PBM-Federal Partners
Board Certification Webinar:
Personality and Eating Disorders

August 2, 2017
3:10 PM ET
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PERSONALITY DISORDERS AND EATING DISORDERS

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Conflict of Interest Disclosures

Speaker has no conflicts of interest to disclose. This presentation is based on the CPNP board review book 2016-2017. It is meant to supplement your study material, and enhance your learning ability, but not to replace your studying of the material.
OBJECTIVES:

• List the distinguishing features between the different personality disorders
• Be able to distinguished between the different clusters that each personality disorders falls into.
• Be able to know the different characteristic of each personality type.
• Know the treatment guidelines for the major personality disorders.
• Know the prevalence and etiology of the different personality disorders
• Know the various types of eating disorders and be able to distinguished between the various types of eating disorders.
• The pathophysiology and prevalence of eating disorders.
• Treatment guidelines of eating disorders.
Classification of Personality Disorders

**Cluster A: Eccentric or odd**
- Paranoid personality
- Schizoid personality
- Schizotypal personality disorder

**Cluster B: Dramatic, emotional or erratic**
- Antisocial personality
- Narcissistic personality
- Histrionic personality disorder
- Borderline Personality disorder

**Cluster C: Anxious or Fearful**
- Avoidant personality disorder
- Dependent personality
- Obsessive – compulsive personality disorder
### Signs and Symptoms:

<table>
<thead>
<tr>
<th>TYPE</th>
<th>Characteristics</th>
</tr>
</thead>
</table>
| Paranoid personality Disorder   | 1. Pervasive mistrust and suspiciousness of others.  
                                  | 2. Belief that someone is “out to get them”  
                                  | 3. Socially isolative  
                                  | 4. Suspicious of loyalty of friends and partners. |
| Schizoid personality disorder    | 1) Inability to form social relationship  
                                  | 2) Choose solitary activity  
                                  | 3) Indifferent to praise or criticism  
                                  | 4) Emotional detachment and restricted range of emotions |
| Schizotypal personality disorder | 1) Odd or bizarre behavior, speech appearance, though process  
                                  | 2) Impaired ability to form social relationships.  
                                  | 3) Minimal emotional reaction to situations.  
                                  | 4) Prefer to be alone. |
| Antisocial Personality Disorder  | 1) Symptoms occur before age 15.  
                                  | 2) Failure to conform to lawful or culturally acceptable behavior  
                                  | 3) Lack of concern for the feelings, needs or suffering of others  
                                  | 4) Impulsive, seeking immediate gratification  
                                  | 5) Engagement in risky, dangerous activities. |
## Signs and Symptoms

<table>
<thead>
<tr>
<th>Type</th>
<th>Characteristics</th>
</tr>
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</table>
| Narcissistic Personality disorder | 1) Preoccupied with success, Power, brilliance, beauty  
2) Impaired ability to identify with the feeling of others.  
3) Interpersonally exploitative, outward arrogant  
4) Feelings of entitlement, self-centered, grandiosity |
| Histrionic Personality Disorder | 1) Pervasive emotionality and attention seeking  
2) Inappropriately sexually seductive or provocative  
3) Draws attention by theatrical dress or mannerisms  
4) Easily influenced by others |
| Borderline Personality Disorder | Unstable Self-image chronic feeling of emptiness  
Dissociative or paranoid episodes under stress  
Frantic efforts to avoid real or perceive abandonment  
Impulsivity and recurrent suicidal or self-harm behavior. |
| Avoidant Personality Disorder | 1) Low Self-esteem, excessive feelings of shame or inadequacy  
2) Sensitive to Criticism or rejection  
3) Avoidance of social contacts, activity, and romantic relationships  
4) Intense feelings of nervousness and fear of rejection or embarrassment. |
### Signs and Symptoms

<table>
<thead>
<tr>
<th>Type</th>
<th>Characteristics</th>
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</table>
| Dependent Personality Disorder     | 1) Needy, clingy, submissive behavior  
2) In need of reassurance in all areas of life.  
3) Difficulty expressing disagreement with others  
4) Difficulty making own decisions and taking initiative |
| Obsessive personality Disorder      | 1) Preoccupied with details, organization, and order.  
2) Rigid perfectionism, at the cost of timeliness.  
3) Unable to discard worthless objects  
4) Reluctant to work with others. |
| Others Specified Personality Disorder | Clinically significant impairment in social, occupational, or other area of functioning predominates but full personality disorder criteria is not met |
# Standardized Rating Scale

<table>
<thead>
<tr>
<th>Scale Name</th>
<th>Description</th>
<th>Values/ Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minnesota Multiphasic Personality inventory 2 (MMP-2)</td>
<td>567 Clinician rated – assist with diag and treatment of PD- Research</td>
<td>True/false</td>
</tr>
<tr>
<td>Personality assessment inventory (PAI)</td>
<td>344 items Clinician rated – adult PD assessment</td>
<td>Entered on 2-part carbonless answer sheet,</td>
</tr>
<tr>
<td>Million Clinical Multiaxial inventory Inventory (MCMI-III)</td>
<td>175 item Clinician Rated – DSM-IV-TR related PD</td>
<td>True/false</td>
</tr>
<tr>
<td>Borderline Evaluation of Severity over Time (BEST)</td>
<td>15-item Clinician rated screening tool.</td>
<td>Items scored 1 (none) to 5 (extreme).</td>
</tr>
<tr>
<td>Zanarini Rating scale for borderline Personality Disorder (ZAN- BPD)</td>
<td>10 –item Clinician rated Screening tool for BPD</td>
<td>Yes/No yes = 1 scoring &gt; 8 is indicative of a diagnosis of BPD</td>
</tr>
</tbody>
</table>
Etiology/Risk Factors

Environmental

- Failure to achieve a critical developmental stage (attachment, Individuation).
- Childhood neglect and or physical, sexual or verbal abuse

Biological

- Hyperarousal of the limbic system.
- Secondary to genetic and biological predispositions
Prevalence

Most common in males
- Paranoid
- Schizoid
- Schizotypal
- Antisocial
- Narcissistic
- Obsessive-compulsive

Most common in female
- Histrionic
- Borderline
- Dependent
- Even in both genders
- Avoidant
Prevalence

• Five most common in General Population
• Avoidant
• Schizoid
• Schizotypal
• Obsessive-compulsive
• Paranoid
Prognosis

• Limited studies for Cluster A and C.
• Cluster B
• Borderline personality disorder diagnosed usually at age 18 - 40.
• May improve over time with proper treatment.
• Premature death associated with increased risk of suicide,
• 70-75% attempt self harm, 9% complete suicide
• 85% have another psychiatric disorder
• Prognosis generally poor.
Neurobiological – reduced serotonin levels
Cerebral abnormalities –
Structural and functional abnormalities of prefrontal cortex, hippocampus and amygdala.
Limbic system – reduced vol. of hippocampus and amygdala.
Frontal Lobe – deficits mediated in frontal lobe include poor cognitive functioning.
Hyperresponsiveness of hypothalamic–pituitary–adrenal system.
Treatment Guidelines for BPD

- Psychotherapy
- Dialectical behavior therapy (DBT) – most effective tx. options in reduction in self-harm and suicidal thinking.
- APA supports targeted symptom
- NICE guidelines specify that pharmacotherapy should not be used for BPD.
- Cochrane review of 28 trials in 2010, supports second generation antipsychotics (SGA), mood stabilizers and omega-3 fatty acids for BPD.
### BPD Treatment Guidelines

<table>
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<tbody>
<tr>
<td>1&lt;sup&gt;st&lt;/sup&gt; line</td>
<td>DBT with or w/o symptom pharmacotherapy Affective dysregulation – SSRI Impulse Dyscontrol –SSRI Cognitive Symptoms- Low dose antipsychotic</td>
<td>Psychological tx. Pharmacotherapy should not be used specifically for BPD. Aim to reduce and stop unnecessary drug treatment.</td>
<td>DBT – reducing self-harming and suicidal behavior. Moderate evidence for efficacy of SGA for TX. Of cognitive and perceptual behavior. SSRIs – depression, anxiety, mood swings</td>
</tr>
</tbody>
</table>

1. **DBT** – reducing self-harming and suicidal behavior.
2. **SSRI** – depression, anxiety, mood swings
# BPD Treatment Guidelines

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Second – Line</td>
<td>Pharmacotherapy: Affective dysregulation symptoms – 2\textsuperscript{nd} SSRI or related antidepressant. Impulsive-behavioral Dyscontrol symptoms – SSRI + antipsychotic Cognitive-perceptual symptoms – Higher dose antipsychotic</td>
<td>Consider drug therapy in the overall treatment of comorbid conditions. Consider cautiously short-term use of sedative medications.</td>
<td>Divalproex, Topiramate, lamotrigine may be effective for impulsive, aggressive behavior. No evidence that SSRIs are effective for chronic feelings of emptiness, loneliness, boredom, or dysphoria. Polypharmacy, FGA, MAOIs and lithium should be avoided.</td>
</tr>
</tbody>
</table>
Assessment and case.

- A patient diagnosed with borderline personality disorder has been on fluoxetine for 12 weeks with no improvement in symptoms. Which of the following would be a good second line option to try for Irritability and aggression.
  - A. Carbamazepine
  - B. Lithium
  - C. Clonidine
  - D. Olanzapine
## Treatment Guidelines for PD

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cluster A</td>
<td>Cognitive therapy&lt;br&gt;Social Skills Building</td>
</tr>
<tr>
<td>Cluster B</td>
<td>Cognitive Therapy&lt;br&gt;NICE for APD&lt;br&gt;DBT&lt;br&gt;IPT- interpersonal therapy</td>
</tr>
<tr>
<td>Cluster C</td>
<td>CBT&lt;br&gt;Group therapy</td>
</tr>
</tbody>
</table>
## Pharmacologic Treatment of PD

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cluster A and C</td>
<td>No pharmacological treatment established.</td>
</tr>
</tbody>
</table>
| **Cluster B: Antisocial personality disorder** | 1) Anticonvulsants / Mood Stabilizers  
   a) Lithium : 1200mg/day  
   b) Phenytoin : 300mg /day  
   c) Divalproex: 750mg /day  
   d) Carbamazepine: 450mg/ day  
2) Stimulants (methylphenidate)  
3) SSRIs |
| **Cluster B: Borderline Personality disorder** | Affective dysregulation (anger, Depressed mood, outburst)  
1) Anticonvulsants  
   a) topiramate 200 – 250mg /day  
   b) Divalproex adjust to level of 50 -100 ng/ml  
   c) Lamotrigine 25 – 200mg /day  
2) Antidepressants – depression/anxiety  
   a) SSRIs |
## Pharmacologic Treatments of PD

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cluster B: Borderline Personality Disorder</td>
<td>Impulsive- behavioral Dyscontrol (aggression, self-harm)</td>
</tr>
<tr>
<td></td>
<td>3) Anticonvulsant</td>
</tr>
<tr>
<td></td>
<td>4) Second- Generation antipsychotics</td>
</tr>
<tr>
<td></td>
<td>a) olanzapine mixed data</td>
</tr>
<tr>
<td></td>
<td>b) aripiprazole</td>
</tr>
<tr>
<td></td>
<td>5) Cognitive perceptual (suspiciousness, paranoia)</td>
</tr>
<tr>
<td></td>
<td>Antipsychotics</td>
</tr>
<tr>
<td></td>
<td>a) Haloperidol – 1-4 mg/day</td>
</tr>
<tr>
<td></td>
<td>b) Olanzapine : 2.5 – 10 mg /day</td>
</tr>
<tr>
<td></td>
<td>c) Aripiprazole : 15 mg /day</td>
</tr>
<tr>
<td></td>
<td>d) Clozapine , Quetiapine</td>
</tr>
<tr>
<td></td>
<td>Others options:</td>
</tr>
<tr>
<td></td>
<td>Naltrexone : 50-200mg /day</td>
</tr>
<tr>
<td></td>
<td>Clonidine : 0.15mg qam , 0.3 mg qhs</td>
</tr>
<tr>
<td></td>
<td>Omega-3 fatty acids : 1-6 g/day</td>
</tr>
</tbody>
</table>
Eating Disorders

• Hallmark Signs and Symptoms
• Anorexia Nervosa
• Emaciated or underweight
• Restriction and ritualistic
• Social withdrawal
• OCD, Depression
Bulimia

- Normal to slightly overweight
- Bingeing and purging
- Impulsive and moody
- BPD, borderline Personality Disorder
- Substance Abuse disorders
Binge Eating Disorder

- Slightly overweight to obese
- Bingeing without purging
- High emotional stress
- Anxiety, Depression, Impulse-control disorder
• ANOREXIA NERVOSA
• Low Body Weight, Intense fear of gaining weight
• Restricting type – not involved in binge eating or purging behavior during the last 3 months.
• Binge eating/Purging type- patient has engaged in binge eating or purging within the past 3 months.
DSM 5 ANOREXIA NERVOSA

• SEVERITY SPECIFICATIONS (WHO)
• MILD – body mass index $\geq 16$
• Moderate – BMI 16 - 16.99
• Severe – BMI 15-15.99
• Extreme – BMI <15 kg/m2.
Physical complications - AN

- Underweight or emaciated
- Constipation, abdominal discomfort
- Decreased metabolic weight,
- Cold intolerance, brittle nails, hypothalamic suppression, lanugo (fine, soft hair that covers the body and face.)
- Hypoglycemia, hypochloremia, hyponatremia, hypokalemia, hypocalcemia, hypomagnesia, refeeding syndrome.
Signs and symptoms - Emaciated
• Hypocartenemia
Signs and Symptoms AN

• Reproductive - hypoestrogenic state, amenorrhea, premature births, infertility
• Cardiac - decreased cardiac output, bradycardia, hypotension, prolonged qtc interval, arrhythmias.
<table>
<thead>
<tr>
<th>Scale Name</th>
<th>Description/purpose/use</th>
<th>Values and interpretations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yale Brown cornell eating disorder scale (YBC-EDS)</td>
<td>65 items clinician rated</td>
<td>Scores interpreted by a psychologist</td>
</tr>
<tr>
<td>Eating Attitudes test (EAT-26)</td>
<td>26 item self rated screening tool</td>
<td>Scores &gt;20 are referred for diagnostic interview.</td>
</tr>
<tr>
<td>Eating Disorders Inventory -3 (EDI-3)</td>
<td>91 item self rated diagnostic scale</td>
<td>4-point scoring system</td>
</tr>
<tr>
<td>Eating Disorder examination questionnaire (EDE-Q)</td>
<td>41 items self rated screening tool.</td>
<td>Averages from 0 to 6 with higher scores reflecting greater pathology</td>
</tr>
</tbody>
</table>
Etiology /Risk Factors

• Strong genetic component AN (22 -76 %)
• Increased rate of anxiety, major depression, substance use disorder among 1st degree biological relatives.
• Separation anxiety
• Trauma and life stressors
• Obsessive –compulsive personality disorder
• High mortality rate of any psychiatric disorder.
Pathophysiology of AN

• Neurobiologic dysfunction
• Starvation + chronic stress + excessive exercise
• \( \rightarrow \uparrow \text{cortisol} \rightarrow \downarrow \text{HPA, HPT, HPG} \rightarrow \downarrow \text{estradiol, progesterone and LH production} \)
• Results: amenorrhea and \( \downarrow \) libido
• TSH inhibition \( \rightarrow \) reduced T4 and T3 conversion
• Results: \( \downarrow \) resting metabolic rate
• Hypothalamic dysregulation \( \rightarrow \) disruption of satiety signals such as leptin
• Results: Abnormal experiences of hunger and satiation.
Neurotransmitter Dysfunction

• ↓Serotonin
• Results: dysregulation of postprandial satiety, anxiety, sleep, mood, obsessive-compulsive and impulse control disorders

• ↓Dopamine
• Results: low energy, anhedonia and decreased feelings of reward

• ↓Norepinephrine
• Result: hypotension, bradycardia, and hypothermia
Treatment Guidelines

• Method of re-feeding –

• Results: abrupt electrolyte shifts and fluid imbalance; leading to ↑ cardiac workload → cardiovascular collapse and heart failure.

• Don’t feed to quickly, use what ever method is available to feed.

• Monitor serum levels and supplement as needed, such as Phosphorus, Magnesium, Potassium and calcium
Treatment Guidelines

• Psychotherapy – for family dynamics and for trauma and life stressors

• Pharmacotherapy: malnourished patients are sensitive to cholinergic and cardiovascular adverse effects of meds, esp. orthostatic hypotension and constipation

• Avoid caffeine and exercise – may cause arrhythmia and bradycardia

• Electrolyte abnormalities may lead to seizures,
Treatment of Anorexia Nervosa

1. • Restore weight and eating patterns
   • Correct Biological and psychological sequelae of malnutrition

2. • SSRI – for comorbidities: Fluoxetine and citalopram
   • Olanzapine or low dose quetiapine – resistance to wt. gain
   • Metoclopramide increased GI emptying, and Zinc

3. • Note medication usually not effective in malnourished and underweight patients
   • Menses usually return after normal weight gain.
Assessment Case study

• A 15 YO female patient presents to clinic with body weight 20% under IBW with the perception of being overweight. Her labs indicated the following: CBC indicated marked anemia (HGB 9.5, HCT 30%) with hyponatremia (Na= 132).

• 1) This patient likely has _________
• A. Narcissistic Personality disorder
• B. Bulimia Nervosa
• C. Anorexia Nervosa
• D. Antisocial Personality disorder
2) After initial treatment following medical stabilization, which medication should be included in this patient regimen?

- A. Fluoxetine
- B. Bupropion
- C. Olanzapine
- D. Amitriptyline
• Bulimia Nervosa

• 2 types of BN

• Purging type – regularly induces vomiting or misuse of laxatives, diuretics or enemas.

• Non-Purging type – uses inappropriate methods to loss weight, such as fasting or exercise. (but not purging)

• Lack of sense of control over eating

• Eating an amount of food larger than most people would eat at one time (whole cake)
Bulimia Nervosa BN

Warning Signs: Eating Disorders
People with eating disorders risk premature death due to medical complications.

- Low self-esteem and body image
- Dramatic weight loss
- Preoccupation with weight, food facts, meal rituals
- Routine bathroom trips immediately after eating
- Binging on and hoarding large amounts of food
- Increased use of laxatives, diuretics or diet pills
- Compulsive exercising
- Withdrawn from friends and activities

Source: National Eating Disorders Association
WebKazoo graphic
Bulimia Nervosa criteria

• Binge eating occurs at least once per week for the past 3 months.

• Severity specifications:
  • A) mild- average of 1-4 episodes per week
  • B) Moderate – average of 4-7 episodes per week
  • C) Severe- Average of 8-13 episodes per week
  • D) Extreme- >14 episodes per week.
Signs and Symptoms of BN

• Comorbidities – depression, impulsivity, borderline personality, substance use, anxiety.

• Loss control over food restrictions, often triggered by dysphoric mood.

• Caloric content of one binge may contain up to 20,000 calories.

• Binge may range from 1- 20 times per day

• Body type- normal to slightly overweight
Physical manifestation

- Russell’s Sign – calluses or scars on dorsal surface of the hand
- Loss of dental Enamel,
- Dental cavities
- Parotid glands enlargement – due to excessive saliva productions.
- Amenorrhea, osteopenia/osteoporosis
- Orthostatic hypotension, bradycardia, qtc prolongation, arrhythmias
Physical Manifestation

- Mallory Weiss Tear – Tear of mucosa at the junction of stomas and esophagus.
- Gastric rupture
- Lethargy and changes in metabolic rate.
- Changes in electrolytes – decrease in chloride, sodium, calcium, magnesium and potassium due to constant vomiting and diarrhea.
- Metabolic acidosis – due to chronic diarrhea.
Pharmacologic Treatment

1. **SSRI: Fluoxetine**
   - Higher daily dose than depression (fluoxetine 60mg/day)

2. **Other SSRI: Citalopram, Fluvoxamine, and sertraline**
   - Topiramate: has shown short term efficacy in binge/purge (100mg/day)
   - Ondansetron

3. **Note Bupropion is contraindicated in both conditions due to seizure risk.**
   - TCA are not recommended due to damage to heart muscle in overdose.
BINGE EATING DISORDER DSM5

A

• Recurrent binge episodes without compensatory behavior to prevent wt. gain

B

• Eating in discrete period of time, larger amt. than normally
• Patient have a sense of lack of control over eating.

C

• Is associated with 3 of the following factors
• Eating Rapidly, until uncomfortably full, lg amt when not hungry,
• Eating alone, feeling disgusted, or guilty after eating, distress about amt. Eaten.
Severity of BED

• 1) Mild – 1- 3 episodes per week
• 2) moderate – 4-7 episodes per week
• 3) Severe – 8- 13 episodes per week
• 4) Extreme – 14 or more episodes per week

Standarized Rating Scales:
• BES – Binge Eating Scale –
• 16 item self-rated screening tool – each 4 facts
• Range of scores from 0- 46 <17 non-binging
• 18-26 : moderate binging >27 severe binging
Binge Eating Disorder

• Pathophysiology

• ↑ Cortisol is common to physical or psychological stress → visceral fat accumulations and weight gain.

• Neurotransmitter dysfunction

• Opioid, DA, and NE influences feeding behavior,

• DA dysfunction found in obesity and 5-HT2c linked in hyperphagia and obesity
for those who served

1. SSRI/SNRI: Binge eating reduction
   - Higher daily dose than for depression (escitalopram 30mg/day)
   - Orlistat: Weight reduction

2. TCAs
   - Topiramate and Zonisamide: as adjunct tx. Binge suppression and wt. Loss
   - Zonisamide and atomoxetine: some data to support reduction in binge eating and wt.

3. Acamprosate, naltrexone, lamotrigine and oxcarbazepine: not shown to be effective in binge suppression
   - Divalproex may worsen binge eating and increase wt. gain
   - Phentermine can help with wt. loss, consider heart valve deformations and pulmonary hypertension
   - Lorcaserin: approved for wt management but not FDA approved for BED
Lisdexamphetamine – Vyanase is FDA approved for BED (moderate to severe)

A stimulant prodrug converted to dextroamphetamine upon ingestion

Dose: begin 30mg po daily and increase by 20mg weekly goal 50 to 70 mg/daily

Adverse events: dry mouth, decreased appetite, increased HR, constipation, feeling jittery and anxiety.

Duration of therapy: 12 weeks
Treatment Guidelines BED

- Orlistat- Alli, Xenical
- Not approved for BED
- Indicated for Obesity
- MOA- Inhibits nutrient absorption by forming a covalent bond with the gastric and pancreatic lipases within the stomach.
- Inhibits dietary fat absorption by 30%.
- Dose 120mg po tid
- May reduce daily absorption of fat soluble vitamins
Orlistat

• C/I: cholestasis, chronic malabsorption syndrome
• Pregnancy category: B
• Adverse effects: flatulence with discharge, fecal urgency, fecal incontinence, steatorrhea, oily spotting, mild to moderate GI effects,
• Drug interactions: inhibits absorption of vitamin E, A and D and betacarotene
• Interactions with warfarin
• Duration of therapy: 24 weeks
Phentermine and Topiramate

- Qsymia- Phentermine and Topiramate
- FDA approved for wt. Management
- Adjunctive for obesity in adults with a BMI >30 kg/m2 or with a BMI of 27 kg/m2 and at least one wt related condition such as DM or HTN.
- MOA- Phentermine increases release of NE and suppress appetite and Topiramate a anticonvulsant that increases satiety and reduce craving.
Phentermine and Topiramate

• Dosing: start with 3.75 phentermine/23 mg topiramate daily and increase in 2 weeks to the recommended dose of 7.5mg /46 mg daily in the morning.

• Max dose: 15mg of P/92mg of T daily.

• Avoid in pt with hx. heart attack, stroke, CHF, or arrhythmia.

• C/I: hyperthyroidism, glaucoma, mao therapy w/in 14 days, pregnancy

• Pregnancy category: X
Phentermine/Topiramate

• Onset of action: 2 weeks

• Adverse effects: tachycardia, headache, constipation, dry mouth, paraesthesia, constipation, insomnia, dysgeusia, urti

• Duration of therapy: 12 weeks

• Educated about cognitive dulling effect of topiramate.
Lorcaserin – Belviq
Not FDA approved for BED
Indicated for weight management.
Adjunctive tx. For obesity
MOA: activates 5-HT2c receptors, stimulating pro-opiomelanocortin (POMC) neurons in the hypothalamus resulting in satiety and decreased food intake.
Dosing: 10mg po bid
Pregnancy category: X
Adverse effects: CNS effects, diarrhea, HTN
Locaserin

- Significant interactions: CYP2D6 inhibitor, avoid with ergots, thioridazines
- Duration of therapy: 12 weeks
- Monitoring Guidelines
  - Weight, waist circumferences
  - CBC, blood glucose, prolactin levels
  - Depression/suicidality
  - Serotonin syndrome
- Symptoms of Valvular heart disease
Assessment case study

• Which of the following medications is/are indicated for BED?

• A. Phentermine/topiramate
• B. Locaserin
• C. Orlistat
• D. Escitalopram
Reference

• CPNP board review book 2016-2017, Personality Disorders and Eating Disorders, Gable, KN; pg 463-504.


• WWW.Nationaleatingdisorders.org

• www.anad.org- national association of Anorexia and Associated Disorders
QUESTIONS

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TUSCALOOSA VA MEDICAL CENTER
Reminders

• All presentations will be held on Thursdays @ 12 noon ET.
• All presentations will be taped and posted to BCPS/BCACP Moodle sites.
• All presentations are ACPE accredited for VA pharmacists.

Upcoming Schedule

• 8-9-17  Schizophrenia and more....
• 8-16-17  Neurodevelopmental Disruptive, impulse-control and Conduct Disorders