By Miriam E. Tucker

VIENNA — A new joint position statement from three European medical organizations is aimed at reducing cardiovascular disease risk and improving diabetes care in people with severe mental illness, as well as improving their overall health and well-being.

The statement is from the European Psychiatric Association and supported by the European Association for the Study of Diabetes (EASD) and the European Society of Cardiology (www.em-consulte.com/article/223719). It was discussed at a press briefing held during the EASD’s annual meeting.

People with severe mental illnesses (SMI), including schizophrenia, depression, and bipolar disorder, have worse physical health and reduced life expectancy compared with the general population. Data suggest that they die young: It’s also much harder for these individuals to access health care services, statement co-author Dr. Richard Holt said at the briefing.

People with SMI are more likely to be overweight, to smoke, and to have diabetes, hypertension, and other metabolic and cardiovascular diseases.

“Of all the risk factors,” Richard Holt said at the briefing, “the most manageable one is obesity.”

“Managing obesity and other metabolic diseases is likely to have a bigger impact,” Holt said.

In addition, people with severe mental illness are more likely to have higher lipids and blood pressure, and to then come together with a strategy to treat them.”

“Putting together this statement, the three organizations have developed pragmatic guidelines,” he said. “Clearly, this is a collaborative effort.”

The document, for which the lead author was Dr. Marc De Hert of University Psychiatric Centre, Catholic University, Leuven, Belgium, urges coordinated CVD risk assessment and management for this population, and names psychiatrists as often being the best placed to lead the health care team that ideally includes shared care arrangements between general and specialist health care services.

Establishing baseline CVD risk at initial presentation is advised, and recommendations are given for assessment of medical history and examination of all CVD risk factors, including lipids, glucose, smoking habit, and blood pressure. Electrocardiogram also is recommended. Monitoring should be carried out at regular intervals, depending on the patient’s individual risk level. Weight should be closely monitored in patients taking psychotropic medications to determine their adverse effects. Psychiatric centers and diabetes centers should cooperate in the care of patients with SMI and diabetes.

A diabetes nurse-educator also should be involved in the care of those on insulin. The document also outlines management of blood lipids and blood pressure, along with smoking cessation counseling.

The choice of psychotropic medications should take into account the potential effects of the agent on CVD risk factors, particularly in overweight or obese patients. A dilemma may arise with clozapine, which is recommended by many guidelines as the antipsychotic of choice for patients with refractory schizophrenia, but it also is associated with the highest risk of weight gain and related CVD risk factors, the document says.

In the United States, a similar set of recommendations from the American Psychiatric Association, the American Diabetes Association, the American Association of Clinical Endocrinologists, and the North American Association for the Study of Obesity was issued in 2004 (Diabetes Care 2004;27:596-61). In addition, the National Association of State Mental Health Program Directors (NASMHPD) issued similar recommendations in 2006 and 2008 that are available at www.nasmhpd.org. The NASMHPD guidelines also focus on the establishment of systems of care for people with SMI at the national and state levels.

In an interview, Dr. Joe Parks, lead author of the NASMHPD papers, said the problem in the United States is that it’s often not clear who is responsible for ensuring that evidence-based standards of care are provided.

“Are the recommendations the responsibility of the individual health care provider? Or the local health care organizations such as hospitals and clinics? Or the payers such as private insurers and Medicaid? Because of this lack of accountability, implementation has been fragmented and spotty,” said Dr. Parks, medical director for the Missouri Department of Mental Health, Jefferson City.

“Some U.S. states have made progress. The New York State Department of Mental Health, for example, has implemented tracking of obesity and blood pressure in its state-operated hospitals and clinics. In Missouri, the Department of Mental Health has just begun to require and fund annual screening and some interventions for obesity, blood pressure, diabetes, cholesterol, and weight management programs serving people with mental illness for both Medicaid covered individuals and the uninsured.

Several private insurers encourage and attempt to incentivize clinics and individual providers to follow these recommendations, but Dr. Parks said he is unaware of any that actually require compliance.

“I don’t know of any health care entity anywhere that delivers on all of either the American or European recommendations,” Dr. Parks said. “If we want to see widespread adoption of these kind of evidence-based standards of care, then the payers need to require it in their contracts, pay more when evidence-based standards of care are followed, and pay less when they are not. Within our current system if you really want something to happen routinely and systematically throughout the health care delivery system, there must be either a legal requirement or financial incentives. Everything else is just wishful thinking.”

Screening for Restless Legs Syndrome Warranted in IBS

By Patrice Wendling

CHICAGO — Screening patients with irritable bowel syndrome for restless legs syndrome may lead to greater identification of RLS and improved treatment for both conditions.

In a single, community-based gastroenterology center, 20% of patients with irritable bowel syndrome (IBS) based on Rome III criteria were also diagnosed with RLS. The prevalence of RLS in the general population is 1%-10%.

All patients with both IBS and RLS had alterations in the initiation and maintenance of sleep, lead author Dr. Patrick Basu and his associates reported in a poster at a meeting on neurogastroenterology and motility. Voluntary jerks and wakefulness during more than 30% of sleep time occurred in 75% and 63% of patients, respectively. The mean age of the cohort was 33 years; 60 were female, 38 were Hispanic, 26 white, 24 Asian, and 2 black.

Of the 26 patients with RLS, 62% had diarrhea-predominant IBS, 4% had constipation-predominant IBS, and 33% had mixed IBS, suggesting the specific pathophysiology of diarrhea-predominant IBS may contribute to or relate to RLS.

Previous research has identified a link between small intestinal bacterial overgrowth, which may contribute to IBS, and several sensory disorders including fibromyalgia, interstitial cystitis, and RLS.

“Diagnosis of simultaneous IBS and RLS may provide enhanced therapeutic efficacy for these patients, as some medications [that is, laxatives] may contribute to or relate to RLS,” wrote Dr. Basu, director of gastroenterology, North Shore–Long Island Jewish Health System at Forest Hills, N.Y., and his associates.

Although the data were not included in the analysis, 19 of the 26 IBS patients with RLS were treated with the antibiotic rifaximin, with 9 reporting relief of both conditions, he said. Basu noted that screening IBS patients with RLS is important because the vast majority of RLS patients are treated with antibiotics, but several sensory disorders including RLS may naturally relate to each other.

“Unfortunately, many patients don’t realize there may be an underlying cause,” he said.

Dr. Basu and his associates noted that previous research has identified a link between IBS and RLS. RLS is a movement disorder of unknown cause characterized by abnormal sensations that may be triggered by the cold, by fatigue, or at night. Patients experience improved symptoms when they rest their limb. RLS symptoms are common in patients with IBS, as well as those with irritable bowel syndrome and Crohn’s disease.

“Even with a positive RLS in a patient who has IBS, it is not clear what the relationship is,” Basu said.

Dr. Basu and associates reported no conflicts of interest. Support for preparation of the poster was provided by Salix Pharmaceuticals, which markets rifaximin as Xifaxan.