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Disclosure

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Cardiovascular risk in bipolar disorder: beyond medication effects and lifestyle factors

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Bipolar disorder (BD) is associated with substantial functional impairment, high health care costs, and premature mortality. The World Health Organization (WHO) ranks BD in the top 10 causes of global disability and premature mortality.[1] The morbidity, mortality, and personal suffering associated with BD are not simply the result of psychiatric symptoms, but are also the consequence of a wide range of comorbid medical disorders. The study from Gomes et al. complements a wide array of worldwide studies pointing to the high burden of cardiovascular disease (CVD) risk factors in BD in developed countries. Globally, over 80% of patients with BD have some degree of medical comorbidity,[2,3] with the vast majority suffering or dying from CVD. The toll of the high rate of medical burden for patients with BD is not only premature mortality, but also worse prognosis with less favorable response to treatment, lower psychosocial functioning, higher rates of unemployment and, thus, a higher overall higher societal cost.[4,5] Nevertheless, one aspect that has not yet entirely permeated the culture of health policy makers is the notion that patients with BD have even higher rates of medical comorbidities than those reported for other severe psychiatric disorders such as schizophrenia. In fact, in most health care settings, integrating psychiatric care with medical care and prevention is still a challenge.

Most implicated in the rampant increase in CVD risk in BD are the widespread use of atypical antipsychotics and the sedentary lifestyle and high-fat diet that prevail in most developed countries. Yet some lines of evidence suggest that cultural and environmental factors account for only part of the problem. This new report by Gomes et al. provides a snapshot of BD-associated CVD risk in developing countries and contributes to the evidence that medical burden – and, more specifically, cardiovascular burden – tends to be higher among patients with BD than in the surrounding general population in a wide variety of geographical contexts, across urban and rural settings, widely different cultural and lifestyle characteristics, and different prescribing practices.

We now have enough evidence to lay the groundwork for two main future developments: on one hand, clinicians and administrators need to develop ways to better integrate prevention and treatment of cardiovascular risk factors and diseases in mental health care settings. On the other, research into the root causes of cardiovascular risk in persons with serious mental illness needs to undertake a more critical approach and uncover those pathways to CVD in BD that go beyond lifestyle factors and medications.

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N-acetylcysteine in the treatment of skin-picking disorder

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N-acetylcysteine (NAC) is a precursor to the amino acid cysteine, a modulator of the glutamatergic system. Thus,

NAC may exert a therapeutic effect in several psychiatric disorders, namely schizophrenia and affective disorders,[1] as well as symptoms and syndromes of the obsessive-impulsive spectrum (e.g., trichotillomania and other grooming disorders, pathological gambling, and substance misuse[2]).

There is only one published case report of treatment of skin-picking disorder with NAC.[3] No controlled studies or case series of this treatment have been reported. Below, we report three cases treated at our Impulse Control Disorder clinic of patients who, among other disorders, presented with skin picking.

Case 1. A 45-year-old woman was diagnosed with depressive episode, trichotillomania, and skin picking (history of hair-pulling since she was 4 years old). She was started on sertraline up to 100 mg/day, with no improvement in mood or grooming disorder, then switched to venlafaxine 75 mg/day. At that time, she was also given NAC 1,200 mg/day. Her mood and trichotillomania improved partially and the skin picking resolved completely. Following this improvement, she decided to discontinue her medications unilaterally, with subsequent worsening of all symptoms. In December 2011, she was restarted on venlafaxine 75 mg/day and NAC 1,800 mg/day, with improvement of depressive symptoms and trichotillomania and complete recovery from skin picking.

Case 2. A 40-year-old woman complained of excessive buying coupled with irritability, pressured speech, inflated self-esteem, and inadequate behavior. At the time of presentation, she was on haloperidol 2.5 mg/day, biperiden 2 mg/day, imipramine 25 mg/day, and diazepam 10 mg/day. There was no history of alcohol or illicit drug use. All medications were discontinued and she was started on lithium 600 mg/day (up to 1,200 mg/day) and quetiapine 50 mg/day (up to 500 mg/day). One month later, she developed skin picking, despite good mood control. NAC 1,200 mg/day was initiated. Skin picking stopped until 10 months later, when she discontinued NAC by herself. NAC was subsequently reintroduced with great improvement in skin picking.

Case 3. A 31-year-old woman sought treatment for a moderate depressive episode, pathological jealousy, internet addiction, and severe skin picking. She was prescribed sertraline up to 250 mg/day, but did not respond. She was then switched to fluoxetine 20 mg/day and started on NAC 1,200 mg/day, with substantial improvement in skin picking and partial improvement of affective symptoms. Medication had no effect on her pathological jealousy or internet addiction. The patient was later referred elsewhere for psychotherapy.

The patients described in this report experienced major improvement of skin-picking behaviors resistant to other treatments following use of NAC. We also observed that discontinuation of NAC treatment led to worsening of symptoms, with remission of symptoms achieved again after rechallenge with NAC, suggesting a direct relation between NAC therapy and remission of skin-picking behavior. Taking into account that skin picking is a highly prevalent and insufficiently studied condition,[4] randomized controlled studies are warranted to ascertain the potential benefits of NAC for patients with this disorder.

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Multidimensional Students' Life Satisfaction Scale: translation into Brazilian Portuguese and cross-cultural adaptation

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Life satisfaction measures are distinct from measures of psychopathology and from objective quality of life (QoL) measures.[1,2] Proponents of the subjective QoL indicators perspective focus on measures that incorporate individuals' subjective perceptions and evaluations of key indicators of QoL, such as life satisfaction.[3]

Life satisfaction studies focus on how and why people experience their lives in positive ways.[4] Both unidimensional and multidimensional ratings of life satisfaction have been examined in the literature. However, multidimensional measures provide the most distinctive information about a person's life satisfaction.[3]

In 1994, Huebner developed the Multidimensional Students' Life Satisfaction Scale[4] (MSLSS), a 40-item self-report questionnaire designed to assess life satisfaction in adolescent students. Information regarding test development, usage, and psychometric properties is available elsewhere.[2] The MSLSS has demonstrated