

Psychopharmacology for the Clinician

The information in this column is not intended as a definitive treatment strategy but as a suggested approach for clinicians treating patients with similar histories. Individual cases may vary and should be evaluated carefully before treatment is provided.

Bariatric surgery in patients with bipolar disorder: an emerging issue

Mrs. F is a 45-year-old woman with type 1 bipolar disorder who has been a patient in your practice for 8 months. She has not experienced an episode of mania since she was started on lithium 6 years ago and has had no mood fluctuations since you initiated treatment with an atypical antipsychotic. Mrs. F has gained substantial weight during her illness: her current body mass index (BMI) is 38 kg/m². She had initially been treated with lamotrigine and ziprasidone, which have lower weight gain potential, but her symptoms were not well controlled on these medications. Attempts to control her weight with lifestyle changes, commercial weight-loss programs and approved weight-loss pharmacotherapy have been unsuccessful. She currently has comorbid type II diabetes, hypertension and dyslipidemia. She has been researching bariatric surgery as a tool to help control her weight and has requested your opinion on this procedure.

According to Canadian obesity guidelines,¹ the initial treatment for overweight and obese adults is an energy-reduced diet and regular physical activity. The additions of an appropriate pharmacologic agent and/or bariatric surgery are to be considered as BMI and medical comorbidities increase and lifestyle interventions fail to result in clinically important weight loss. However, these recommendations are designed to address the obesity epidemic in the general population and may not adequately reflect the needs of patients with chronic mental illness. For this population, the

added burdens caused by a symptom profile that increases the consumption of calorie-rich foods and decreases ability to be physically active, combined with pharmacological treatments that contribute to weight gain, may mean that interventions as an adjunct to lifestyle changes need to be implemented earlier.

As obesity rates increase in the general population, so does the number of people seeking bariatric surgery as a tool to deal with this problem. Bariatric surgery, also known as weight loss surgery, refers to the various procedures performed to modify the gastrointestinal tract to reduce nutrient intake and/or absorption. The surgeries are divided into 2 main types: predominantly malabsorptive procedures that impact food absorption and restrictive procedures that primarily reduce stomach size. Despite numerous studies having documented increased rates of psychiatric comorbidities in patients seeking surgical treatment of obesity, little is known about specific contraindications for the procedure, and psychological screening for determining surgical suitability has been described by some as yet another form of discrimination against those with mental illness.² However, bariatric surgery is not uniformly successful, and appropriate patient selection improves outcome. About 15%–30% of patients are denied bariatric surgery in the United States, and some of the most frequent reasons for refusal are psychiatric: current substance abuse, an active eating disorder and severe, untreated mental illness.³ Understanding the psychological factors impacting weight control such as the use of food as a coping mechanism or as a consequence of

trauma is also important, as is a realistic understanding of the physical and psychological outcomes of the surgery.³ Although major depression is not a contraindication for bariatric surgery, bariatric surgery is not an acceptable treatment for depression.

The impact of bariatric surgery on psychiatric pharmacotherapy has not received much attention, and few specific recommendations exist to optimize medication regimens for this population. Based on potential for decreased absorption, it has been suggested that patients taking lamotrigine, olanzapine and quetiapine be monitored for decreased efficacy, as should those on controlled or extended-release antidepressants.⁴ Given that lithium is influenced by factors such as fluid volume, levels of this medication should also be monitored postoperatively to prevent problems with toxicity.

Patients with a psychiatric illness are especially vulnerable to obesity, and as a consequence of the factors contributing to weight gain in this population, they may also be less amenable to changes in diet and exercise alone. Bariatric surgery, a weight-loss tool that essentially cures obesity-related comorbidities such as type II diabetes, hypertension and dyslipidemia,⁵ may be lifesaving for this population and is an option that we need to thoroughly consider.

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Psychopharmacology for the Clinician columns are usually based on a case report that illustrates a point of interest in clinical psychopharmacology. They are about 500–650 words long and do not include references. Columns can include a bibliography which will be available only on the journal website and can be accessed through a link at the bottom of the column.

Please submit appropriate columns online at <http://mc.manuscriptcentral.com/jpn>; inquiries may be directed to jpn@cma.ca.

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