Metabolic Syndrome in Patients With Mental Illness: Challenges and Solutions

SAN DIEGO—Christoph Correll, MD, explained the difficulties involved in treating patients with severe mental illness and metabolic syndrome, and he outlined some best practices for clinicians.

Why is metabolic disorder so common in people with severe mental illness?

It’s a complex web of different reasons why people with severe mental illness have metabolic disorder and metabolic syndrome. The underlying genetics that might predispose patients, but that link isn’t clear. What’s more clear is that unhealthy lifestyle behaviors are more common in the mentally ill, including sedentary behavior and unhealthy diet, which in the general population are also linked with lower socioeconomic status. In addition, lower socioeconomic status is also more likely to be found in the mentally ill.

When patients are very sick they also have an increase in stress levels. Cortisol can have some bad effects on inflammation and oxidative stress, and it can feed into the metabolic syndrome.

In addition, unfortunately some of our medications have side effects that can also increase the risk of metabolic illness, particularly antipsychotics, but also mood stabilizers and antidepressants. Medications can increase weight, have effects on blood lipids, and even cause some insulin resistance.

How much of the increased incidence of metabolic disorder is due to mental illness and how much is due to medication?

I think a lot results from unhealthy lifestyle, and then the medications clearly add to that. We did a study on antipsychotic-naïve patients and the change in the first 3 months is dramatic, so dramatic that the incidence of metabolic disorder can’t just be due to healthy lifestyle or to the illness.

Patients should be involved in the medication choice, and doctors should make the choice mostly based on safety issues because efficacy differences among the medications are relatively slim and hard to predict, whereas the side effect differences are relatively large and easy to predict.

Usually metabolic syndrome is seen as accompanying schizophrenia. Has any evidence shown that it’s an issue with depression?

The focus only recently shifted to depression and bipolar disorder. The metabolic concern was mostly concentrated in schizophrenia because those patients are likely to have unhealthy lifestyle behaviors. But we know that unhealthy lifestyles are also common in these other 2 conditions, either related to the illness or the medications.

We did 2 meta-analyses in which we did not find a difference in metabolic syndrome rates in people with schizophrenia, bipolar disorder, or depression. They had similar rates.
This might be due to the fact that antipsychotics are given more now outside of schizophrenia. It may also be a result of the shared environmental and genetic risk. We are also finishing the same meta-analysis in diabetes and we see relatively few differences between those conditions there too.

**Antipsychotics have very similar efficacy but differ in terms of safety. What are your thoughts on the differences between various medications?**

If you wanted to classify antipsychotics in 3 big buckets, then one would say the most concerning—clozapine and olanzapine—have the most weight gain effect but they also, independent of weight gain, after a couple of days, change insulin resistance and change lipid profile.

Then we have medications in the middle that are most others. For example, quetiapine has similar weight to others in the middle but is a little bit more on the lipid side like olanzapine.

And then the drugs on the lower end are aripiprazole, ziprasidone, lurasidone, brexpiprazole. I think iloperidone causes some more weight gain like the middle group, but it is pretty clean when it comes to the lipids.

**What strategies do you recommend clinicians practice for monitoring and intervening?**

Monitoring is the first step. Unfortunately, you see in publication after publication that monitoring is not done enough. It’s important that when we use medications and treat the mentally ill, that we keep close tabs on cardiovascular and cardiometabolic health.

We need to get at least a blood draw, height and weight, and blood pressure. We need that at baseline, at 3 months after we initiate an antipsychotic, and annually, unless patients are high risk and have gained a lot of weight.

Clinicians also need to do healthy lifestyle instruction and counseling. We should be telling patients how to deal with the increased appetite and talking about what to eat and what’s unhealthy. Physicians have little time in busy practices, but there are resources online that you can refer patients to use to see what is healthy and unhealthy.

In terms of behavior, we need to encourage patients to try to exercise a more, even if it’s just walking. We also need to keep in mind that mental health and physical health go together. The healthy, active life initiative that we’ll start in Australia and Britain has a manifesto so to speak, that mentally ill patients have the same right to physical health as the general population, but we need to facilitate that through healthy lifestyle instruction and then intervention if needed. We should keep in mind though, that not every patient is highly motivated.

We need to give patients the choice of a better, safer medication and perhaps switch to lower-risk agents. However, switching can be de-stabilizing, so it’s better to start with a lower risk agent first.

If all these strategies don’t work, we need to interact with physical health care providers that can initiate the antidiabetic, antihypertensive, and lipid-lowering medication. We need to orchestrate this intervention so that patients don’t fall between the cracks.