TAKE HOME MESSAGES

Bari,
7-10 novembre 2013

An early approach to nervous anorexia

- Early diagnosis: when to raise the suspicion?
- Endocrine consequences
- Endocrinologist, psychiatrist and nutritionist: a complex game

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IN SYNTHESIS…

- DCA are serious diseases, dangerous and difficult to treat.
  They are disorders having psychological and biological complexity.

- **Psychological complexity:**
  frequent transitions between different nosographic situations Polymorphism: frequent psychiatric comorbidity (impulsive, obsessive, hysterical, depressive and schizoid spectrum)

- **Biological complexity**
  frequent impairment of various districts of the body (cardiovascular, bone, gastrointestinal, endocrine, gynecological and neuropsychological)

Transdiagnostic Approach inside ED (Fairburn 2003)

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Anoressia Nervosa	DCA NAS	Bulimia Nervosa	DCA NAS DAI

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Area Borderline
ADHD

Spettro
Ossessivo
Compulsivo

Ansia
Fobia Sociale

Spettro
Dipendenze

Obesità

Anoress
Nervosa

DCA NAS

Bulimia
Nervosa

DCA NAS
DAI

Spettro
Cluster A

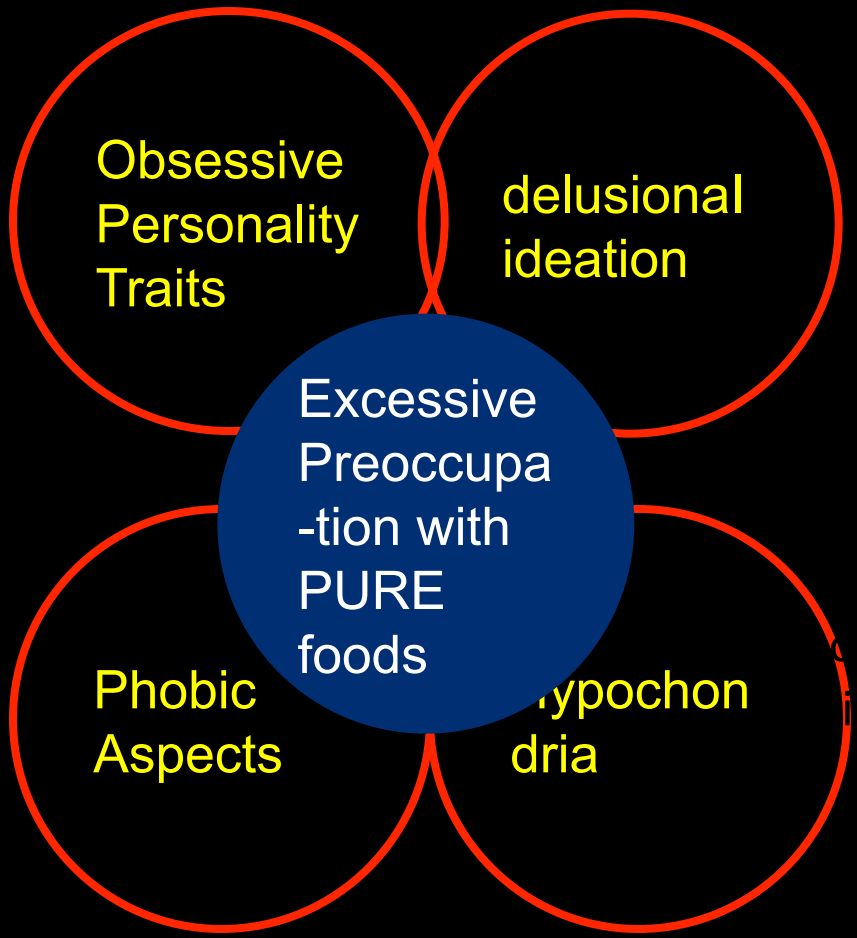
Disturbi Affettivi

Spettro
Bipolare

Approccio transdiagnostico all'interno dei disturbi psichiatrici

(Hollander et al 2007, Hudson & Pope 2007, Strober et al 2007, Palister & Waller 2007)

Ortoressia

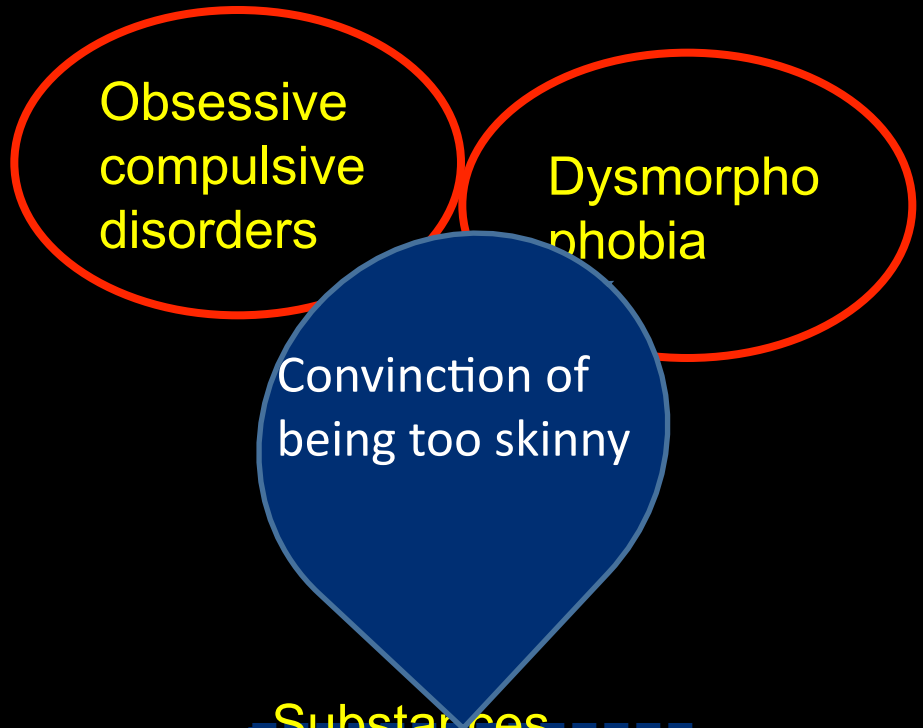


Maggior interessamento del Sesso maschile (Donnini,2004)

Bigoressia

5 % BodyBuilders (Pope,1997)

Maggior Interessamento del Sesso Maschile (Lindstrom,1990)



Criticality

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- Few epidemiological studies
- Lack of homogeneity of diagnostic criteria – for all ED, in particular for EDNOS

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Early Identification

APA 2006

ONSET of SYMPTOMS → HIGHLY STRUCTURED TREATMENT

YOUNG PATIENTS WITH BODY WEIGHT < 85% have many difficulties to regain weight in therapeutic and assistential non structured programs.

RISKS:

- **Irreversible deficit of cerebral gray matter;**
- **Irreversible deficit of growth and sexual development;**
- **Increase of resistance to treatment**
- **Appetite dysregulation**

(Russell et al 1987; Eisler et al 1997; NICE, 2004; APA, 2006; Van Holle et al 2008)

Comorbidity, mortality and outcome of ANOREXIA NERVOSA

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Psychiatric Comorbidity lifetime

Anxiety Disorders
>50%

Personality Disorders
40%

DOC e DPOC
16 – 35%

Depressive Disorder
51 – 84%

Mortality

Whole for AN
4% *(Crow et al.2009)*

SMR suicide 31*(Preti 2011)*

Cause mediche 52%

SMR all causes
1,70 *(all'interno del campione)* e 6,7 per AN *(Papadopoulos 2009)*

Outcome (5 years)

Clinical recovery
66,8% *(Keski-Rahkonen 2007)*

Persistence of AN 6 – 10%

Conversion to BN 22% DCANAS 14%

Outcome of eating disorders: a sistematic review of the literature Int J Eat Dis, 2007

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- A disease primarily psychiatric in origin
- A key feature is chronic starvation
- Profound neuroendocrine dysregulation
- Hypogonadism
- A relative growth hormone resistance
- Hypercortisolemia
- An appetite hormone dysregulation (pathophysiological or compensatory)
- The primary therapy for anorexia remains psychiatric
- Therapies directed at specific complications has a particular focus of research

Miller KK 2013.

PLEASURE and PAIN

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- The stimulation of the areas of Lymbic system, related to pleasure, occurs through the Dopamine (DA).
  Everyone orients his attitude, according to the desires.
  The DA has a crucial role in the pleasurable sensations related to the fulfillment of a desire; reinforcement of circuits related to "want". To increase the feeling of "pleasure", you want more: mechanism of Addictions.
  FOOD, where takes on the meaning of "award", it becomes a drug.

Maintenance Factors

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Schmidt U, Treasure J. ***Anorexia Nervosa: Valued and Visible. A Cognitive-Interpersonal Maintenance Model and its Implications for Research and Practice****. Br.J.Clin.Psychol. 2006;45:1-25.*

THERAPY

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In the treatment of eating disorders different professionals and theoretical models should be involved

organic failure **psychic failure**

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Goals of treatment

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- Recovery of physiological body weight
- Functional food and dietary behaviors appropriate to different social situations
- Defining a realistic treatment plan with the right combination of medical treatment, psychological and pharmacological
- Increase awareness of family
- Relapse prevention through continuous treatment

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WORKING Multiprofessional Group

- It is necessary to set up a working group composed by various professionals who work from the beginning within a shared therapeutic project, verified by weekly team meetings and daily briefings.

The intervention protocols are subjected to continuous auditing and monitoring in connection with similar experiences already present in Italy.

All staff are inserted into a path of continuing education characterized by internal teams and external supervision.

MODIFICATION of INTENSITY of CARE

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- CONTINUITY 'OF CARE;
  Changing therapeutic team
  and Increase or Decrease the therapeutic intensity
  could be destabilizing
- THE TRANSITION PLAN
- MEETINGS WITH THE MEMBERS OF THE NEW TEAM:
- the ability of the patient to continue the path in a different welfare regime, with a new team that he knows and trusts contributes to the success of "projects of cure"
- IDENTIFY THE REFERENCE who coordinate ACTIONS:
  he plans the transition and brings attention of the care team to the salient features;

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

different assistance levels

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- Different assistance levels are necessary (Day hospital, Residential Treatment, Hospital for acute situations, Outpatient Ambulatory)
- It is necessary that they are all available and cohordinate each other.
- Outpatient Ambulatory remains the first step and it may have connection with all other treatment levels when a more intensive therapy would be necessary. The rehabilitation is not necessarily in the hospital (ambulatory,DH, Residence)

CARACTERISTICS OF TREATMENT

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- MULTIFOCAL
  - *Medical – psychoterapeutic management, rehabilitation, psychopharmacologic therapy*
- INTERDISCIPLINAR
  - *psychiatric, psychologist, dietist , endocrinologist, rehabilitation therapist, nurse ,..etc*
- MULTIPLE ASSISTENTIAL LEVELS

  Residential, Hospital , Ambulatory, Day-hospital….

Evidence and appropriateness

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Among 10 International Guide Lines, **4** are **selected (multidisciplinary panel, reccomandation grading, methodology of literature systematic research, presence of patient associations)**

- **NICE 2004 - AIAQS 2008 - APA 2006 - RANZCP 2004**
- **Consensus Conference ISS Ottobre 2012**
- **Linee Guida Regione Umbria- Luglio 2013**

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They can heal!!!