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TREATMENT STRATEGY IN SCHIZOPHRENIA COMBINED WITH EATING DISORDER

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SUMMARY

Like any other patient, a schizophrenic patient can get a physical illness, too. As such patients tend to ignore reality and neglect themselves and are stigmatized by society, due to which their physical symptomatology is often ignored, physical illness can remain undetected. If the schizophrenic patient is observed and adequate care is provided by the family, family doctor and a psychiatrist, it is possible to recognize the physical illness and intervene promptly.

We are presenting a case of a female patient who has been treated for schizophrenia for a number of years. The treatment was mostly ambulatory (i.e. the patient was hospitalized twice) and consisted of first-generation antipsychotics. During the past two years, for reasons unknown, the patient stopped taking regular meals and as a result lost significant body weight, became apathetic and withdrawn, started avoiding social contacts and neglected personal hygiene. She reportedly took the psychopharmaca regularly, but rarely attended psychiatric follow-up consultations. Due to substantial weight loss and hypotonia, correction of antipsychotic was made and internist treatment administered. The choice of olanzapine was not an accidental one. We decided to take advantage of its side effect for the treatment of an anorectic syndrome. Interdisciplinary cooperation proved to be a justified decision.

Key words: *schizophrenia - eating disorder - olanzapine*

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INTRODUCTION

Schizophrenia is a mental illness that can occur as early as adolescence or in young adulthood. The illness is characterised by distinctive psychopathology. Schizophrenic patients are oriented towards their inner world where delusional events prevail, thus making them apathetic towards the reality they tend to isolate themselves from. Clinical manifestations of the illness, as well as its types can vary. However, in a psychopathological sense, their common features are thought and affective disorder and failure to function adequately.

Etiology of illness is multifactorial. Despite the fact that scientists and psychiatrists have been pursuing a single goal, their efforts in curing the disease have been fruitless. The illness is chronic in its nature.

The objective in the treatment of schizophrenic patients is to lower the number of hospitalizations (relapses) and obtain a stable and long-term remission in which patients can function well in society within their own limits or, in other words, to live a healthy lifestyle in spite of the mental illness.

The basis for the treatment of schizophrenia is psychopharmaca, i.e. antipsychotics. First-generation antipsychotics (typical antipsychotics) have a beneficial effect on illness symptoms, but due to the profile of side effects (motion disorders) they are less frequent in treatment today. Advances in the pharmacology and clinical tests have resulted in new generation antipsychotics (atypical antipsychotics) that have their advantages in comparison to typical antipsychotics (i.e. milder profile of side effects, straightforward use, possibility to use one daily dose etc.).

New generation antipsychotics can also cause serious side effects (Uzun et al. 2005, Hotujac et al. 2002). Increased body weight, metabolic, endocrine, sexual and cardiovascular are the most common side effects. Some of them can be used in favour of the patient, as was the case of the patient with the increased body weight (Barbarich et al. 2004).

Eating disorders are diagnosed according to the valid DSM IV criteria and include three diagnostic categories: anorexia nervosa, bulimia nervosa, and eating disorder unspecified.

Taking into consideration the diagnostic criteria, as well as the findings on anorexia nervosa, the disorder appears in the adolescence, although uncured cases can be diagnosed later.

Eating disorder (anorexia) can occur as a symptom of another physical or mental disorder. In that case we talk about anorexic symptom (syndrome).

The most common comorbidity with anorexia nervosa among mental disorders are obsessive compulsive disorder, posttraumatic stress disorder, major depressive disorder, specific personality disorders, and schizophrenia (Cinemre & Kulaksizoğlu 2007, Folnegović-Šmalc 2004).

Anorexic syndrome among schizophrenic patients can be a manifestation of a psychotic or depressive decompensation. Due to paranoid delusions the patient can believe that their food or drink is being poisoned or

that the food is contaminated and therefore refuses to eat it. Apart from poor appetite, the depressive shift in schizophrenia can also lead to body weight loss, along with the associated depressive symptoms. Reduced food intake inevitably leads to body weight reduction, which in some cases can be drastic.

CASE REPORT

38-year-old female patient has been receiving psychiatric treatment for 16 years. Mental illness was diagnosed during two (and the only) hospitalizations in the ages of 22 and 27, respectively. She did not continue education after graduating from high school. She has never been married, lives with her parents, and has never been employed.

Following the last hospitalization the patient attended regular ambulatory psychiatric treatment and took her medications regularly (i.e. promazine 300 mg/day, clozapine 75 mg/day). In the past 2 years, she occasionally refused food, stating she had no appetite or that she was feeling tired, with the prevailing negative symptomatology of schizophrenia. She became sloppy in personal hygiene; verbal contacts with the members of her family were reduced to a minimum, and she isolated herself from society. Paranoid interpretations of reality and occasional auditory hallucinations intensified. The psychiatrist she was seeing at the time was not ready to change the psychopharmaca, so the patient's mother decided to visit another therapist.

In May 2010, the patient arrived to a psychiatric appointment accompanied by her mother. Upon arrival she was actively negativistic, appeared under the influence of auditory hallucinations, despite the combination of psychopharmaca she was taking for years (as stated previously). Mother reported her refusing food, which resulted in body weight loss. Her mobility was severely limited due to physical weakness and exhaustion.

Apart from the evident psychiatric symptoms (based on psychiatric assessment and mother's information), anorexic syndrome was suspected. Mother reported that the patient used to weigh 75 kg. Upon measuring, her body weight was 43 kg and her height 172 cm. Since the mother was faced with a severe physical condition of the patient and the potential risks, she agreed to do the internist tests. Former antipsychotic therapy (i.e. promazine, clozapine) are gradually stopped and olanzapine was (2.5 mg/evening) was introduced, along with paroxetine 20 mg and vitamin B.

Internist tests diagnosed sideropenic anemia and anorexic syndrome. Hypercaloric diet and iron supplement were added to the therapy.

Two months later (July 2010), the patient attended the psychiatric follow-up consultations accompanied by her mother. The communication was non-verbal. She was taking her psychiatric and internist regularly, which resulted in the body weight gain (+ 4 kg). Mother reported that the patient started taking care of her hygiene. Social contacts were still limited and the mood reduced. Mother also reported on the improved physical activity (the patient was motivated to move around the house).

Correction of antipsychotics dose was suggested for a period of 15 days, up to a daily dose (7.5 mg in the evening).

October 2010 saw verbal contact with the patient. Psychopathology (delusions and hallucinations) were absent. Further weight gain was reported (+5 kg) and the patient self-initiated going out of the house. She took her medication regularly. Olanzapine 10 mg in the evening was suggested.

In December 2010, the patient reported that according to the internist there was no need for the high energy diet, thanks to the satisfactory body weight gain (56 kg). Sideropenic anemia was improving, but was not completely cured. The patient was much calmer in contact, more cooperative, contact was established, and she adequately replied to questions asked. She did not project typical symptomatology.

DISCUSSION

Personality observation in psychiatry is specific when compared to other medical profession. A psychiatrist observes a patient as a whole and does not separate body from the soul, as they present unity. The soul-body relationship is all about balance - mental disorders can affect the physical status and vice versa.

Schizophrenia is a specific mental illness in its distinctive symptoms and in its course. Apart from illness relapse in terms of acutisation of the symptoms, a mood disorder can be manifested as a depressive shift with symptomatology similar to a major depressive episode.

When we speak about comorbidity, more often than not another illness or a disorder can be associated to schizophrenia. Given the specifics of schizophrenic patients who do not pay attention to their body or health, patient observation by the psychiatrist and the patient's family is of great importance.

It is necessary to be familiar with the differential diagnostics, to judge well and to combine it with the diagnostic criteria. Eating disorder of the schizophrenic patient was evident in the reported case. Loss of appetite, avoiding food, severe weight loss could have pointed out to anorexia. Psychopathology did not meet the diagnostic criteria for anorexia. Age of the patient in which the symptoms appeared did not suit the common age for anorexia to appear, which made us reluctant to make such diagnosis. Isolated symptoms indicated anorexic syndrome which was verified by the internist.

Given the fact that the patient diagnosed with schizophrenia showed a severe body weight loss, olanzapine proved to be a medication of choice (Dunican & DelDotto 2007, Jensen & Mejlhede 2000).

On the one hand, its indication for treatment of psychotic symptoms was justified. On the other hand, we used its well-known side effect of increasing body weight (Dadiæ-Hero et al. 2009). The patient's low body weight within the anorexic syndrome demanded a slow and careful titration of olanzapine.

Any medication can cause side effects that pose a problem in a treatment, for both the patient and the psychiatrist. Knowing the psychopharmaca side effects is of great importance for a successful treatment. Although side effects often bear negative connotations, an experienced clinician can take advantage of those in a treatment (Powers et al. 2002).

CONCLUSION

Each medication poses a potential risk of side effects. However, some side effects can be used for therapeutic purposes. Olanzapine has proven to be an efficient antipsychotic in treatment of a schizophrenic patient, and its side effect proved beneficial to the anorexic syndrome. Physical status of the patient dictated a slower titration of the medication. Comorbidity of the physical illnesses and schizophrenia is a mitigating factor in treatment of a mental patient. Interdisciplinary cooperation proved justified and resulted in a positive outcome in treatment of schizophrenia and anorexic syndrome.

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