Guidance on the use of atypical antipsychotics as an adjunct to the treatment of anorexia nervosa in adults and young people

Background

To date there is no strong evidence of beneficial effects of antipsychotic use in adults and adolescents with eating disorders.

Side effects of antipsychotic drugs are more common in adolescents and include sedation and dyslipidaemia *(Norris et al 2011)*.

Despite this there is recognition that specialists prescribe regularly on empirical grounds for symptomatic treatment *(Gowers et al 2010)*.

This is usually in young people with more severe illness and with co morbidities, often in inpatient settings.

Which patients should be offered treatment?

Given the lack of robust evidence, the use of atypical antipsychotic medication should be on a patient specific basis, i.e. it is anticipated that the majority of patients would **not** require such medication. Atypical antipsychotics should very much be regarded as an **adjunct** to the holistic treatment available on the ward. The circumstances in which atypical antipsychotics might be used could include (not an exclusive list of examples):

- Those patients with highly distressing and persistent “anorexic” ruminations not amenable to psychological interventions
- Those patients who are agitated by these ruminations and for whom this is a hindrance to utilising the interventions (nursing, psychological, OT etc) available on the ward (Birch and Evergreen)
- Those patients whose ruminations are such that they are driven to self harm as a consequence

When should treatment be offered?

Treatment should be offered after full assessment of the Eating Disorder and of any co morbid conditions. Psychological approaches should be the first line intervention, alongside the therapeutic milieu of the ward.

How long should treatment be continued for?

This should be patient specific. The underlying principal should be to treat with as low an effective dose for as short a time as possible. From local (albeit limited) experience,

patients seem to benefit most in the early stages of their treatment, when the anorexic cognitions are first being challenged with the reality of consistent weight gain. It might be predicted that this may last for several months.

What are the reviewing and monitoring arrangements?

All patients should have baseline physical observations, ECG and bloods. Patients should be reviewed by the multi-disciplinary team twice weekly. On-going physical monitoring is dependent on weight (using a red, amber, green zone system – red being the patients at lowest weight). Each zone has a different protocol with regard to blood testing, BP, pulse, temperature monitoring. For example, patients in the red zone - who have progressed beyond the very early re-feeding stage - should have their bloods taken twice a week, and physical observations done four times a day. ECGs are performed on admission. Psychiatric review is usually at least weekly.

Which drug(s) should be prescribed and at what dose?

Most clinical evidence and experience supports the use of low dose **olanzapine** – the guiding principle should be to start at a low dose and increase slowly according to response and side effects. A typical starting dose would be 2.5 mg daily and should rarely need to be titrated to above 5 mg daily.

Quetiapine is also approved by the Trust as an alternative to olanzapine – in adolescents at a starting dose of 25 mg twice daily, up to a maximum of 50 mg twice daily; in adults up to 300 mg daily.

Both olanzapine and quetiapine are <u>unlicensed</u> for this indication

References

Olanzapine use for the adjunctive treatment of adolescents with anorexia nervosa
Citation: Journal of Child and Adolescent Psychopharmacology, June 2011, vol./is. 21/3 (213-220), 1044-5463; 1557-8992 (01 Jun 2011)
Author(s): Norris M.L.; Spettigue W.; Buchholz A.; Henderson K.A.; Gomez R.; Maras D.; Gaboury I.; Ni A.

Drug prescribing in child and adolescent eating disorder services
Citation: Child and Adolescent Mental Health, February 2010, vol./is. 15/1(18-22), 1475-357X;1475-3588 (February 2010)
Author(s): Gowers S.; Claxton M.; Rowlands L.; Inbasagaran A.; Wood D.; Yi I.; Hugo P.; Clark-Stone S.; Bryant-Waugh R.; Nicholls D.; Ayton A.

Dr. Sarah Bartlett
Dr. Jo Etherington
The Evergreen Centre, West Lane Hospital

Dr. Melanie Temple
Dr. Ali Abdelmoniem
Birch Ward, WPH