IMPACT OF PSYCHOFARMACOLOGY ON THE FREQUENCY OF METABOLIC SYNDROME IN PATIENTS WITH SCHIZOPHRENIA

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Most patients with schizophrenia regularly used medications and it is difficult to disengage metabolic abnormalities which are related to disease, from those that may have been caused by medication. Results of previous studies showed that the frequency of obesity among patients with schizophrenia, 1.5 to 2 times higher than in the general population. Tendency to increase body weight and frequency of abdominal obesity was present among patients with schizophrenia, particularly in women, before the appearance of a so-called atypical antipsychotics (especially olanzapine and clozapine) in a much larger extent than with low-potency conventional antipsychotics such as chlorpromazine. Many so-called atypical antipsychotics II and III generation are related to the increase in body weight, especially with the development of central obesity, which has an adverse effect on health and patient cooperation. Other research has shown that patients with schizophrenia who did not use drugs or they were used it in smaller quantities had almost three times larger amount of intra-abdominal fat compared to the control group, and that patients with schizophrenia might have metabolic abnormalities associated with metabolic syndrome even before they start antipsychotic treatment.

The aim of our study was to determine the impact of individual psychopharmacs to increase body weight, increase in BMI, abdominal obesity and the frequency of metabolic syndrome in patients with schizophrenia.

Patients with schizophrenia in Clinical Hospital Mostar (n=205). We studied prospectively. Measurements were made at the beginning of treatment and after six months. Increase in body weight was more often appeared in patients who were treated with clozapine (66.7%) and olanzapine (60.4%) (p=0.303), as the value of BMI (clozapine 66.7%) and (olanzapine 58.3%). Abdominal obesity has a statistically significant increase in patients who were treated with clozapine (69.2%) and olanzapine (62.5%), unlike in patients who are treated with haloperidol (30%), fluphenazine (37.1%) and risperidone (39.5%) (p=0.001). Metabolic syndrome was more often appeared in patients who are treated with clozapine (64.1%) and olanzapine (60.4%) (p=0.002).

With long-term use of psychofarmacs, each psychiatrist should routinely determine if there was metabolic syndrome and its individual components and then recommend a medication with a suitable metabolic profile.

CONTROVERSIES RELATED TO NEUROLEPTIC MALIGNANT SYNDROME

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Neuroleptic malignant syndrome (NMS) is an uncommon but one of the most serious and lifethreatening side effects produced by antipsychotic medications. The syndrome is characterized by severe rigidity, tremor, fever, altered mental status, autonomic dysfunction, and elevated serum creatinine phosphokinase and white blood cell count.

The literature on NMS is rather extensive, but many aspects related to the syndrome remain controversial. These controversies are related to the nature of this drug reaction, different diagnostic criteria, incidence, pathophysiology, differential diagnosis and treatment. Although, by definition idiosyncratic drug reactions cannot be explained on the basis of the pharmacology of the drug, NMS is often defined as an idiosyncratic drug reaction exclusively associated with the use of neuroleptics. Although many diagnostic criteria have been used, there is no single set of criteria that is unisonly accepted. Estimates of the incidence of NMS once ran as high as 3%, but more recent data suggest that incidence has decreased to 0.01% or 0.02%. It has been suggested that such decrease could be consequence of different factors such as increased awareness of the disorder, earlier recognition and intervention, and the shift to use of atypical antipsychotics. Yet, earlier recognitions and interventions are not usually related the decrease of incidence. It is usually considered that central neuroleptic-induced dopamine blockade plays a major role in NMS. Due to others, the key factor in development of NMS is a dysfunction of the sympathetic nervous system. A very large number of conditions that are presented with fever or rigidity should be considered in the differential diagnosis of NMS. Yet, the most controversies are related to distinguishing between serotonin syndrome (SS), malignant catatonia (MC) and NMS that might have practically identical clinical presentation.

Our aim is to emphasize the importance of some of these controversies in usual clinical practice.