Palliative Care in Severe-Enduring Anorexia Nervosa: A New Paradigm

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Background

Psychiatrists collaborate closely with palliative care specialists in the management of life-limiting medical illness, but such services are rarely offered to patients suffering from severe, persistent mental illness.3 Anorexia nervosa boasts the highest mortality rate of any mental illness, and 20% of cases constitute severe-enduring anorexia nervosa (SE-AN), a treatment refractory illness with high rates of morbidity and mortality.1

Discussion

Approximately 20% of cases of anorexia nervosa represent SE-AN, the most severe subtype.[1] Such individuals oftentimes face a myriad of medical complications from an unrelenting disease, are underemployed, and perceive themselves as burdensome to caregivers and social supports.[1, 2] Many have undergone aggressive therapy that has impeded their quality of life, threatened individual autonomy, and done little to mitigate the trajectory of their illness.[3] Without the option to pursue palliative care, which can be delivered alongside curative or rehabilitative treatments, the only therapies available to such individuals are those that have previously proved unhelpful.[4] Similar to patients suffering from life-limiting medical illness, those suffering from SE-AN deserve the right to compassionate care that validates their experience with this highly burdensome disease. Ideally, this modality of care should honor patient's individual autonomy and outline clearly defined goals to guide further clinical care.[4, 1]

Conclusion

SE-AN is a life limiting and burdensome illness with high rates of relapse and significant medical and psychiatric comorbidities. Individuals who suffer from this disorder deserve the right to palliative care services to maximize individual autonomy, mitigate physical and psychological suffering, and enhance their quality of life.

Case #1

Ms. J is a 43-year-old female with past psychiatric history of OCD, MDD, and anorexia nervosa admitted for recurrent hypoglycemic episodes secondary to malnutrition. She was ultimately transitioned to hospice care after repeated hospitalizations aimed at medical stabilization proved futile.

Case #2

Ms. M is a 73-year-old female with past psychiatric history of OCD, MDD, and anorexia nervosa admitted for chronic malnutrition complicated by pelvic fracture. Past psychotherapeutic and pharmacologic treatments – as well as more aggressive strategies such as gamma-knife capsulotomy and ECT – have proved unsuccessful. At her request, she was ultimately trialed on ultra low-dose Zyprexa to improve appetite, facilitate weight gain, and enhance cognitive flexibility.

Medication	Maximum Dose	Years Trialed	Side Effects
Luvox	50 mg daily	Oct 1995-Jan 1996	Apathy, metal taste, N/V/D, decreased energy, tachycardia, restlessness, exhaustion
Anafranil	25 mg daily	February 1996	N/V/D, swollen lower extremities, water retention, detachment, bad taste
Wellbutrin	100 mg daily	1996-1998	Headache, insomnia, N/V/D, cognitive decline, worsening mood
Zoloft	50 mg daily	Mar-Oct 1998	Lower extremity "tightness", rash, headache, N/V/D, emotional detachment, lethargy
Paxil	5 mg daily	Sep 1998-Dec 1998	
Prozac	20 mg daily	Jan-Mar 2000	N/V/D, headache, bad taste, increased appetite/binge eating
Trazodone	--	Jan-Apr 2000	Headache, metal taste, lethargy worsened mood symptoms, GI upset
Topamax	--	Jan-May 2001	--
Celexa	20 mg daily	Nov 2001-Jan 2002	Night sweats, sedation, headache, lethargy, N/V/D, bad taste

References

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