.
PSICOLOGICI	Lavoro sulla motivazione con il fine di acquisire una consapevolezza di malattia con l'aumento della collaborazione al trattamento.	Ristrutturazione cognitiva; Aumento della consapevolezza di malattia e aumento capacità insight; Attenuazione distorsioni cognitive e disturbo percezione immagine orporea(riconoscimento e disidentificazione DAI sintomi) ; Miglioramento relazioni familiari	Miglioramento delle condizioni generali nel tono dell'umore e nella dispercezione; Recupero della funzionalità sociale, lavorativa e scolastica.
NUTRIZIONALI	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	Consolidamento della autonomia nella gestione del pasto e dei comportamenti disfunzionali; Miglioramento della alterazione dell'immagine corporea e delle dispercezioni.	Autonomia nella gestione della alimentazione a domicilio ; Acquisizione di competenze nutrizionale della paziente e della sua famiglia; Diminuzione del conflitto con la famiglia in merito al cibo.

The End