Le linee guida forniscono raccomandazioni basate sulle evidenze scientifiche e norme di buona pratica clinica per informare le decisioni di tutti i professionisti sanitari. Con l’approvazione della Legge Gelli/Bianco (L. 24/2017) sulla responsabilità professionale del personale sanitario, le linee guida assumono una maggiore rilevanza nelle situazioni di responsabilità professionale. Le Società scientifiche e le Associazioni tecnico-scientifiche delle professioni sanitarie sono chiamate a collaborare tra di loro nella stesura delle linee guida sotto il coordinamento dall’Istituto Superiore di Sanità che verifica la correttezza metodologica e la rilevanza delle evidenze scientifiche a supporto.

Occorre tenere presente che le linee guida non devono essere intese come protocolli rigorosi da applicare in maniera indiscriminata, è necessario considerare infatti le caratteristiche cliniche del paziente, oltre che le sue aspettative e preferenze. Anche nell’ambito psichiatrico le Società scientifiche sono chiamate a redigere linee guida condivise e supportate scientificamente. La patogenesi bio-psico-sociale delle patologie psichiche complica la redazione delle linee guida poiché sul risultato terapeutico possono influire anche fattori non clinici come la complessità dell’intervento sociale, la disponibilità economica, l’innovazione tecnologica, le differenze religiose e l’orientamento sessuale. Questi aspetti si devono integrare alla medicina basata sulle esperienze e alle regole di buona pratica clinica. Le linee guida di buona pratica clinica definiscono la protezione dei diritti degli esseri umani in quanto soggetti di studi clinici e forniscono altresì assicurazioni circa l’attendibilità dei dati relativi agli studi clinici stessi. I documenti sulle buone pratiche, provenendo da fonti di alto valore scientifico ma non sempre nazionali, possono contenere raccomandazioni e consigli clinici non direttamente applicabili al contesto sanitario italiano.

In generale la prescrizione di una qualsiasi terapia è sotto la diretta responsabilità professionale ed etica del medico e non può che far seguito a una diagnosi circostanziata o, quantomeno, a un fondato sospetto diagnostico. Su tale presupposto al medico è riconosciuta autonomia nella programmazione, nella scelta e nell’applicazione di ogni presidio diagnostico e terapeutico fatta salva la libertà del paziente di rifiutarle e di assumersi la responsabilità del rifiuto stesso. Maggiore attenzione nel seguire le linee guida va posta nel trattamento di un paziente in regime di Trattamento Sanitario Obbligatorio, poiché per definizione vi è un vizio di consenso e, quindi, dobbiamo essere sicuri di assumere la condotta clinica migliore eticamente e scientificamente, perseguendo il beneficio del paziente. In pazienti volontari la prescrizione di farmaci, sia per indicazioni non previste dalla scheda tecnica, sia non ancora autorizzati al commercio, è consentita purché la loro efficacia e tollerabilità sia scientificamente documentata e si ottenga il consenso scritto del paziente debitamente informato. L’art. 5 della Legge Gelli-Bianco (n. 24/2017), rubricato “Buone pratiche clinico-assistenziali e raccomandazioni previste dalle linee guida”, prevede che gli operatori sanitari, nell’esercizio delle loro prestazioni, si attengano, salve le specificità del caso concreto, alle raccomandazioni previste nelle linee guida pubblicate pre stabilite e aggiornate nell’ambito del Sistema Nazionale delle Linee Guida (SNLG). Le linee guida così validate producono effetti sia rispetto alla responsabilità penale dell’esercente la professione sanitaria, sia rispetto alla determinazione del risarcimento del danno. La responsabilità medica si occupa di studiare le questioni mediche e giuridiche che coinvolgono il rapporto tra medico e paziente. Non essendo però la medicina una scienza esatta, a supporto delle decisioni del medico, sono stati prodotti strumenti di informa-
zione e di aiuto alla pratica clinica, come le linee guida, i PDTA (Percorsi diagnostico terapeutico assistenziali), le buone pratiche clinico-assistenziali e i protocolli, l’utilizzo dei quali costituisce garanzia di osservanza di buona pratica clinica ed è considerata sinonimo di osservanza delle “regole dell’arte”, ma non sempre il giurista accoglie con favore tale sovrabbondanza produttiva. In altre parole, se la medicina ha compiuto passi importanti in tema di linee guida, il giurista ha incominciato a occuparsene in tempi più recenti, ricercando, spesso, soluzioni inconfutabili, là dove la scienza non può essere ancora definitiva. Infine la medicina difficilmente può essere standardizzata, in considerazione della rapida evoluzione scientifica e per la considerazione che la sanità italiana è piuttosto differente tra regione e regione.

Concludendo, la produzione di linee guida psichiatriche deve tenere conto del contesto scientifico internazionale, della complessità patogenetica dei disturbi e della varietà organizzativa e normativa regionale oltre che delle preferenze del paziente e dei suoi familiari. In questo contesto le linee guida potrebbero ridurre il difficile rapporto tra pazienti, familiari e medici quando questo si esprime sfortunatamente in un contenzioso. La collaborazione tra le diverse società scientifiche è la premessa necessaria a condividere i percorsi di cura e le risorse necessarie a sostenerli dalle amministrazioni. In questo modo si potrebbe ridurre la distanza che separa i buoni risultati dei trattamenti delle malattie mentali dimostrati dalla ricerca in confronto ai risultati realizzabili con le risorse disponibili nei dipartimenti di salute mentale italiani.

Con questo spirito abbiamo volute organizzare il presente Convegno sulle buone pratiche verso le linee guida.

Enrico Zanalda e Massimo di Giannantonio
Gambling Disorder (GD) is a behavioral addiction characterized by the persistent and recurrent engagement in gambling behaviors, determining severe consequences in terms of disruption in personal, family and work life. Since 1980, the World Health Organization (WHO) has identified GD as a pathological condition that, in the absence of suitable information and prevention measures, can represent, due to its diffusion, an authentic social disease. Based upon neurobiological and clinical similarities shared with substance dependence, the DSM-5 considers GD as part of the “Substance-Related and Addictive Disorders”. Among treatment-seeking GD patients emerged a very high incidence of psychiatric comorbidity 1; hence, evidence considering GD as an addictive disorder supports the direction of treatments following multimodal, multidisciplinary and integrated approaches, and directing subjects towards personalized therapeutic programs. Within the Italian National Health Service, public services treating addictions (Ser.D.) represent the units responsible for the prevention, diagnosis and treatment of GD. They operate from a perspective of integration and networking, offering both residential and semi-residential structures. In the absence of a specific legislation on GD, we currently refer to the regulations concerning addictions and existing practices. Furthermore, the gold standard of GD treatment involves an integrated pharmacological and psychosocial approach, involving patient and family members.

Pharmacological treatments
Among the psychotrophic drugs used for the treatment of GD, researchers have studied the efficacy of antidepressants, mood stabilizers, opiate antagonists and atypical antipsychotics 2. The literature displays controversial results regarding the use of antidepressants. Several studies emphasize the positive effects of these drugs, while other trials highlight a non-significant, or even negative, effect of such drugs on the course of the disease. The conceptualization of GD as an obsessive-compulsive spectrum disorder has supported the use of antidepressant drugs, and patients with pronounced obsessive aspects can benefit from these treatments. The effectiveness of mood stabilizers is arguable in non-comorbid GD patients. The use of lithium, rather than valproate, is not related to a significant difference in efficacy. Mood stabilizers have a positive effect on impulse control because they reduce craving and the risk of relapse in patients using substances. In subjects with bipolar spectrum comorbidity, a mood stabilization can result in a significant reduction in GD symptoms 2. Regarding opiate antagonists, three positive RCTs and two uncontrolled studies revealed that both naltrexone and nalmefene are promising drugs to be utilized in the treatment of GD. Long-term follow-up in patients who responded to a naltrexone treatment for 12 weeks showed that patients remained asymptomatic for six months after drug withdrawal. Even patients treated with nalmefene had a significant reduction in GD symptoms. In particular, subjects with a family history of alcoholism seem to have a greater chance of responding to opiate antagonists 3. Only a few studies explored the use of atypical antipsychotics in the management of GD, with negative results leading to the discontinuation of this pharmacological approach 2. Moreover, glutamate has gained a greater attention in addiction research, especially in the treatment of craving and relapse prevention 4. Recently, positive results have been found in the combination of topiramate and cognitive intervention in the treatment of GD 5. Topiramate was superior to placebo in reducing gambling cravings and behaviors, as well as gambling-related cognitive distortions. These findings are in contrast with the data from a previous clinical trial with topiramate for GD, and could be interpreted as probably due to a synergistic interaction between topiramate and the cognitive intervention.

Psychotherapeutic and psychosocial treatments
Several psychotherapeutic and psychosocial interventions have been studied in the treatment of GD, including: cognitive and behavioral interventions; cognitive-behavioral therapy (CBT); motivational enhancement therapies (MET); minimal or brief interventions; self-help interventions; Gamblers Anonymous (GA) 6. These interventions could be delivered to individuals or to groups, both in single or prolonged sessions, as they aim at reducing the suffering associated with the disorder, minimizing and preventing relapses, and ultimately at maintaining abstinence from gambling behaviors. Cognitive interventions intend to identify the distorted cognitive beliefs and prejudices that are hidden behind gambling problems. They then attempt to correct them through cognitive restructuring techniques. For example, the belief that winning may depend on strategies or strange superstitions can be disconfirmed by explaining that the outcome of the game is completely independent and cannot be controlled. Cognitive therapy may hold promise in the treatment of gambling behavior, but does not appear to be more efficacious than other interventions. Cognitive-behavioral interventions use elements of both cognitive and behavioral techniques. The latter typically use procedures derived from the principles of classical and operant conditioning to reduce the excite-
ment associated with gambling. These techniques often advance by identifying cognitive biases to then correct them using cognitive restructuring techniques and behavioral strategies, expected to reduce the excitement associated with gambling.

Cognitive Behavioral Therapy (CBT) has proven to be effective in the treatment of GD. The analysis of motivational components and cognitive restructuring, typical of CBT programs, intends to address patients’ awareness about the GD-associated cognitive distortions. Recently, it has been proposed a possible utility of Internet-based CBT interventions with the potential to add flexibility, anonymity, and confidentiality in the treatment of gambling-related cognitive distortions. Moreover, this approach could allow the spreading of specialized treatments far beyond the large centers specialized in GD management. Numerous studies reveal that CBT is effective in treating GD. Current literature emphasizes the importance of motivational components and cognitive restructuring found in CBT programs.

Motivational Interviews (MI) and Motivational Improvement Therapy (MET) are client-centered treatments that improve the patient’s intrinsic motivation for change. These interventions are rooted on the principle of collaboration, in which the therapist and the patient work together to drive the change. MET initiates from the assumption that the client owns the intrinsic objectives and resources to operate a change; another fundamental resource of the patient is autonomy, in fact the therapist respects the client’s right and capacity for self-direction. Several studies reported these treatments to be associated with both a reduction in the severity of the disorder and a diminishment in gambling frequency. Minimal or brief practitioner-delivered interventions are interventions that last from a minimum of ten minutes to a maximum of four sessions total; they usually combine motivational interviewing and cognitive-behavioral techniques. Finally, research has shown that even brief mindfulness interventions can reduce gambling-related ruminations, increase cognitive and behavioral flexibility and improve quality of life. Similarly, the use of both virtual reality and serious video games allows the simulation of emotionally charged contexts in which patients with GD can apply the therapeutic tools they have acquired through CBT. Although the results obtained so far are promising, more research is needed in order to determine the exact role of these interventions in GD treatment outcomes.

Conclusions
GD is currently a behavioral disorder whose treatment guidelines are still under study. Joining the results from different lines of research together with the best experiences from the naturalistic field, to this day we can reason that, in order to obtain optimal results, it would be necessary to combine pharmacotherapy with psychotherapy. Currently, there are no guidelines available for the pharmacological treatment of GD, although a possible synergistic effect between psychosocial and pharmacological interventions has been recently proposed. This combination could improve GD patients’ quality of life, as well as the definition of an optimal target for disease prevention. In addition, optimal subtyping of patients’ clinical profile should be better explored. Conceptualizing GD as an obsessive-compulsive spectrum disorder supports the application of serotonergic agents, while the addiction framework suggests the need for supplementary research in the direction of opiate antagonists. Finally, a more prominent affective dysregulation in GD subjects could lead to the prescription of mood stabilizer agents. In clinical practice different patients could benefit from different therapeutic strategies, based on co-occurring psychiatric conditions and on the accurate sub-typing of the disorder. Because of the lack of consolidated guidelines for the treatment of GD, settling these algorithms could help advise clinicians through different therapeutic options.

References
New insights and future directions for Transcranial Electrical and Magnetic Stimulation in Addiction Psychiatry

Giovanni Martinotti, Franca Ceci, Mauro Pettoruso, Gaia Baroni, Silvia Fraticelli, Massimo di Giannantonio

Department of Neuroscience, Imaging, Clinical Sciences, University “G. d’Annunzio”, Chieti-Pescara

Substance use disorders (SUD) represent a major public health concern in the western world, with about 27.7 million young adult users in the last year, a recent increase of direct and indirect deaths, and an increase in the use of stimulants and novel opioids, including novel psychoactive substances 1. A general consensus has emerged on drug addiction as a substance-induced, aberrant form of neural plasticity, with both acute and long lasting neurobiological modifications 2. In spite of recent significant progress in understanding the neurobiology of SUD, therapeutic advances have proceeded at a slower pace 3.

The field of neuromodulation encompasses a wide spectrum of interventional technologies that modify the pathological activity within the nervous system to achieve a therapeutic effect. Nowadays there is growing interest in non-invasive brain stimulation (NIBS) as a novel treatment option for substance-use disorders (SUDs). Human neuroimaging and preclinical investigations have advanced our knowledge of the neural circuitry that perpetuates the cycle of relapse and recovery in substance use disorders (SUD). Two tools that demonstrate promise in bridging this gap are transcranial electrical stimulation (tES) and transcranial magnetic stimulation (TMS). Transcranial magnetic stimulation is based on the electromagnetic induction principle where brief focal electromagnetic pulses penetrate the skull to stimulate target brain regions. The magnetic field is usually strong enough to induce firing of neurons beneath the area where the coil is positioned over the scalp. TMS pulses can be applied as single pulses (spTMS), as two paired-pulses (PP-TMS), or as repetitive trains of stimulation that may be either continuous at a specific frequency (repetitive- or rTMS), or patterned with specific inter-train intervals (e.g. either intermittent or continuous theta-burst stimulation, iTBS/cTBS). For all applications of TMS, and indeed for all types of NIBS, stimulation frequency, pattern of stimulation, and the intensity of the stimulation are crucial parameters. In contrast to TMS, transcranial electrical stimulation (tES) involves delivering low-intensity electric currents through electrodes placed on the scalp and/or upper body. The two most common stimulation paradigms are transcranial direct current stimulation (tDCS) and transcranial alternating current stimulation (tACS). In contrast to TMS, tDCS does not directly induce neuronal firing, but is thought to modulate cortical excitability by a polarity-dependent shift of the neuronal membrane potential. The primary hypothesized mechanism underlying the neuromodulatory effects of these techniques is a long-term potentiation (LTP)- or long-term depression (LTD)-like change in the synaptic coupling of neurons. Furthermore, a recent study showed a possible modulatory effect of rTMS on dopaminergic terminals. TranscranialIES/TMS induce effects at a cellular level through different mechanisms including the modulation of glutamatergic receptors and neuronal excitability elicit- ing prolonged, offline after-effects similar to LTP and LTD: IES/TMS induced-LTP/LTD are strictly dependent on NMDA and AMPA receptor signalling within glutamatergic synapses within addiction related brain regions. In addition to glutamatergic signalling, dopaminergic transmission also plays a significant role in shaping some of the TMS-induced effects. Finally, tES/TMS techniques could also exert their effects modulating the expression of neurotrophic factors, such as BDNF, an active regulator of synaptic plasticity, within cortical and subcortical areas. More recently, non-synaptic events have been suggested to be involved in tES/TMS long-term effects, including plasticity-related gene expression, and neurogenesis. Whether these mechanisms remain to be explored.

In addiction psychiatry different controversies have been showed: although there is promising evidence for persisting and long-lasting effects with repeated stimulation sessions, the relatively large heterogeneity of these studies with regard to stimulation technique, timing, repetition, and montage precludes a clear understanding of how repetition may affect therapeutic outcomes in SUD, warranting a need for systematic research designs: randomized blinded pilot studies with sham arms are mandatory.

NIBS in addiction psychiatry represent a novel area of interest, with positive but not conclusive results, mainly in stimulant use disorder. Specifically, three meta-analyses show preliminary but promising results with tES/TMS in addiction medicine 4-6. However, different NIBS studies published in the SUD field have small sample sizes, have methodological biases, do not contain rigorous control conditions, and are not sufficiently blinded. This makes reproducibility and interpretation difficult. Of course some gaps are shared by other NIBS application in psychiatry, a specific field that can be considered at its early stages. A specific limitation in addiction psychiatry refers to absence of a univocal outcome measure. Different outcome measures can usually be considered: craving is the primary outcome and self-report on a visual analogue scale (VAS) was the most frequently used craving measure, followed by questionnaires for different drugs with variations in items and structure. Other outcomes are: objective measures (e.g., urine drug tests, breath analyzers), self-report measures for drug use or addiction severity, positive valence (e.g., motivation, willingness, and hedonic tone), negative valence (e.g., depression, anxiety, and withdrawal), cognition (e.g., memory, attention and inhibition), general mental or physical health (e.g., daily functioning, quality of life and sleep), neurophysiologic measures (e.g., ERP, fMRI and fNIRS). Of course the gold standard for evaluating efficacy of a therapeutic agent for SUDs remains its ability to stop consumption of the substance being used or to reduce consumption to less harm-
ful levels. Different hypothesis have also been proposed concerning the specific time interval at which rTMS/IDCS interventions should be administered: a) before the participant sought standard treatment; (b) while the subject was treatment seeking but before undergoing standard treatment; (c) after the first month of standard treatment and the initial recovery period. The efficacy of neuromodulatory treatments has been promising during detoxification, but an important problem is the high risk of relapse following successful treatment. Effects of tES/TBS can also be affected by the ‘baseline’ brain state, so the response to stimulation varies from person to person and from moment to moment. Likely, this explains the substantial heterogeneity of findings in this field. It would therefore be important to refine, adapt, and individualize stimulation.

Neuromodulatory treatments have also been used for co-morbidities with SUDs, often with a positive outcome. Perhaps the benefit of brain stimulation treatments targeting underlying neurobiological factors in SUDs may also extend to deficiencies found in other psychiatric disorders, as for the specific dimension of anhedonia. A frequently comorbidity is “Non-substance-related addictive disorders,” in particular gambling disorder, as recently reported for IDSC.

As regard to the area of stimulation the most frequent anatomical target of tES/TMS is the left DLPFC, followed by the right DLPFC. In addition, other brain areas targeted are: medial prefrontal cortex (mPFC), ventromedial prefrontal cortex (vmPFC), frontal pole (FP), frontal-parietal-temporal (FPT), inferior frontal gyrus (IFG), superior frontal gyrus (SGF), and motor cortex. There are also studies that used TMS intended to target deeper and wider regions including anterior cingulate cortex (ACC) and insula. For TMS the primary outcome is the activation of the cortex under the TMS coil, with secondary activation of networks through synaptic connectivity. On the contrary in conventional tES (IDCS/tACS) the stimulated cortex is a large area under and between electrodes. There is very little information available from empirical studies to help guide the selection of laterality of sided targets for neuromodulation approaches in SUD. Left DLPFC is it is the most frequently stimulated area, but recent reviews shown positive effects on cognition and on craving of both right-sided and left-sided DLPFC stimulation.

Few stimulation parameters (duration, number of stimulation sessions, stimulation frequency, intensity, target brain region and interval between treatments) have systematically investigated for addiction treatment, therefore others should be investigated to define the dose response of tES/TMS techniques.

Future studies should some specific main targets: the use of double-blind sham-control designs, the personalization of the tES/TMS treatment, and the optimization of stimulation parameters, electrodes/coil size and shape, duration and number of stimulations.

As with other neuropsychiatric disorders, there are currently no clinically useful biomarkers for SUD, so it is impossible to predict an individual’s vulnerability to addiction, the severity of an individual’s current level of dependence, treatment effectiveness, or risk of relapse. Emerging evidence suggests that persistent drug use determines a dysregulation of multiple cognitive constructs subserved by multiple neural circuits, networks, and neurotransmitter systems. As such, to effectively diagnose and treat individuals suffering from SUDs, rather than concentrating on any given brain region, a better understanding of how specific substances affect the topological organization of brain connectivity networks may be more important. A large-scale network measure of connectivity may provide a helpful instrument to explore the efficacy of SUD diagnosis and treatment interventions.

At the moment different RCTs are run, specifically in the area of stimulant disorders. This new data with different therapeutic methodologies will help to clarify how, when, and where these different NIBS techniques can help to improve the outcome of Addiction Disorders.

References


Use of long-acting injectable antipsychotics during pregnancy

Claudia Palumbo, Emi Bondi
ASST Papa Giovanni XXIII, Bergamo

Introduction
Unplanned or unwanted pregnancies are more frequent in patients with psychotic symptoms than in the general population also due to the lower use of contraceptive methods compared to the normal population. All mental disorders are known to worsen during pregnancy and patients are more at risk of exacerbating psychotic symptoms 1. Pregnant women with a history of psychotic symptoms are commonly treated with antipsychotics (APs), although exposure to APs during pregnancy can potentially be associated with the risk of neonatal toxicity and obstetric, neurobehavioural and teratogenic complications. The evaluation of this type of risk should be balanced against the risks associated with untreated psychotic symptoms on the mother and the fetus. Because all antipsychotics cross the placenta, recent literature has identified the presence of some, although rare, risks for fetal exposure to drugs such as prematurity, low birth weight, neonatal withdrawal symptoms, abnormal muscle movements (akathisia, tremor, hypertonia, dystonia and parkinsonism), atrio-ventricular defects, gestational diabetes and preeclampsia 2. Current clinical practice is discordant about the use of APs during pregnancy: many clinicians treat women with the most recent atypical APs, some suspend them and others introduce the oldest typical AP, believing that they are safer 3.

The use of SGA in clinical practice
Second-generation antipsychotics (SGA) are new molecules that use an action mechanism that involves the relatively potent blockade of 5-HT2A receptors combined with transient D2 receptor occupancy. To date, there has been no clear association between fetal exposure to SGA and specific malformations or neonatal complications. However, while it is reasonable to suspect an increased risk of neonatal abstinence, extrapyramidal symptoms (EPS) and sedation, it is known that the offspring of mothers with psychotic symptoms is at higher risk of developing neurological and motor retardation, generalized cognitive deficits and difficulties of learning, as well as having lower performance on specific neurocognitive tasks. Furthermore, all untreated psychotic symptoms seem to be associated with reduced maternal sensitivity to the newborn, with a potential impact on subsequent socio-emotional development and with a poorer mother-child relationship 4.

Purpose of the study
Prolonged-release injectable APs ensure constant blood drug levels, better patient’s compliance and offer a simpler treatment regimen for both patients and caregivers.

Materials and methods
The study was conducted in collaboration with the Anti-Poison Center (CAV) of the Papa Giovanni XXIII in Bergamo Hospital. The study involved women of all ages from all over the country, suffering from psychotic disorders during pregnancy, who contacted directly or indirectly (relatives, psychiatrists, gynecologists, pediatricians) the CAV between 2015 and 2017, for explanations on the possible risks or possible consequences for the exposure of the unborn child to LAI therapy. The collection of follow-up data (2018) was carried out by telephone interview or direct contact with the patient. Between 2015 and 2017, the center of Bergamo was contacted by 8 patients. Two calls were made by a patient’s family member, four by the assisting psychiatrist, one by the gynecologist and one by the same patient. The calls came from different Italian cities (Messina, Legnago, Milan, Esine, Aquila, Appiano, Genoa, Rome).

Results
Although the sample is numerically limited, the study conducted shows clearly that taking LAI does not compromise the normal intrauterine development of the fetus. The eight pregnant patients who received AP LAI had age range between 25-44 years. Five patients received Xeplion, two received Maintena and one patient taking Zipadhera contacted CAV of Bergamo only for information purposes as an anticipation of a possible pregnancy. The study shows that the intake of AP with a LAI formulation or orally formulation does not cause significant differences in terms of outcome. All children of the sample born healthy even though they were exposed during the course of pregnancy to AP. In fact, the gestational age at delivery was between 38 and 40 weeks and the Apgar indexes on the first and fifth minute were equal to 9 or 10; the birth weight was between 2900 and 3650 kg. The children were all subjected to the normal pediatric controls foreseen, without the need to resort to neonatal pathology (only a child of 1 patient being treated with Xeplion was admitted in Neonatal Pathology for a few days as a precaution). All pregnancies had a course without infectious or obstetric complications (only 2 patients had recurrent cystitis which, however, did not complicate the course of pregnancy). In 3 cases admission to the SPDC was necessary only in the post-partum period. Mothers maintained a psychopathological compensation during pregnancy. Only 1 patient with schizophrenic psychosis treated by Xeplion therapy was admitted to the third month of pregnancy due to a psychotic exacerbation.

Conclusion
Literature data on the use of Risperidone, Paliperidone...
and Olanzapine in pregnancy showed that there were no significant differences in the health of unborn children compared to women who did not take them and Olanzapine treatment was not associated with an higher incidence of gestational diabetes, compared to other APs 5. As is the case for other APs, definitive evidence on Aripiprazole reproductive safety is lacking, but newer safety data are relatively reassuring. In many cases, the potential benefits of aripiprazole for patients with bipolar disorder or schizophrenia outweigh the potential risks 4. It can be concluded that, despite the small size of the sample under examination, the administration of SGA does not compromise the intrauterine development of the unborn child, nor does it alter its subsequent development; on the contrary, it helps the mother to maintain a good psychopathological compensation and to maintain an adequate and congruent behavior towards the child’s management. It is important to underline that the exacerbations of the psychopathological situation had especially in the postpartum, may be due to the important physiological reorganization of the hormonal picture resulting from birth, in addition to the significant psychological and social changes that involve the involvement of a mother.

**Discussion**

Although knowledge about the safety of antipsychotic drugs in pregnancy is limited, it is important to consider their role in patients with psychotic symptoms at this crucial stage of life.

There is evidence to suggest that maternal mental illness is associated not only with increased morbidity for the mother and child, but also with an increase in maternal mortality. Furthermore, mothers who are not well, are less sensitive toward their children and this can increase the risk of abuse and neglect. In these patients the pharmacological management of the disease is only part of an integrated multidisciplinary approach. Other indispensable tools must include the implementation, before conception, of educational programs aimed at containing unhealthy behaviors and which can therefore help reduce the risk of fetal malformations such as the use of drugs (alcohol, nicotine and other drugs) or implementation of unhealthy sexual practices (which amplify the risk of sexually transmitted diseases). However, the main clinical concern is probably psychotic relapse due to poor patient’s compliance to antipsychotic drugs, which can lead to interruption of pregnancy and institutionalization of offspring due to the reduced ability to take care of children 7. Therefore, doctors should do everything possible to inform these vulnerable mothers of the advantage of accepting a possible, modest increase in teratogenic risk compared to the need to maintain mental health during pregnancy 8.

**Reference**

Mortality gap e stili di vita non salutari nei pazienti con disturbi mentali gravi: quale ruolo per gli interventi psicosociali?

Gaia Sampogna, Mario Luciano, Benedetta Pocai, Carmela Palummo, Vincenzo Giallonardo, Lisa Giannelli, Valeria Del Vecchio, Andrea Fiorillo
Dipartimento di Psichiatria, Università della Campania “Luigi Vanvitelli”

Introduzione
L’aspettativa di vita delle persone con disturbi mentali gravi (schizofrenia, altri disturbi psicotici, disturbo bipolare, depressione maggiore) è ridotta di 10-25 anni rispetto alla popolazione generale. Questo divario è aumentato progressivamente negli ultimi anni per la maggiore mortalità per malattie fisiche. Infatti, i pazienti con disturbi mentali gravi hanno una prevalenza significativamente maggiore, rispetto agli altri individui della stessa età e dello stesso sesso, di essere affetti da varie patologie fisiche, come diabete mellito tipo 2, ipertensione arteriosa, coronaropatie, ictus, malattie polmonari croniche ostruttive, epatiti e AIDS 1.

Rispetto alla popolazione generale le persone con disturbi mentali gravi hanno un rischio aumentato di sovrappeso e obesità addominale, anche nelle fasi precoci di malattia e/o in assenza di un trattamento farmacologico. Anche la sindrome metabolica è più frequente nei pazienti con disturbi mentali gravi rispetto alla popolazione generale, con una prevalenza del 40-70% nei pazienti con schizofrenia e del 20-30% nei pazienti con disturbo bipolare 2. L’eccesso di mortalità nei pazienti con disturbi mentali gravi rappresenta un problema di sanità pubblica particolarmente rilevante a livello globale. L’Organizzazione Mondiale della Sanità (OMS) ha sottolineato il bisogno di migliorare l’accesso alle cure dei pazienti con disturbi mentali gravi con un focus specifico sulla promozione della salute fisica. L’OMS ha recentemente sviluppato delle linee guida per la promozione della salute fisica nei pazienti con disturbi mentali gravi, a conferma di come questo argomento rappresenti una priorità nella pratica clinica 3.

Fattori di rischio
La maggiore morbidità e mortalità per malattie fisiche osservate nei pazienti con disturbi mentali gravi sono dovuti a diversi fattori, riportati in Tabella I 4.

In particolare, per quanto riguarda il primo gruppo, i pazienti con disturbi mentali gravi riportano spesso una significativa compromissione delle capacità cognitive a cui si associa una trascuratezza della cura personale. I pazienti tendono a sottovalutare la salute fisica, evitando di sottoporsi a controlli routinari presso il medico di medicina generale rispetto alla popolazione generale 5.

Tabella I. Fattori di rischio per il mortality gap nei pazienti con disturbi mentali gravi

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<th>Fattori associati al disturbo mentale</th>
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Per quanto riguarda i fattori correlati all’assistenza sanitaria, l’accesso ai servizi sanitari per i pazienti con disturbi mentali gravi è spesso difficile per la mancanza di integrazione tra la psichiatria e le altre discipline mediche, con i servizi per la salute mentale fisicamente separati dalle altre branche mediche. Inoltre, gli stessi operatori della salute mentale tendono a sottostimare la presenza di patologie fisiche nei propri assistiti, attribuendo le lamentele somatiche dei pazienti al disturbo mentale piuttosto che alla presenza di una patologia fisica in comorbidità. La frammentazione dell’assistenza sanitaria, con una dirottomia tra le cure per la salute fisica e quelle per la salute mentale, rappresentano un ostacolo significativo per i pazienti stessi.

Un altro fattore coinvolto nell’aumentata mortalità che si osserva in questi pazienti è relativamente al trattamento farmacologico. Infatti, alcuni antipsicotici di seconda generazione presentano effetti collaterali somatici, quelli diabeti mellito, obesità, dislipidemie e patologie cardiovascolari. Infine, nei pazienti con disturbi mentali gravi la prevalenza di stili di vita non salutari è ampiamente superiore rispetto alla popolazione generale. Gli stili di vita sono fattori modificabili e, se corretti in maniera adeguata, possono contribuire a ridurre l’incidenza di patologie fisiche e quindi del tasso di mortalità.

Rispetto alla popolazione generale, i pazienti affetti da disturbi mentali gravi, soprattutto da schizofrenia, presentano una prevalenza significativamente maggiore di dipendenza da fumo di sigaretta.

Inoltre, oltre il 50% dei pazienti con disturbi mentali gravi nel corso della vita ha fatto uso di almeno una sostanza psicoattiva, prevalentemente cannabis, alcol e sostanze stimolanti. Le abitudini alimentari adottate dai pazienti sono spesso non salutari. Più del 30% tende a consumare un unico pasto al giorno e a consumare cibi ad alto contenuto di grassi con una scarsa assunzione di frutta e verdura. Infine, i pazienti con disturbi mentali gravi svolgono generalmente poca attività fisica e sono prevalentemente sedentari 6.

Interventi psicosociali attualmente disponibili
Gli stili di vita rappresentano dei fattori di rischio modificabili e che possono determinare una riduzione significativa della mortalità dei pazienti con disturbi mentali gravi. Pertanto, vi è un obbligo etico, oltre che professionale, per gli operatori della salute mentale di intervenire sugli stili di vita. Recentemente, sono stati sviluppati numerosi interventi psicosociali, costituiti da componenti comportamentali, educazionali e psicoeducativi, orientati alla promozione di stili di vita sani, la cui efficacia è stata testa-
ta in numerosi studi clinici randomizzati controllati 2. Le principali differenze tra gli interventi psicosociali disponibili con un focus sugli stili di vita dei pazienti con disturbi mentali gravi riguardano il tipo di format (individuale o di gruppo), il setting (reparto ospedaliero o ambulatorio), il tipo di operatori sanitari coinvolti (psichiatri, psicologi, infermieri, tecnici della riabilitazione, dietisti, etc.), la durata complessiva dell’intervento, l’utilizzo di inclusione di diverse componenti nell’intervento (educaativa, motivazionale, etc.). Tuttavia, gli studi finora condotti non hanno valutato l’applicabilità e l’accettabilità di tali interventi nella routine clinica dei servizi di salute mentale.

Il progetto LIFESTYLE
Il Dipartimento di Psichiatria dell’Università della Campania “L. Vanvitelli” ha promosso lo studio dal titolo “Migliorare la salute fisica delle persone con patologie mentali gravi modificando lo stile di vita”, finanziato dal Ministero dell’Istruzione, dell’Università e della Ricerca (MIUR) nell’ambito del bando PRIN 2015. Lo studio ha coinvolto le Università di Bari, Genova, L’Aquila, Pisa e Roma Tor Vergata con l’obiettivo di sviluppare un nuovo intervento psicosociale orientato al miglioramento degli stili di vita dei pazienti con disturbi mentali gravi e per valutarne l’efficacia in un campione di pazienti con disturbi mentali gravi 7. L’intervento sperimentale incorpora elementi della psico- educazione classica e dell’approccio cognitivo-comportamentale, e tiene conto delle linee-guida sulla promozione degli stili di vita salutari dell’Organizzazione Mondiale della Sanità, dell’Associazione Europea per lo Studio del Diabete, della Società Europea di Cardiologia e dell’Associazione Europea di Psichiatria. L’intervento prevede circa 25 sedute, somministrate a cadenza di 7-10 giorni a gruppi di 5-10 pazienti affetti da disturbi mentali gravi. L’obiettivo primario dello studio è valutare l’efficacia sulla salute fisica delle persone con patologie mentali gravi di un intervento psicoeducativo rispetto ad un intervento di controllo in termini di miglioramento del body mass index (BMI) e di numerosi altri parametri metabolici.

Conclusioni
Il mortality gap tra i pazienti con disturbi mentali gravi e la popolazione generale è dovuto all’interazione tra numerosi fattori personali, sociali e legati al disturbo. Tra questi elementi, gli stili di vita rappresentano un target modificabile attraverso interventi psicosociali adeguati. Nel prossimo futuro, sarà necessario fornire ai pazienti con disturbi mentali gravi non solo interventi farmacologici e psicoterapeutici tradizionali, ma anche interventi psicosociali focalizzati sugli stili di vita 8. Inoltre, la promozione e la disseminazione di interventi per la salute fisica nei pazienti con disturbi mentali gravi dovrebbe diventare prioritaria, anche attraverso la promozione di campagne di sensibilizzazione sull’argomento o la conduzione di interventi di screening per questa popolazione a rischio.

Bibliografia
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Clinical presentation and personalized treatment in pathological gamblers

Silvia Ronzitti

Prevalence rate of gambling disorder among Italian adult population (i.e. 15-64 years old) ranges from 0.5-2.2%, while 1.3-3.8% of Italian adults is at risk of developing gambling disorder. In the last decades, many studies were carried out in order to provide the typical profile of pathological gamblers, and possible risk factors for developing gambling disorder. Some socio-demographic characteristics were identified: male sex, younger age, belong to a minority ethnicity, low educational level, unemployment and being separated or divorced were strongly associated with gambling disorder. Gambling games can be divided in two main categories: changes/luck and skill games. Generally, women prefer chance games (i.e. bingo) while men prefer skill games (i.e. sports betting). In Italy, scratch cards and national lotteries are the most practiced games.

Different theoretical approaches have attempted to explain gambling disorder. Blaszczynski & Nower have advanced a pathways model that integrates current empirical and clinical knowledge concerning the biological, personality, cognitive, learning theory, developmental and ecological determinants of gambling disorder. They identified three subgroups of pathological gamblers:

1. **Behaviourally conditioned.** Behaviourally conditioned pathological gamblers do not have a psychiatric premorbidity history. They start to gamble for entertainment reasons, and fluctuate between regular and excessive gambling. They can develop psychiatric disorders, particularly depression, anxiety or substance use disorders, in response to gambling-related problems;

2. **Emotionally vulnerable.** Emotionally vulnerable pathological gamblers present a strong psychiatric premorbidity history, particularly anxiety and depressive disorders. They also have family problems, and utilize gambling as a way to escape and reduce their psychological distress. Compared to behaviourally conditioned gamblers they are less inclined to change, and often require an integrate treatment for psychiatric comorbidities;

3. **Impulsive antisocial.** Impulsive antisocial pathological gamblers present psychiatric and psychopathological comorbidities and family problems similar to emotionally vulnerable gamblers. Moreover, they are characterized by features of impulsivity, antisocial personality traits, resulting in severe maladaptive behaviors, such as drug experiment, destructive relationship, and criminal acts. Compared to behaviourally conditioned and emotionally vulnerable gamblers they are less motivated to change, and demonstrated poorer treatment compliance and prognosis.

The emotionally vulnerable and impulsive antisocial pathological gamblers groups were validated by other authors. Moreover, research has shown that emotionally vulnerable pathological gamblers prefer chance games, while impulsive antisocial gamblers prefer skill games.

It is clear that gambling disorder is strongly associated with a range of comorbid psychiatric conditions. Thus, during the clinical interview, clinicians should examine, not only gambling behavior, but also the possible presence of co-occurring psychiatric disorders. Moreover, clinicians should assess suicidal ideation: international research indicates that people with gambling disorder show a high rate of suicidal ideation and suicide attempts. Several authors have highlighted that psychiatric comorbidities are associated with suicidal ideation in gamblers, particularly mood, anxiety and substance use disorders.

Gambling disorder may not always follow a chronic and persisting course: almost one third of pathological gamblers recover without treatment. However, research has indicated that only a small percentage of individuals with chronic problem gambling seek formal assistance (≈10%). Different treatment options for gambling disorder have been developed in the last decades, and they can be divided in two main categories: psychological and psychopharmacological interventions. Evidence-based literature about psychological treatment reports that cognitive and behavioral approaches are the most effective approach for treating gambling disorder. However, studies have shown high rates of dropping out of treatment (≈50%). Regarding psychopharmacological treatment, there is currently no Food and Drug Administration (FDA)-approved medication for this disorder. Currently, the reasonable justification in adding psychopharmacological therapy in treating pathological gamblers should be to treat the comorbid psychiatric disorders and/or symptoms.

References

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