XXIII EDICIÓN 2022

INTERPSIQUIS

Preferencias alimentarias en el inicio del tratamiento con clozapina

Marina Garriga, MD, PhD
Servicio de Psiquiatría y Psicología Clínica
Hospital Clínic Barcelona
Universidad de Barcelona
IDIBAPS, CIBERSAM

MORTALITY "GAP" ON SMI

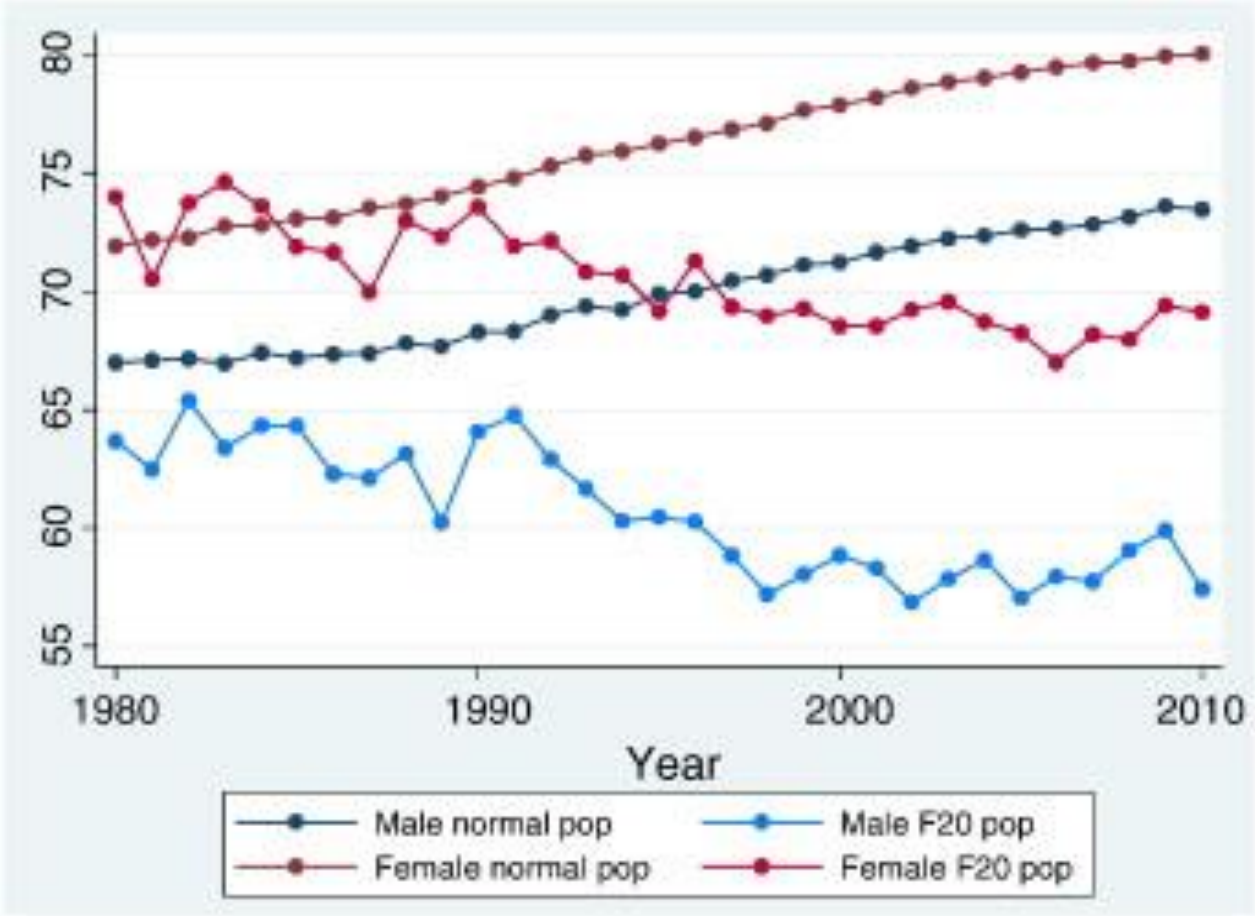


Fig. 2. Average age of death by year for the schizophrenia and general population over three decades with intentional self-harm excluded as cause of death.

Contents lists available at SciVerse ScienceDirect

Schizophrenia Research

journal homepage: www.elsevier.com/locate/schres

Increasing mortality gap for patients diagnosed with schizophrenia over the last three decades — A Danish nationwide study from 1980 to 2010

René Ernst Nielsen [a,b,*], Anne Sofie Uggerby [a], Signe Olrik Wallenstein Jensen [a], John Joseph McGrath [c,d]

[a] Unit for Psychiatric Research, Aalborg Psychiatric Hospital, Aarhus University Hospital, Aalborg, Denmark
[b] Team for Young People with Schizophrenia, Aalborg Psychiatric Hospital, Aarhus University Hospital, Aalborg, Denmark
[c] Queensland Centre for Mental Health Research, The Park Centre for Mental Health, Queensland, Australia
[d] Queensland Brain Institute, The University of Queensland, Queensland, Australia

Average age of death (2010):
62.2 yo SCH
73.4 yo general pop

MORTALITY "GAP" ON SMI

Acta Psychiatrica Scandinavica

Original Article

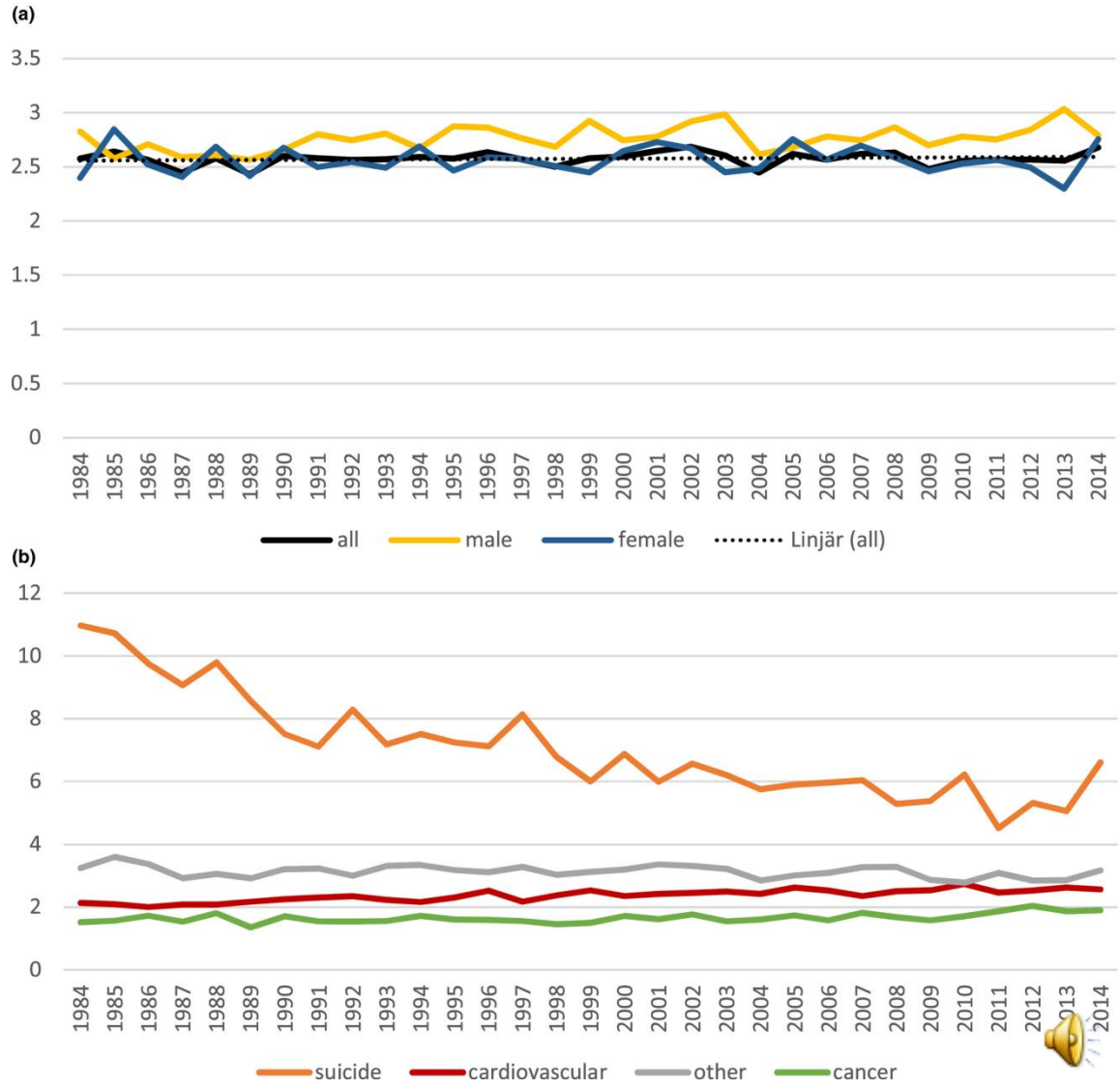
Mortality in schizophrenia: 30-year nationwide follow-up study

A. Tanskanen, J. Tiihonen, H. Taipale

First published: 13 June 2018 | https://doi.org/10.1111/acps.12913 | Citations: 53

Mean age at death increased from 57.6 years in 1984 to 70.1 years in 2014 in persons with schizophrenia, and from 70.9 to 77.5 years in the general population.

The SMRs for cardiovascular and cancer deaths showed increasing trends.



MORTALITY "GAP" ON SMI

Schizophrenia Bulletin vol. 47 no. 2 pp. 474–484, 2021
doi:10.1093/schbul/sbaa137
Advance Access publication 3 October 2020

Excess Mortality and Life-Years Lost in People With Schizophrenia and Other Non-affective Psychoses: An 11-Year Population-Based Cohort Study

Nicholas Chak Lam Yung[1], Corine Sau Man Wong[1,*], Joe Kwun Nam Chan[1], Eric Yu Hai Chen[1,2], and Wing Chung Chang[*,1,2]

[1]Department of Psychiatry, Queen Mary Hospital, The University of Hong Kong, Pokfulam, Hong Kong; [2]State Key Laboratory of Brain and Cognitive Sciences, The University of Hong Kong, Pokfulam, Hong Kong

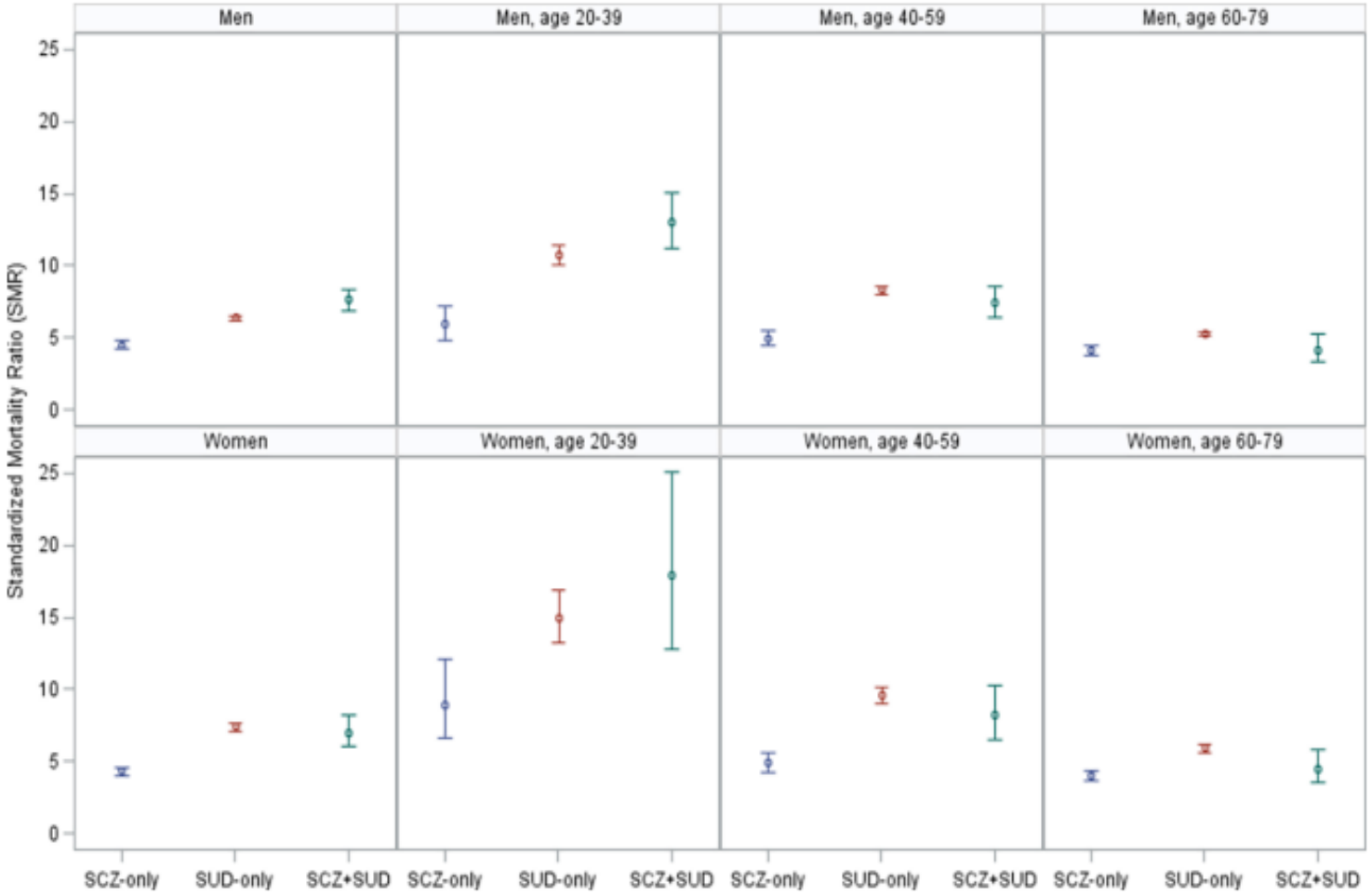
*To whom correspondence should be addressed; Department of Psychiatry, Queen Mary Hospital, The University of Hong Kong, Pokfulam, Hong Kong; tel: (852)-22554486, fax: (852)-28551345, e-mail: changwc@hku.hk

Life-years lost (LYLs) (2016):
Men and women with schizophrenia had 9.53 years and 8.07 years of excess LYLs, respectively.

Standardized mortality ratios (SMRs) (2016):
natural-cause (1.80 [1.74–1.85])
unnatural-cause (6.97 [6.47–7.49])

Respiratory diseases, cardiovascular diseases, and cancers accounted for the majority of deaths.

MORTALITY "GAP" ON SMI



PLOS ONE

RESEARCH ARTICLE

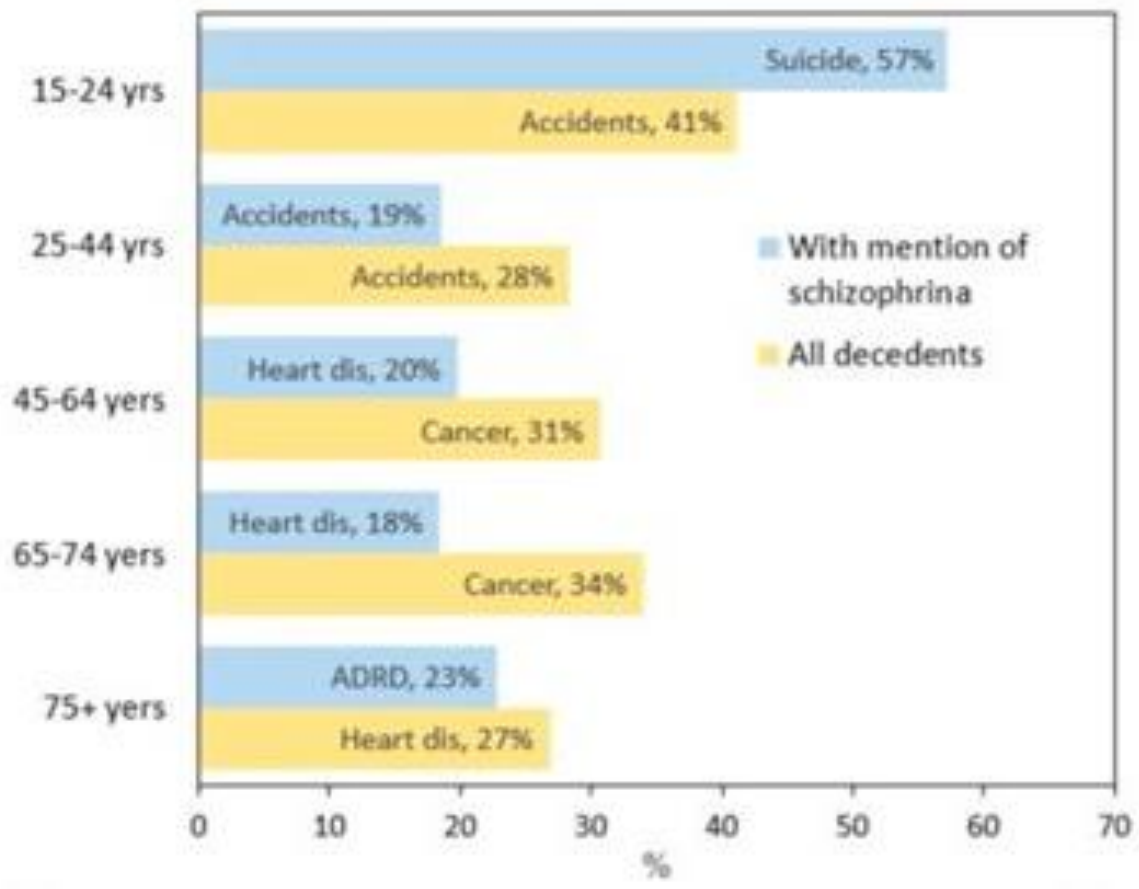
Total and cause-specific standardized mortality ratios in patients with schizophrenia and/or substance use disorder

Ina H. Heiberg[1]*, Bjarne K. Jacobsen[1,2], Ragnar Nesvåg[3], Jørgen G. Bramness[4,5], Ted Reichborn-Kjennerud[6,7], Øyvind Næss[7,8], Eivind Ystrom[6,9,10], Christina M. Hultman[11], Anne Høye[1,5,6,12]

Standardized mortality ratios (SMRs) (2015):
4.9 (95% CI 4.7–5.1) all SCH
4.4 (95% CI 4.2–4.6) SCH (no SUD)
6.6 (95% CI 6.5–6.8) SUD
7.4 (95% CI 7.0–8.2) SCH + SUD

Fig 1. All-cause age, gender, and calendar-year standardized mortality ratios according to gender and age among patients with schizophrenia and/or substance use disorders.

MORTALITY "GAP" ON SMI




Schizophrenia Research 197 (2018) 116–123
Contents lists available at ScienceDirect
Schizophrenia Research
journal homepage: www.elsevier.com/locate/schres
ELSEVIER

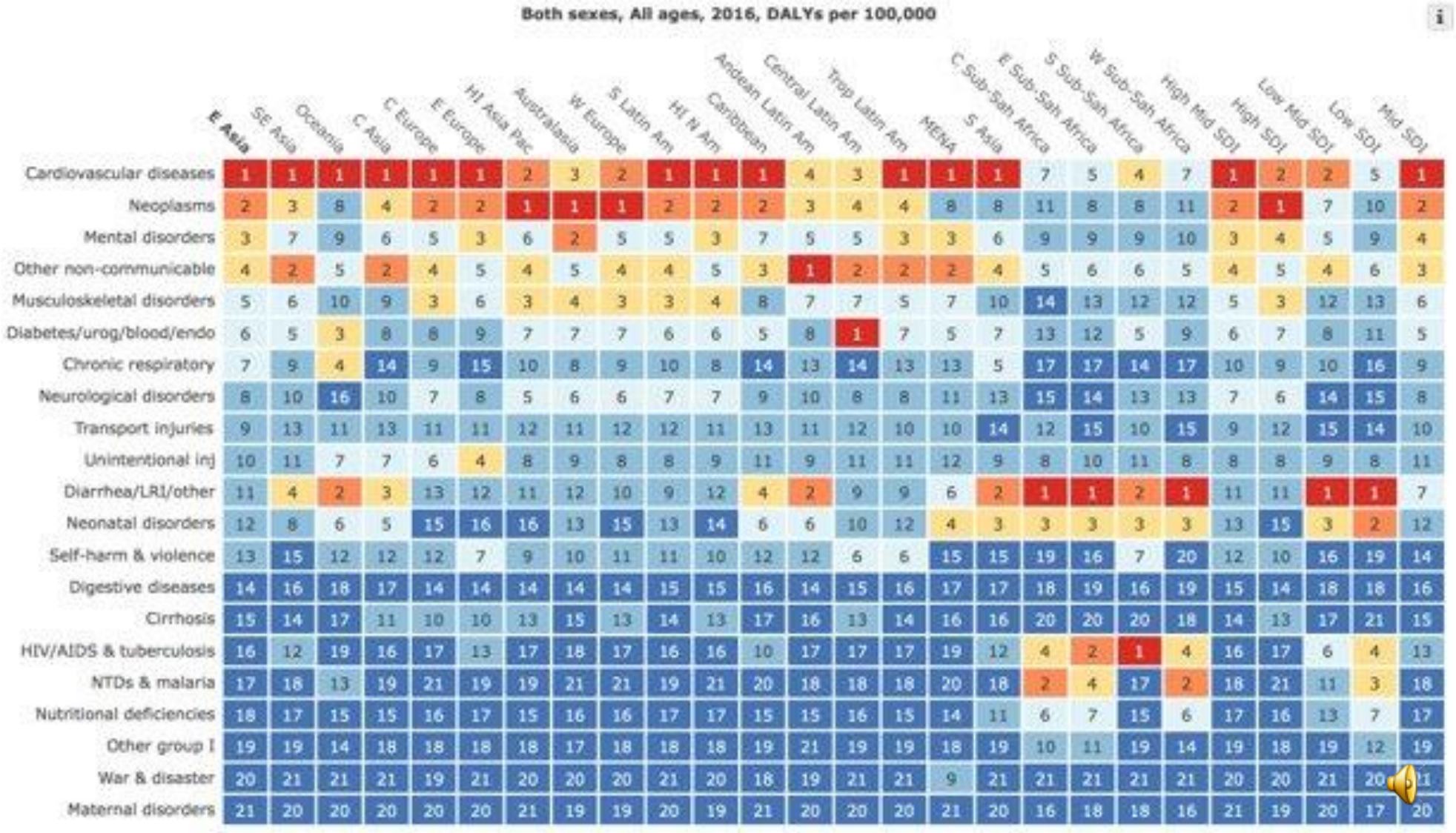
Leading causes of death among decedents with mention of schizophrenia on the death certificates in the United States

Jin-Jia Lin [a,b], Fu-Weng Liang [c], Chung-Yi Li [c,d], Tsung-Hsueh Lu [c,*]

[a] The Department of Psychiatry, Chi Mei Medical Center, Tainan, Taiwan
[b] Department of Psychiatry, School of Medicine, College of Medicine, Taipei Medical University, Taipei, Taiwan
[c] The NCKU Center for Health Data and Department of Public Health, College of Medicine, National Cheng Kung University, Tainan, Taiwan
[d] Department of Public Health, College of Public Health, China Medical University, Taichung, Taiwan

Cause of death (COD) (2015):
Heart disease and cancer was the first and the second leading COD throughout the study years

DISABILITY "GAP" ON SMI



IHME

Measuring what matters

TRIP TO THE PAST…

In 1674, Thomas Willis, the famous British physician who identified glycosuria as a sign of diabetes, was the first to address the natural history of comorbid depression and diabetes when he wrote that diabetes was caused by “sadness or long sorrow and other depressions.”

“Diabetes is a disease which often shows itself in families in which insanity prevails: whether one disease predisposes in any way to the other or not, or whether they are independent outcomes of a common neurosis, they are certainly found to run side by side, or alternately with one another more often than can be accounted for by accidental coincidence or sequence”.

Henry Maudsley, 1898

“*Besides the psychic disorders, there are also in the physical domain a series of morbid phenomena to record... The obscurity... has been a frequent motive for an examination of the blood picture and of metabolism, but the endings up to now are not very satisfactory*.”

—Emil Kraepelin, 1913

TRIP TO THE PAST…

1952 the first antipsychotic arrived (chlorpromazine).

The connection remained forgotten for almost 50 years.

Table 1. Are patients with mood and psychotic disorders at higher risk for type 2 diabetes? Pre-DSM-III investigations (adapted from reference 45)

Study (reference)	*N*	*Diagnostic method*	*Results*
Kooy, 1919 (39)	40 mood disorder 10 DP 20 controls	FPG	Hyperglycemia in melancholia, catatonia
Raphael et al, 1921 (92)	7 controls 29 DP MDI 7 D	OGTT	Hyperglycemia in DP, MDI (subjects excluded for obesity)
Lorenz, 1922 (93)	107 inpatients	OGTT	Hyperglycemia in catatonia, depressed MDI
Kasanin, 1926 (94)	40 inpatients	OGTT	Hyperglycemia in 22/40 (55%)
Bowman et al, 1929 (90)	295 inpatients 41 controls	FPG >7.5 mmol/L	Diabetes: 14% inpatients, 0% controls
McCowan et al, 1931 (95)	85 psychotic 12 controls	OGTT	Hyperglycemia in mania, melancholia
Tod, 1934 (96)	36 inpatients	OGTT	Hyperglycemia in mania, melancholia and stupor
Whitehorn, 1934 (91)	951 "excited" inpatients	FPG >8.75 mmol/L	13% diabetes (age; chronicity)
Diethelm, 1936 (97)	26 patients	OGTT	Hyperglycemia during acute illness, especially anxiety
Tod, 1937 (98)	28 inpatients	OGTT	Hyperglycemia in patients reduced by hypnotics
Braceland et al, 1946 (99)	29 schizophrenia 25 controls	2h insulin (0.1 U/kg)	Greater insulin resistance in schizophrenia
Freeman, 1946 (100)	95 soldiers, psychosis, 20 controls	2h insulin (0.1 U/kg)	Greater insulin resistance in schizophrenia, MDI

MetS FROM THE BEGINING

Table 3
Metabolic syndrome criteria (IDF and ATP-III-A) and T2DM or impaired glucose prevalence.

	Psychosis (n=84)	Healthy controls (n=98)	Statistics, P
Waist criteria IDF	20% (n=17)	17% (n=17)	0.618
Waist criteria ATP-III	7% (n=6)	5% (n=5)	0.562
Triglyceride criteria	6% (n=5)	8% (n=8)	0.564
HDL criteria	37% (n=31)	25% (n=24)	0.069
Blood pressure criteria	31% (n=26)	28% (n=27)	0.615
Systolic blood pressure	25% (n=21)	19% (n=19)	0.362
Diastolic blood pressure	14% (n=12)	12% (n=12)	0.685
Glucose criteria	4% (n=3)	2% (n=2)	0.529
Metabolic syndrome criteria IDF	6% (n=5)	4% (n=4)	0.562
Metabolic syndrome criteria ATP-III	6% (n=5)	4% (n=4)	0.562
Impaired fasting glucose or T2DM	4% (n=3)	2% (n=2)	0.529
Impaired glucose tolerance or T2DM	12% (n=10)	3% (n=3)	0.021
Total abnormal glucose diagnosis	14% (n=12)	5% (n=5)	0.034


European Psychiatry xxx (2016) xxx–xxx

Contents lists available at ScienceDirect

European Psychiatry

journal homepage: http://www.europsy-journal.com

ELSEVIER

Original article

Metabolic syndrome or glucose challenge in first episode of psychosis?

C. Garcia-Rizo[a,b,c,*], E. Fernandez-Egea[b,d,e], C. Oliveira[a], A. Meseguer[a], B. Cabrera[a,b], G. Mezquida[a], M. Bioque[a,b], R. Penades[a,b,c,f], E. Parellada[a,b,c,f], M. Bernardo[a,b,c,f], B. Kirkpatrick[g]

MetS FROM THE BEGINING

Schizophrenia Research 179 (2017) 57–63

Contents lists available at ScienceDirect

Schizophrenia Research

journal homepage: www.elsevier.com/locate/schres

Meta-analysis of glucose tolerance, insulin, and insulin resistance in antipsychotic-naïve patients with nonaffective psychosis

Anne Marie Greenhalgh [a], Leticia Gonzalez-Blanco [b,c], Clemente Garcia-Rizo [c,d,e], Emilio Fernandez-Egea [f,g], Brian Miller [h], Miguel Bernardo Arroyo [c,d,e], Brian Kirkpatrick [a,*]

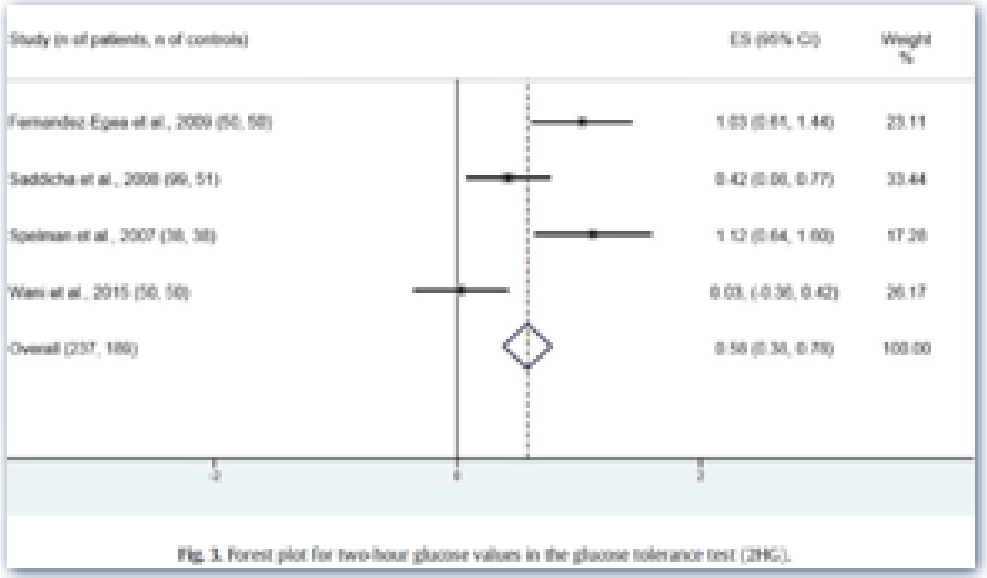
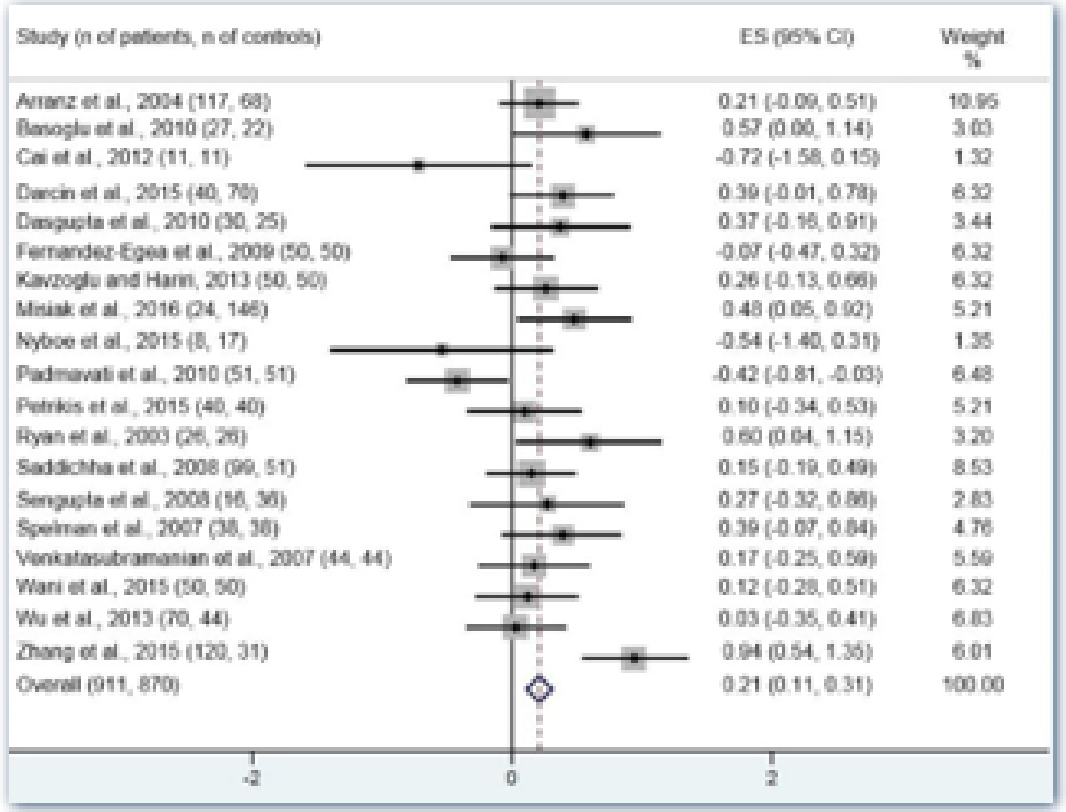
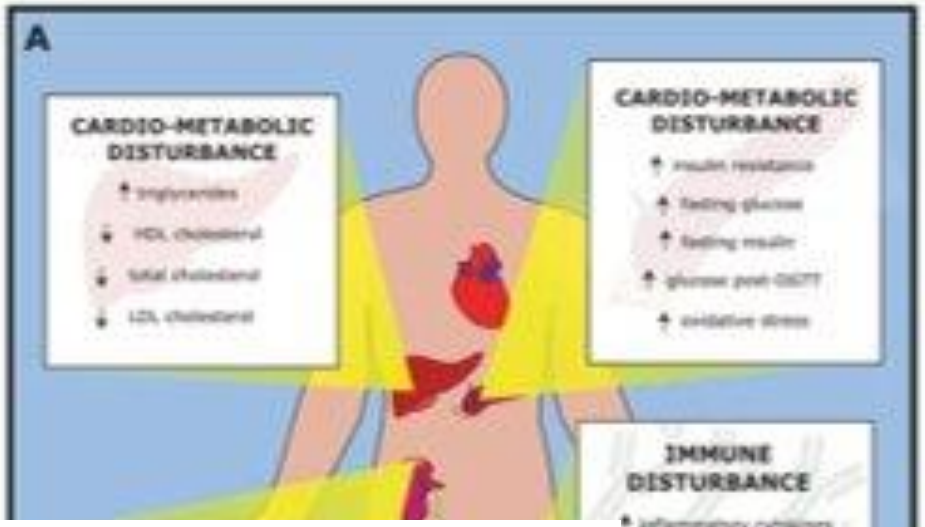


Fig. 3. Forest plot for two-hour glucose values in the glucose tolerance test (2HG).



SCH AS A SYSTEMIC DISORDER



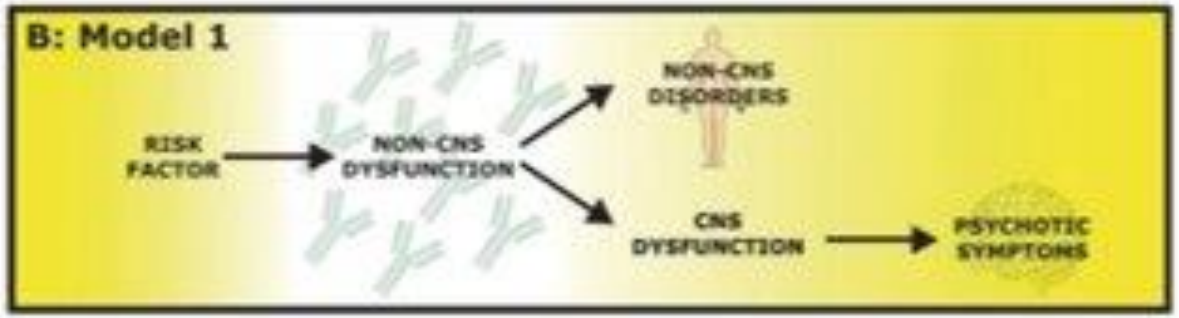
Molecular Psychiatry
https://doi.org/10.1038/s41380-018-0058-9

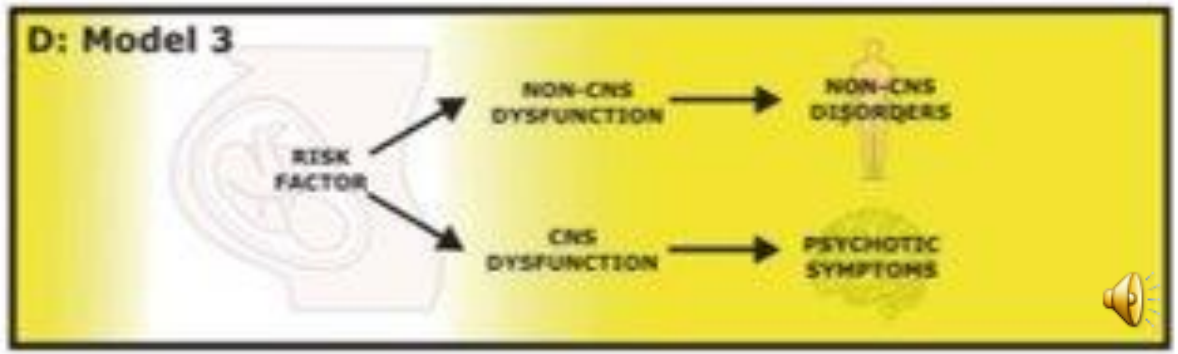
PERSPECTIVE

Is psychosis a multisystem disorder? A meta-review of central nervous system, immune, cardiometabolic, and endocrine alterations in first-episode psychosis and perspective on potential models

Toby Pillinger[1] · Enrico D'Ambrosio[1] · Robert McCutcheon[1] · Oliver D Howes[1,2,3]

Received: 8 December 2017 / Revised: 1 February 2018 / Accepted: 21 February 2018





SCH AND FETAL PROGRAMMING

Acta Psychiatrica Scandinavica

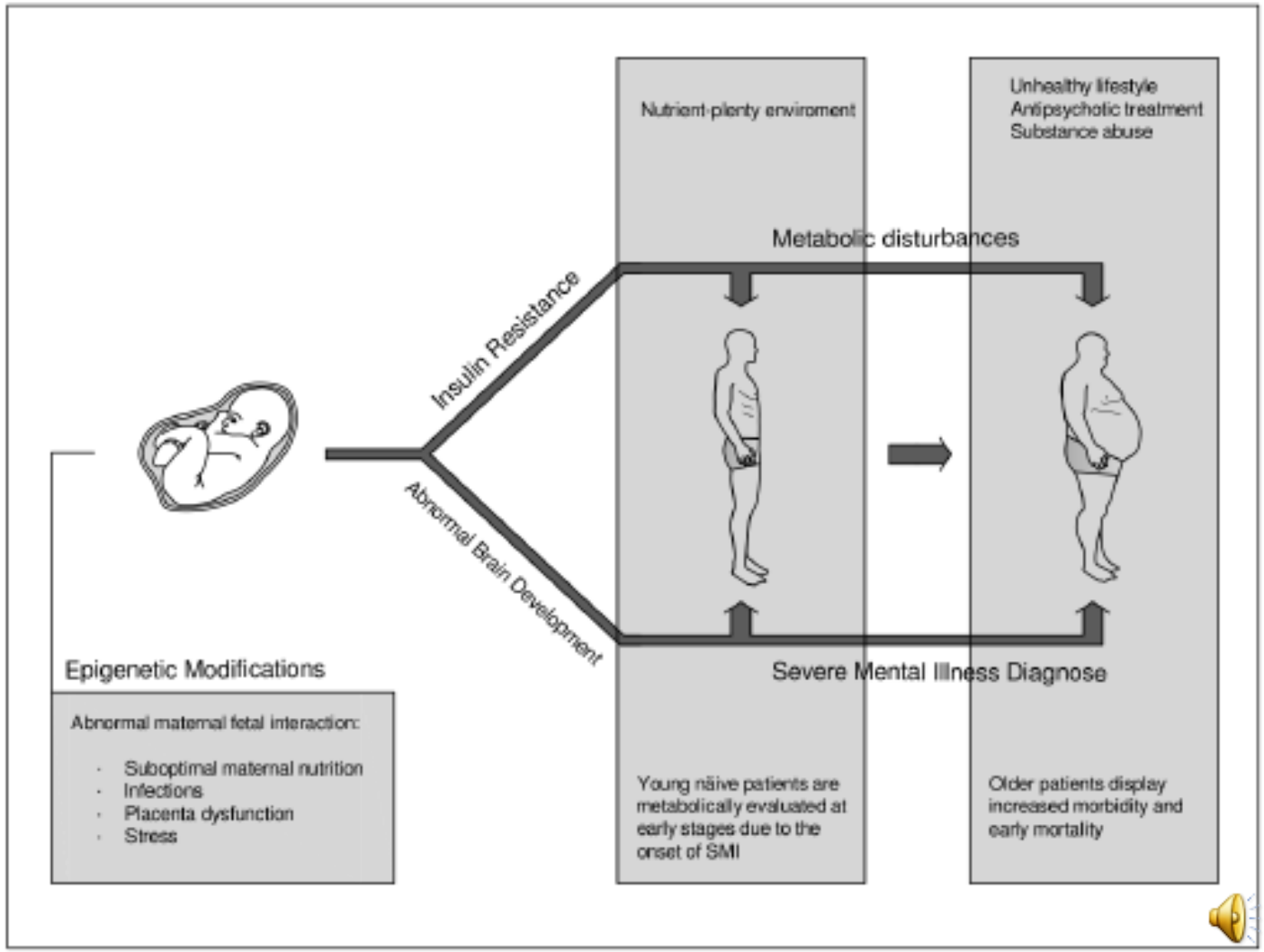
Acta Psychiatr Scand 2014: 1-3
All rights reserved
DOI: 10.1111/acps.12309

ACTA PSYCHIATRICA SCANDINAVICA

Editorial comment

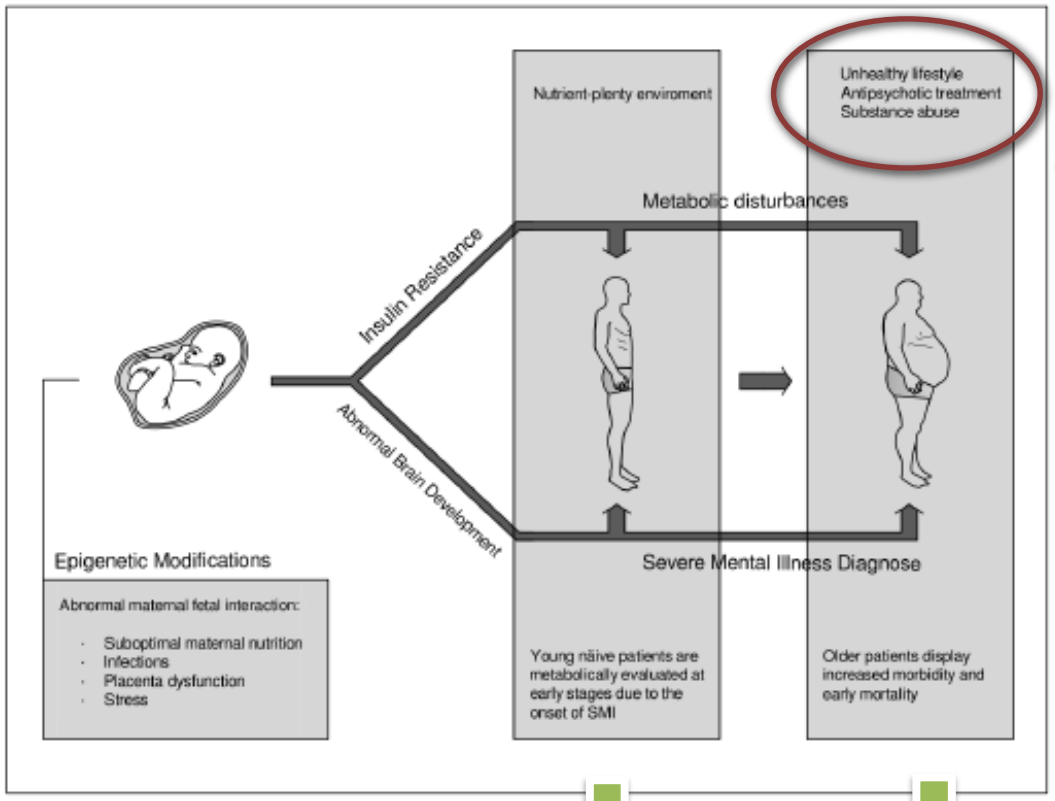
The thrifty psychiatric phenotype

Thrifthy psychiatric phenotype schema



INCEPTION

Thrifthy psychiatric phenotype schema



OLZ

CLZ

FEP | **TRS**

Early epigenetic modifications might predict similar evolutive Physical/weight changes?

MetS AND ANTIPSYCHOTICS

		Weight gain	Diabetes risk
SGA	Clozapine	**Severe**	**Severe**
	Olanzapine	**Severe**	**Severe**
	Quetiapine	Intermediate	Significant
	Risperidone	Intermediate	Low/neutral
	Paliperidone	Intermediate	Low/neutral
	Asenapine	Intermediate	Low/neutral[a]
	Lurasidone	Low/neutral	Low/neutral[a]
	Aripiprazole	Low/neutral	Low/neutral
	Ziprasidone	Low/neutral	Low/neutral
FGA	Chlorpromazine	Significant	Significant
	Haloperidol	Intermediate	Low/neutral
	Fluphenazine	Low/neutral[a]	Low/neutral[a]
	Perphenazine	Low/neutral[a]	Low/neutral

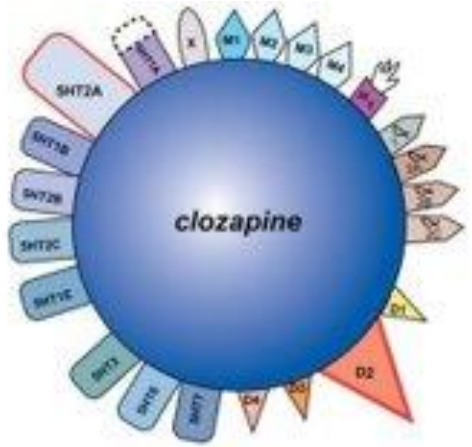
[a] More data needed

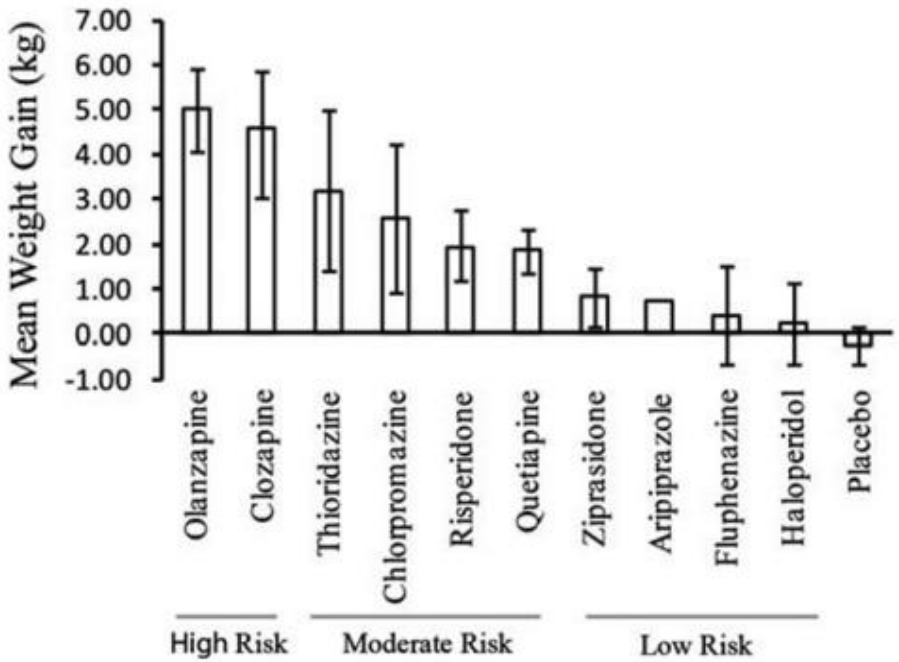
- **Psychiatryc illness** — Vancampfort et al., 2012
- **Poor life-style behaviours** — Jackobsen et al., 2018
- **Poor medical monitoring** — Vancampfort et al., 2012
- **Pro-inflamatory states** — Radhakrishnan et al., 2017
- **"Accelerating aging"** — Ridout et al., 2018
- **Psychopharmacological** — Correll et al., 2015 and 2017
- **Genetic risk** — Gebhardt et al., 2010
- **Epigenetic modifications** — Cariaga-Martine et al., 2017

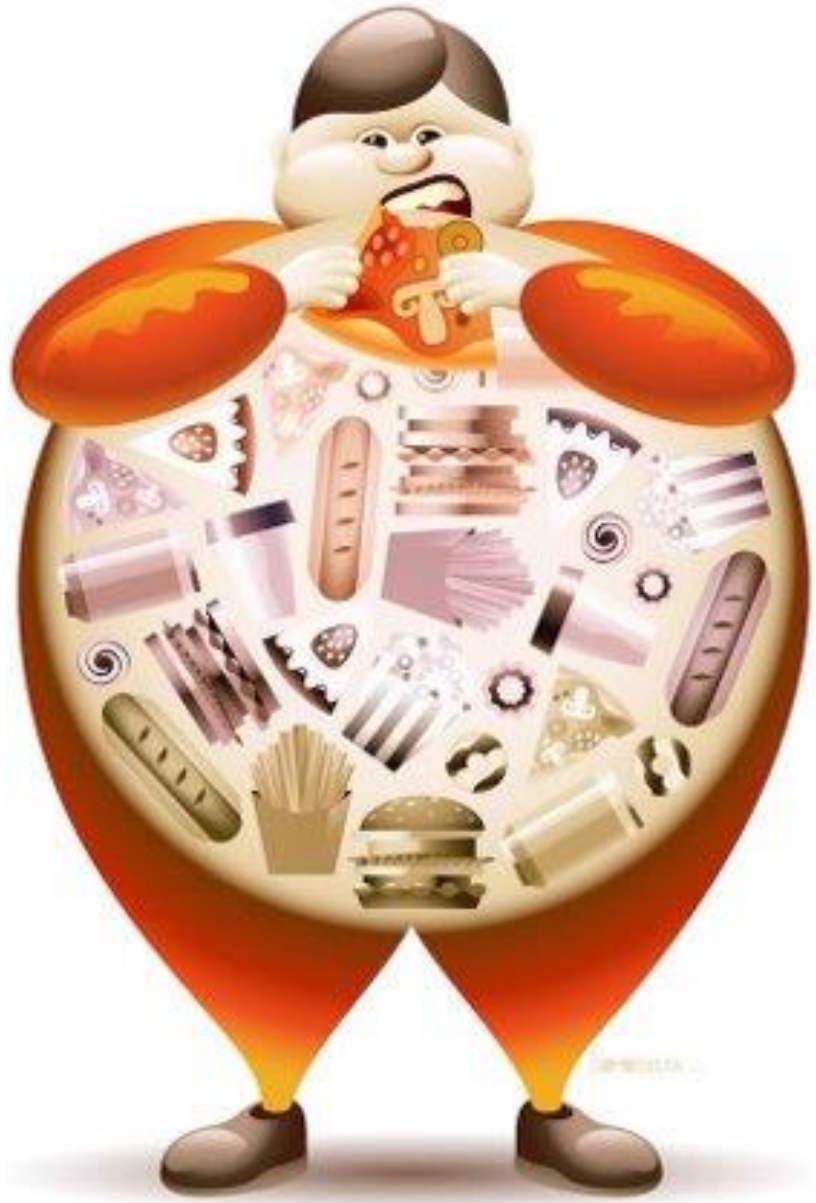
CARDIOVASCULAR RISK FACTORS

NON-MODIFIABLE	MODIFIABLE
• Genes • Age • Gender • Ethnicity • Famiy history • …	• Tabacco / Alcohol • High blood preassure • **Hyperlipidemia** • Diabetes • **MetS** • Physical inactivity • Obesity (abdominal) • Unhealthy diet • Psychosocial factors • …

CLOZAPINE


clozapine
5HT2A
5HT2B
5HT2B
5HT2C
5HT1C
D1
D2
5HT7
5HT6
5HT
D4


Mean Weight Gain (kg)
7.00
6.00
5.00
4.00
3.00
2.00
1.00
0.00
-1.00
Olanzapine
Clozapine
Thioridazine
Chlorpromazine
Risperidone
Quetiapine
Ziprasidone
Aripiprazole
Fluphenazine
Haloperidol
Placebo
High Risk
Moderate Risk
Low Risk



CLOZAPINE AND MetS

GOBIERNO DE ESPAÑA · MINISTERIO DE ECONOMÍA Y COMPETITIVIDAD · Instituto de Salud Carlos III

RESULTADO EXPEDIENTE - PI14/00753

Centro Solicitante: FUNDACION PRIVADA CLINIC

Centro Realizador: HOSPITAL CLINICO Y PROVINCIAL DE BARCELONA

Título: Evolución metabólica e immune del tratamiento con clozapina: implicaciones terapeuticas

50 pacientes incluidos (06/ 2015-06/2019)
Agudos HCP
CSM Esquerra Eixample, CSM Sants, CSM Montjuic, Hospital de Día Corcega

Inicio	35 ambulatorios 15 Ingresados
Diagnostico	40 Esquizofrenia y psicosis relacionadas 10 Trastorno Bipolar

SCH AND EATING PATTERNS

nutrients

MDPI

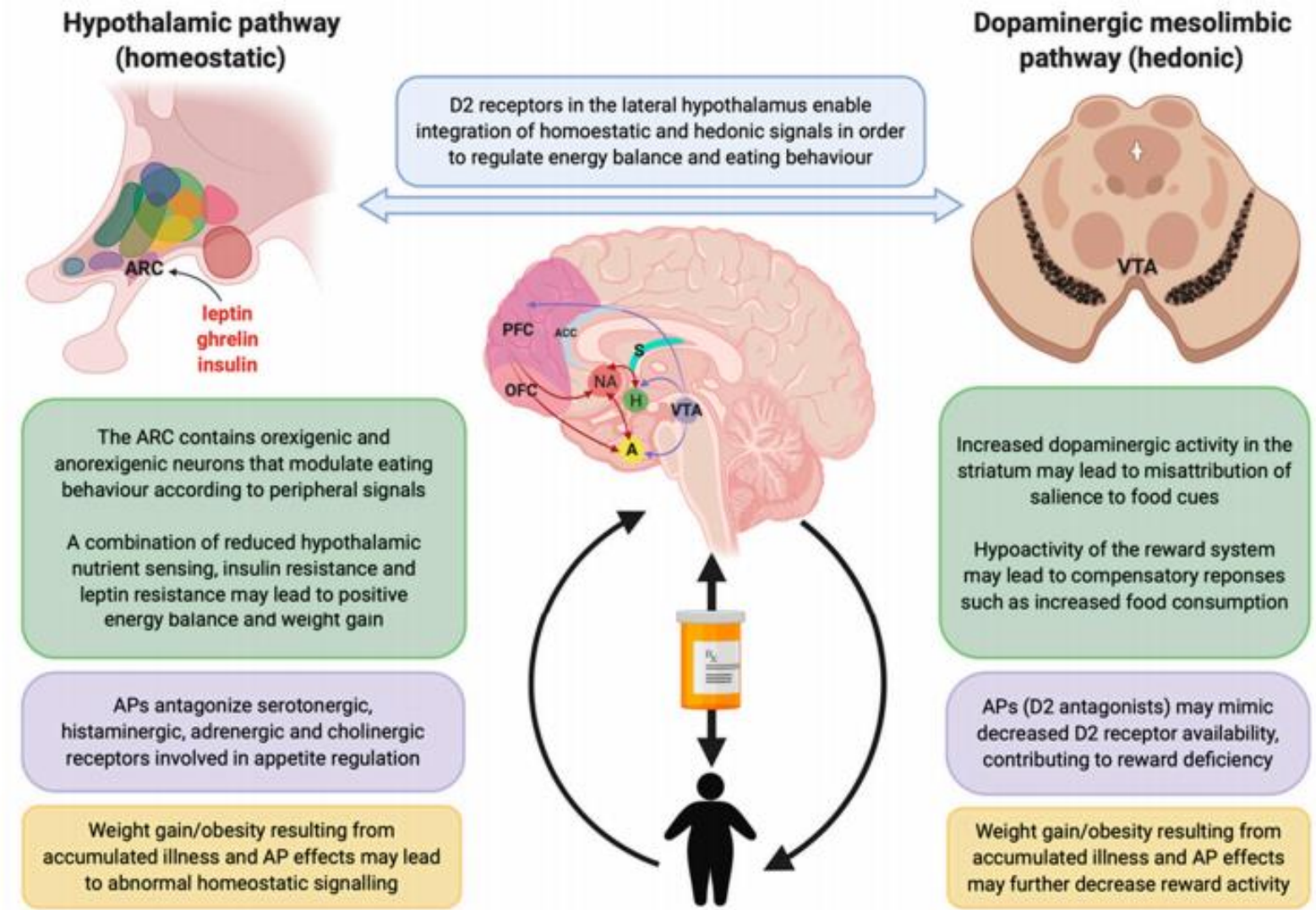
Review

Exploring Patterns of Disturbed Eating in Psychosis: A Scoping Review

Nicolette Stogios [1,2,†], Emily Smith [1,2,†], Roshanak Asgariroozbehani [1,2,†], Laurie Hamel [1], Alexander Gdanski [3], Peter Selby [1,4,5,6], Sanjeev Sockalingam [1,2,6,7], Ariel Graff-Guerrero [1,2,6], Valerie H. Taylor [8], Sri Mahavir Agarwal [1,2,6,‡] and Margaret K. Hahn [1,2,6,*,‡]

Abstract: Disturbed eating behaviours have been widely reported in psychotic disorders since the early 19th century. There is also evidence that antipsychotic (AP) treatment may induce binge eating or other related compulsive eating behaviours. It is therefore possible that abnormal eating patterns may contribute to the significant weight gain and other metabolic disturbances observed in patients with psychosis. In this scoping review, we aimed to explore the underlying psychopathological and neurobiological mechanisms of disrupted eating behaviours in psychosis spectrum disorders and the role of APs in this relationship. A systematic search identified 35 studies that met our eligibility criteria and were included in our qualitative synthesis. Synthesizing evidence from self-report questionnaires and food surveys, we found that patients with psychosis exhibit increased appetite and craving for fatty food, as well as increased caloric intake and snacking, which may be associated with increased disinhibition. Limited evidence from neuroimaging studies suggested that AP-naïve first episode patients exhibit similar neural processing of food to healthy controls, while chronic AP exposure may lead to decreased activity in satiety areas and increased activity in areas associated with reward anticipation. Overall, this review supports the notion that AP use can lead to disturbed eating patterns in patients, which may contribute to AP-induced weight gain. However, intrinsic illness-related effects on eating behaviors remain less well elucidated, and many confounding factors as well as variability in study designs limits interpretation of existing literature in this field and precludes fir conclusions from being made.

CLOZAPINE AND FOOD PREFERENCES



CLOZAPINE AND FOOD PREFERENCES

Psychopharmacology
https://doi.org/10.1007/s00213-019-05291-3

ORIGINAL INVESTIGATION

Food craving and consumption evolution in patients starting treatment with clozapine

Marina Garriga[1,2,3,4] · Andrea Mallorquí[5] · Lourdes Serrano[5] · José Ríos[6,7] · Manel Salamero[5] · Eduard Parellada[2,3,4,8] · Marta Gómez-Ramiro[8] · Cristina Oliveira[8] · Silvia Amoretti[2,3,4,8] · Eduard Vieta[1,2,3,4] · Miquel Bernardo[2,3,4,8] · Clemente García-Rizo[2,3,4,8]

Abstract

Background Antipsychotic-induced weight gain has been especially related to clozapine and olanzapine. Underlying mechanisms in relation to food preferences with an increased food craving and consumption of specific nutrients have not been extensively studied in patients with serious mental illness (SMI). We aim to describe specific food preferences (craving) and subsequent food consumption in SMI patients starting clozapine, as well as their possible relation to weight and body mass index (BMI).

Methods An observational prospective follow-up study (18 weeks) was conducted in a cohort of 34 SMI patients who started clozapine due to resistant-psychotic symptoms. Anthropometric measures, Food Craving Inventory (FCI), and a food consumption frequency questionnaire were evaluated at baseline, weeks 8 and 18 of treatment. Statistical analysis included generalized estimating equations models with adjustment for potential confounding factors.

Results No longitudinal changes over time were found across the different food craving scores after 18 weeks of treatment. However, adjusted models according to BMI status showed that the normal weight (NW) group presented an increased score for the "complex carbohydrates/proteins" food cravings (− 0.67; 95% CI [− 1.15, − 0.19]; $P = 0.010$), while baseline scores for "fast-food fats" cravings were significantly higher in the overweight/obese (OWO) group in comparison with NW patients (NW, 2.05; 95% CI [1.60, 2.49]; OWO, 2.81, 95% CI [2.37, 3.25]; $P = 0.016$). When considering if food craving could predict weight gain, only increments in "fast-food fats" cravings were associated ($\beta = -5.35 \pm 1.67$; 95% CI [− 8.64, − 2.06]; $P = 0.001$).

Conclusions No longitudinal differences were found for any of the food craving scores evaluated; however, in the NW group, food craving for "complex carbohydrates/proteins" changed. Thus, changes in "fast-food fats" cravings predicted weight increase in this sample. Interventions targeting food preferences may help to mitigate weight gain in patients starting treatment with clozapine.

CLOZAPINE AND FOOD PREFERENCES

APPENDIX

FOOD CRAVING INVENTORY

Food craving is defined as an intense desire to consume a particular food (or food type) that is difficult to resist.

Directions: For each of the foods listed below (Items 1-28), please circle the appropriate letter using the following scale.

Over the past month, how often have you experienced a craving for the food?

A = Never
B = Rarely (once or twice)
C = Sometimes
D = Often
E = Always/almost every day

List of foods:

Cake	A	B	C	D	E
Pizza	A	B	C	D	E
Fried Chicken	A	B	C	D	E
Sausages	A	B	C	D	E
French Fries	A	B	C	D	E
Rice	A	B	C	D	E
Hot Dogs	A	B	C	D	E
Hazelnut Spread	A	B	C	D	E
Hamburger	A	B	C	D	E
Biscuits	A	B	C	D	E
Ice Cream	A	B	C	D	E
Pasta	A	B	C	D	E
Fried Fish	A	B	C	D	E
Cookies	A	B	C	D	E
Chocolate	A	B	C	D	E
Pancakes	A	B	C	D	E
Rolls	A	B	C	D	E
Donuts	A	B	C	D	E
Candies	A	B	C	D	E
Brownies	A	B	C	D	E
Bacon	A	B	C	D	E
Croissant	A	B	C	D	E
Steak	A	B	C	D	E
Pie	A	B	C	D	E
Baked Potatoes	A	B	C	D	E
Barbecued Foods	A	B	C	D	E
Mashed Potatoes	A	B	C	D	E
Bagel	A	B	C	D	E

FOOD CRAVING INVENTORY-SP
(Spanish version)

(White, Whisenhunt, Williamson, Greenway, and Netemeyer, 2001. Adaptation and validation by Jáuregui, Bolaños, Valero, and Carbonero, 2010)

El "food craving" se define como un intenso deseo de consumir un alimento concreto (o un tipo de alimento), que resulta difícil de resistir.

Instrucciones: Para cada alimento que figura en la lista rodee con un círculo la letra apropiada usando la siguiente escala.

A lo largo del pasado mes, ¿con qué frecuencia ha experimentado "craving" por el alimento?

A = Nunca
B = Rara vez (una o dos veces)
C = Algunas veces
D = A menudo
E = Siempre, casi todos los días

Lista de alimentos:

Pastel	A	B	C	D	E
Pizza	A	B	C	D	E
Pollo frito	A	B	C	D	E
Salchichas	A	B	C	D	E
Patatas fritas	A	B	C	D	E
Arroz	A	B	C	D	E
Perritos calientes	A	B	C	D	E
Crema con avellanas	A	B	C	D	E
Hamburguesas	A	B	C	D	E
Biscuits	A	B	C	D	E
Helado	A	B	C	D	E
Pasta	A	B	C	D	E
Pescado frito	A	B	C	D	E
Galletas, cookies	A	B	C	D	E
Chocolate	A	B	C	D	E
Tortitas, barquillos	A	B	C	D	E
Panecillos	A	B	C	D	E
Donuts	A	B	C	D	E
Caramelos	A	B	C	D	E
Pastelito de chocolate (tipo Brownie)	A	B	C	D	E
Bacon/Panceta	A	B	C	D	E
Croissant	A	B	C	D	E
Filete	A	B	C	D	E
Tarta	A	B	C	D	E
Patatas cocidas	A	B	C	D	E
Alimentos de barbacoa (Costillas, chuletas)	A	B	C	D	E
Puré de patatas	A	B	C	D	E
Rosquillas	A	B	C	D	E

ANEXO I. Cuestionario de Frecuencia de Consumo Alimentario - CFCA

LISTADO DE ALIMENTOS	¿CUÁNTAS VECES COME?	
	A LA SEMANA	AL MES
Leche		
Yogur		
Chocolate: tableta, bombones, "Kit Kat", "Mars"…		
Cereales inflados de desayuno ("Corn-Flakes", "Kellog's")		
Galletas tipo "maría"		
Galletas con chocolate, crema…		
Magdalenas, bizcocho…		
Ensaimada, donut, croissant…		
	A LA SEMANA	AL MES
Ensalada: lechuga, tomate, escarola…		
Judías verdes, acelgas o espinacas		
Verduras de guarnición: berenjena, champiñones		
Patatas al horno, fritas o hervidas		
Legumbres: lentejas, garbanzos, judías…		
Arroz blanco, paella		
Pasta: fideos, macarrones, espaguetis…		
Sopas y cremas		
	A LA SEMANA	AL MES
Huevos		
Pollo o pavo		
Ternera, cerdo, cordero (bistec, empanada,…)		
Carne picada, longaliza, hamburguesa		
Pescado blanco: merluza, mero,…		
Pescado azul: sardinas, atún, salmón,…		
Marisco: mejillones, gambas, langostinos, calamares,…		
Croquetas, empanadillas, pizza		
Pan (en bocadillo, con las comidas,…)		
	A LA SEMANA	AL MES
Jamón salado, dulce, embutidos		
Queso blanco o fresco (Burgos,…) o bajo en calorías		
Otros quesos: curados o semicurado, cremosos		
	A LA SEMANA	AL MES
Frutas cítricas: naranja, mandarina,…		
Otras frutas: manzana, pera, melocotón, plátano…		
Frutas en conserva (en almíbar…)		
Zumos de fruta natural		
Zumos de fruta comercial		
Frutos secos: cacahuetes, avellanas, almendras,…		
Postres lácteos: natillas, flan, requesón		
Pasteles de crema o chocolate		
Bolsas de aperitivos («chips", "chetos", "fritos"…)		
Golosinas: gominolas, caramelos…		
Helados		
	A LA SEMANA	AL MES
Bebidas azucaradas ("coca-cola", "Fanta"…)		
Bebidas bajas en calorías (coca-cola light…)		
Vino, sangría		
Cerveza		
Cerveza sin alcohol		
Bebidas destiladas: whisky, ginebra, coñac,…		

CLOZAPINE AND FOOD PREFERENCES

APPENDIX

FOOD CRAVING INVENTORY

Food craving is defined as an intense desire to consume a particular food (or food type) that is difficult to resist.

Directions: For each of the foods listed below (Items 1-28), please circle the appropriate letter using the following scale.

Over the past month, how often have you experienced a craving for the food?

A = Never
B = Rarely (once or twice)
C = Sometimes
D = Often
E = Always/almost every day

List of foods:

Cake	A	B	C	D	E
Pizza	A	B	C	D	E
Fried Chicken	A	B	C	D	E
Sausages	A	B	C	D	E
French Fries	A	B	C	D	E
Rice	A	B	C	D	E
Hot Dogs	A	B	C	D	E
Hazelnut Spread	A	B	C	D	E
Hamburger	A	B	C	D	E
Biscuits	A	B	C	D	E
Ice Cream	A	B	C	D	E
Pasta	A	B	C	D	E
Fried Fish	A	B	C	D	E
Cookies	A	B	C	D	E
Chocolate	A	B	C	D	E
Pancakes	A	B	C	D	E
Rolls	A	B	C	D	E
Donuts	A	B	C	D	E
Candies	A	B	C	D	E
Brownies	A	B	C	D	E
Bacon	A	B	C	D	E
Croissant	A	B	C	D	E
Steak	A	B	C	D	E
Pie	A	B	C	D	E
Baked Potatoes	A	B	C	D	E
Barbecued Foods	A	B	C	D	E
Mashed Potatoes	A	B	C	D	E
Bagel	A	B	C	D	E

FOOD CRAVING INVENTORY-SP
(Spanish version)

(White, Whisenhunt, Williamson, Greenway, and Netemeyer, 2001. Adaptation and validation by Jáuregui, Bolaños, Valero, and Carbonero, 2010)

El "food craving" se define como un intenso deseo de consumir un alimento concreto (o un tipo de alimento), que resulta difícil de resistir.

Instrucciones: Para cada alimento que figura en la lista rodee con un círculo la letra apropiada usando la siguiente escala.

A lo largo del pasado mes, ¿con qué frecuencia ha experimentado "craving" por el alimento?

A = Nunca
B = Rara vez (una o dos veces)
C = Algunas veces
D = A menudo
E = Siempre, casi todos los días

Lista de alimentos:

Pastel	A	B	C	D	E
Pizza	A	B	C	D	E
Pollo frito	A	B	C	D	E
Salchichas	A	B	C	D	E
Patatas fritas	A	B	C	D	E
Arroz	A	B	C	D	E
Perritos calientes	A	B	C	D	E
Crema con avellanas	A	B	C	D	E
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Biscuits	A	B	C	D	E
Helado	A	B	C	D	E
Pasta	A	B	C	D	E
Pescado frito	A	B	C	D	E
Galletas, cookies	A	B	C	D	E
Chocolate	A	B	C	D	E
Tortitas, barquillos	A	B	C	D	E
Panecillos	A	B	C	D	E
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Croissant	A	B	C	D	E
Filete	A	B	C	D	E
Tarta	A	B	C	D	E
Patatas cocidas	A	B	C	D	E
Alimentos de barbacoa (Costillas, chuletas)	A	B	C	D	E
Puré de patatas	A	B	C	D	E
Rosquillas	A	B	C	D	E

SIMPLE CARBOHYDRATES + TRANS FAT

- (e.g. processed sugar, fruit, dairy)+(e.g. fast food)

COMPLEX CARBOHYDRATES + PROTEINS

- (e.g. breads, vegetables, nuts, legumes)

SATURATED FAT

- (e.g. fatty meat, butter)

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Cereales inflados de desayuno ("Corn-Flakes", "Kellog's")		
Galletas tipo "maría"		
Galletas con chocolate, crema…		
Magdalenas, bizcocho…		
Ensaimada, donut, croissant…		
	A LA SEMANA	AL MES
Ensalada: lechuga, tomate, escarola…		
Judías verdes, acelgas o espinacas		
Verduras de guarnición: berenjena, champiñones		
Patatas al horno, fritas o hervidas		
Legumbres: lentejas, garbanzos, judías…		
Arroz blanco, paella		
Pasta: fideos, macarrones, espaguetis…		
Sopas y cremas		
	A LA SEMANA	AL MES
Huevos		
Pollo o pavo		
Ternera, cerdo, cordero (bistec, empanada,…)		
Carne picada, longaliza, hamburguesa		
Pescado blanco: merluza, mero,…		
Pescado azul: sardinas, atún, salmón,…		
Marisco: mejillones, gambas, langostinos, calamares,…		
Croquetas, empanadillas, pizza		
Pan (en bocadillo, con las comidas,…)		
	A LA SEMANA	AL MES
Jamón salado, dulce, embutidos		
Queso blanco o fresco (Burgos,…) o bajo en calorías		
Otros quesos: curados o semicurado, cremosos		
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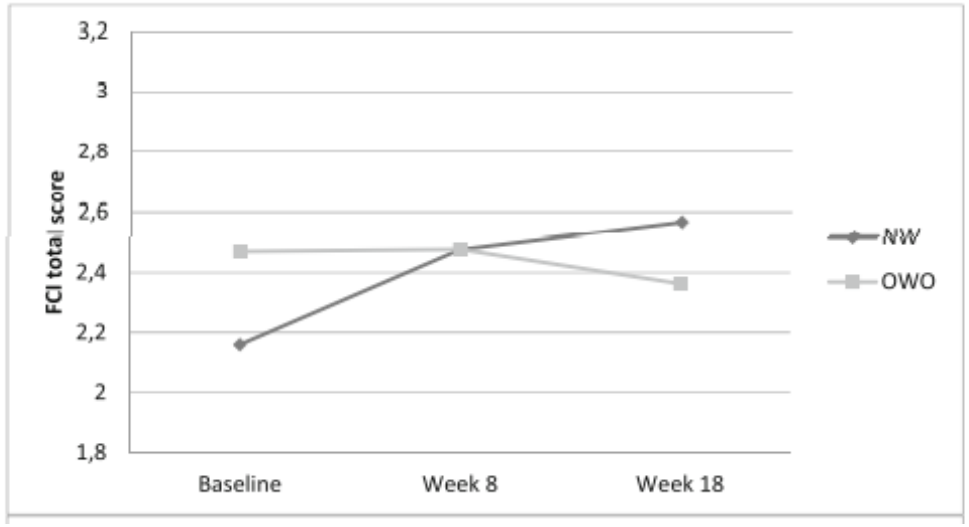
Frutas cítricas: naranja, mandarina,…		
Otras frutas: manzana, pera, melocotón, plátano…		
Frutas en conserva (en almíbar…)		
Zumos de fruta natural		
Zumos de fruta comercial		
Frutos secos: cacahuetes, avellanas, almendras,…		
Postres lácteos: natillas, flan, requesón		
Pasteles de crema o chocolate		
Bolsas de aperitivos («chips", "chetos", "fritos"…)		
Golosinas: gominolas, caramelos…		
Helados		
	A LA SEMANA	AL MES
Bebidas azucaradas ("coca-cola", "Fanta"…)		
Bebidas bajas en calorías (coca-cola light…)		
Vino, sangría		
Cerveza		
Cerveza sin alcohol		
Bebidas destiladas: whisky, ginebra, coñac,…		

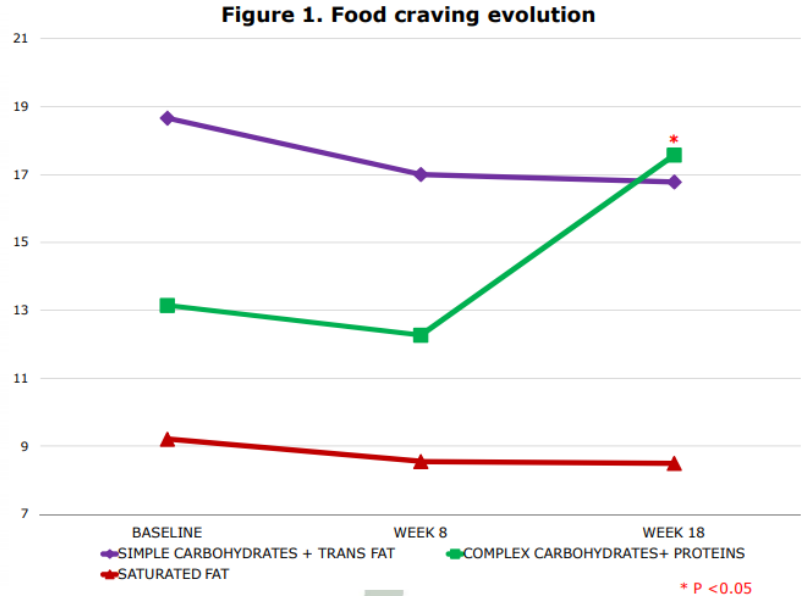
CLOZAPINE AND FOOD PREFERENCES

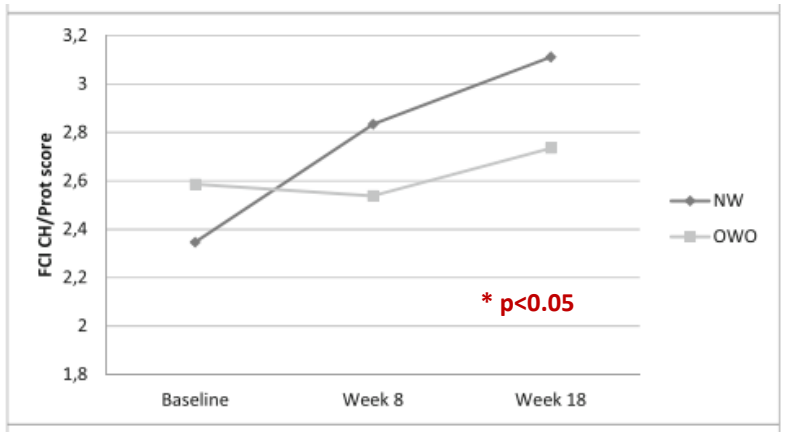
Table 1 Descriptive characteristics of the sample by BMI status

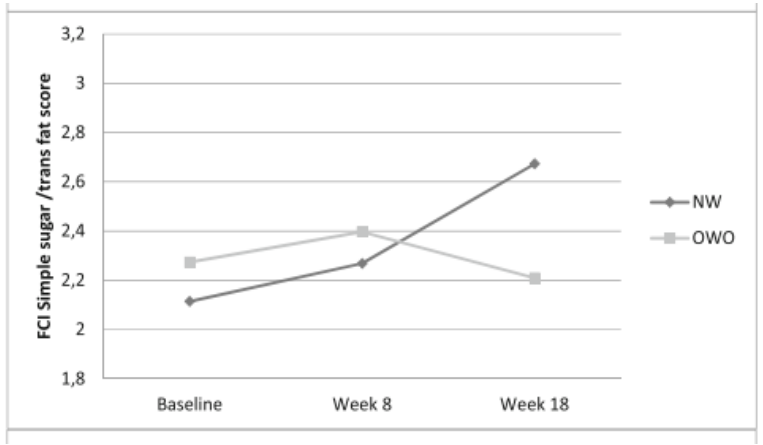
		BMI baseline status			*P* value
		NM (BMI < 25) *n* = 13 Mean (SD) or *N* (%)	OWO (BMI > 25) *n* = 21 Mean (SD) or *N* (%)	Total *n* = 34 Mean (SD) or *N* (%)	
Age, year		34.5 (11.4)	38.2 (12.8)	36.8 (12.2)	0.411†
Gender	Male	7 (53.9)	14 (66.7)	21 (61.8)	0.456*
	Female	6 (46.2)	7 (33.3)	13 (38.2)	
Early onset psychosis		4 (33.3)	15 (71.4)	19 (57.6)	0.033*
Time on antipsychotics, year		5.2 (7.6)	10.9 (11)	8.5 (10.1)	0.117†
Previous antipsychotic type	FGA	3 (23.1)	0 (0)	3 (8.8)	0.034*
	SGA	7 (53.8)	21 (100)	28 (82.4)	
	None	3 (23.1)	0 (0)	3 (8.8)	
Axis I diagnosis (DSM-IV-TR)	Schizophrenia	9 (69.3)	18 (85.7)	27 (79.4)	0.127*
	Schizoaffective	2 (15.4)	3 (14.3)	5 (14.7)	
	Bipolar disorder	2 (15.4)	0 (0)	2 (5.9)	
PANSS total		80.3 (9.5)	78.7 (23.1)	79.2 (19.3)	0.828†
CGI-S		5.1 (0.4)	4.4 (0.9)	4.7 (0.8)	0.016†
CV risk factors					
Smokers		9 (69.3)	5 (23.8)	14 (41.2)	0.009*
HTA		0 (0)	3 (14.3)	3 (9.1)	0.091*
CV illness		0 (0)	1 (4.8)	1 (3.1)	0.337*
DM		1 (8.3)	1 (4.8)	2 (6.1)	0.685*
Dyslipidemia		1 (8.3)	3 (14.3)	4 (12.1)	0.605*
Anthropometric measures					
Weight (kg)		63.3 (11.8)	90.9 (14.6)	80.9 (19.1)	< 0.001†
ΔWeight (kg)		6.3 (5.2)	0.2 (6.1)	2.3 (6.4)	0.012†
BMI (kg/m^2)		22 (2.7)	30.3 (3.7)	27.3 (5.3)	< 0.001†
ΔBMI (kg/m^2)		2.3 (1.9)	0.1 (2.0)	0.9 (2.2)	0.009†

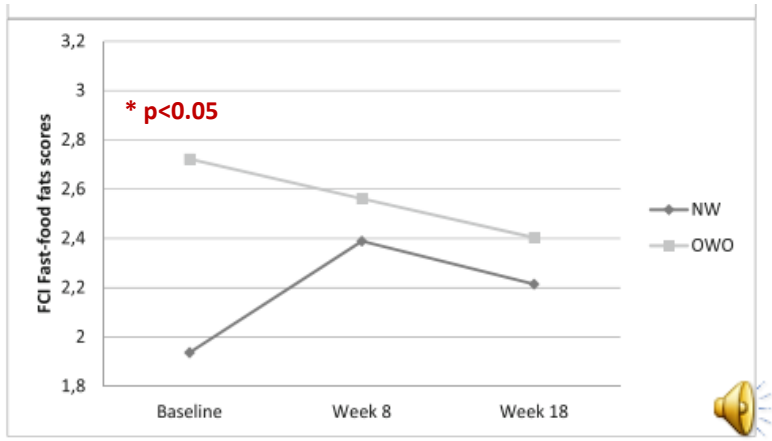
CLOZAPINE AND FOOD PREFERENCES











CLOZAPINE AND ITS "MORTALITY" ROLE

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ACTA PSYCHIATRICA SCANDINAVICA

Clozapine and all-cause mortality in treatment-resistant schizophrenia: a historical cohort study

Cho J, Hayes RD, Jewell A, Kadra G, Shetty H, MacCabe JH, Downs J. Clozapine and all-cause mortality in treatment-resistant schizophrenia: a historical cohort study.

Objective: Large-scale epidemiological studies have demonstrated a protective effect of clozapine on mortality in people with schizophrenia. Clozapine is reserved for use in patients with treatment-resistant schizophrenia (TRS), but evidence of clozapine's effect on mortality exclusively within TRS samples is inconclusive. Hence, we aimed to investigate the effect of clozapine use on all-cause mortality in TRS patients.

J. Cho[1], R. D. Hayes[1,2], A. Jewell[3], G. Kadra[1], H. Shetty[1,2,3], J. H. MacCabe[1,2,3], J. Downs[1,2,3]

[1]Institute of Psychiatry Psychology and Neuroscience, King's College London, [2]NIHR Maudsley Biomedical Research Centre, and [3]South London and Maudsley NHS Foundation Trust, London, UK

Table 3. Hazard ratios of all-cause mortality related to clozapine use in patients with treatment-resistant schizophrenia

	Deaths/total *N*	HRs (95% CIs)	*P*
Crude	110/2837	0.73 (0.49–1.08)	0.12
Multivariate Cox proportional hazard models adjusted for			
Sociodemographic variables	110/2837	0.60 (0.40–0.92)	0.02
Plus history of substance use disorders	110/2837	0.61 (0.40–0.93)	0.02
Plus clinical monitoring	110/2837	0.67 (0.43–1.03)	0.07
Plus mental health symptom severity	108/2788	0.71 (0.46–1.11)	0.14
Plus additional mental and physical health problems	108/2783	0.66 (0.42–1.03)	0.07
Plus functional status	104/2720	0.61 (0.38–0.97)	0.04

HR, hazard ratio; 95% CI, 95% confidence interval.

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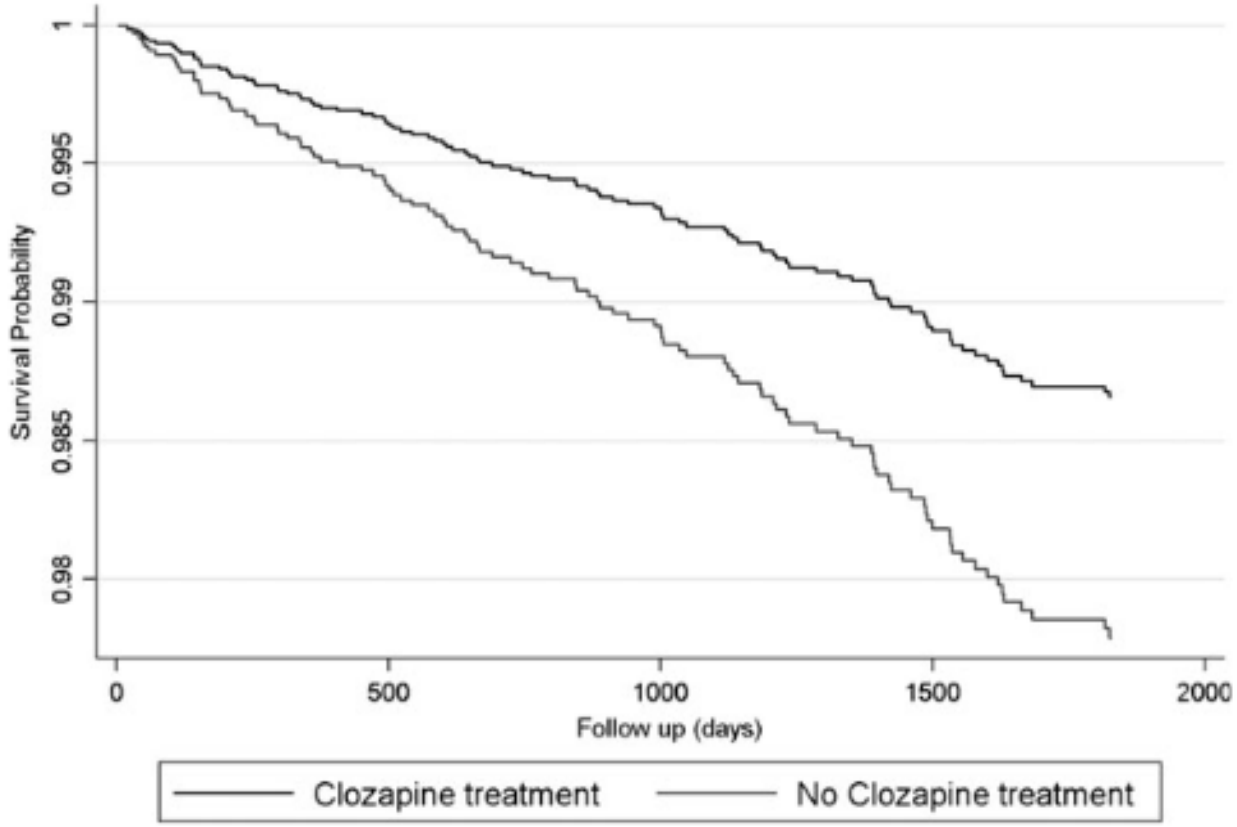

Fig. 2. Survival curves of all-cause mortality in patients with treatment-resistant schizophrenia, stratified by antipsychotic use.

TAKE HOME MESSAGES

- SMI patients have experienced an increase on the mortality gap in comparison with general population in the last 30 years
- COD are related to cardiovascular risk factors
- AP such as clozapine and olanzapine may influence on this mortality gap
- Underlying mechanisms not deeply studied are related with changes on food preferences
- AP may only influence changes on food preferences on NW SCH patients (complex-CH, proteins)
- Fast food consumption/craving might be related with AIWG

Gracias por su atención!

Magarriga@clinic.cat