Guidance on the use of atypical antipsychotics as an adjunct to the treatment of eating disorders 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.

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., according to their level of complexity and co-morbidity. It is anticipated that the majority of patients would **not** require such medication. Atypical antipsychotics should very much be regarded as an **adjunct** to holistic treatment. The circumstances in which atypical antipsychotics might be used could include (not an exclusive list of examples):

- Those patients with highly distressing and persistent "eating disorder" ruminations not amenable to psychological interventions
- Those patients who are agitated by these ruminations and for whom this is a hindrance to utilising other interventions (nursing, psychological, OT etc) that are available
- Those patients whose ruminations are such that they are driven to self-harm as a consequence

When should treatment be offered?

Psychological approaches should be offered as the first line intervention, within the context of the patient's social environment. Drug treatment should be offered when ruminations are not amenable to psychological interventions, or where they hinder the effectiveness of such interventions. There must be a full assessment of the Eating Disorder and of any co morbid conditions before starting drug treatment.

How long should treatment be continued for?

This should be patient specific. The underlying principle 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 eating disorder 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 review and monitoring arrangements?

All patients should have baseline physical observations, ECG and bloods. Patients should be reviewed by the multi-disciplinary team regularly. 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. Regular psychiatric review should be considered (at least annually)

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 10 mg daily (average 7.5 mg daily).

Patient information: *https://www.choiceandmedication.org/tees-esk-and-wear-valleys/generate/pillolanzapineeatinguk.pdf*

Olanzapine is unlicensed for this indication, but off-label use is pre-approved by the Trust. Prescribing responsibility must stay with the specialist (i.e. not transfer to GP).

If olanzapine is ineffective or not suitable, ensure any co-morbidities that may be impacting on eating behaviours are identified and appropriately managed e.g. agitated behaviour associated with ASD. Seek the advice of a specialist in eating disorders if an alternative antipsychotic is required. No other antipsychotic is pre-approved for this indication, so a single application form would be required for patient-specific approval.

References

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