La rete assistenziale
AOU Careggi-ASL Toscana Centro
per pazienti con Disturbi dell'Alimentazione

Valdo Ricca

SODc Psichiatria, AOU Careggi

Dipartimento di Scienze della Salute

Università di Firenze

Firenze, 17 Ottobre 2022

Azienda Ospedaliero Universitaria Careggi

Regione Toscana

Università degli Studi Firenze

Disturbi dell' Alimentazione

-Patologie psichiatriche croniche caratterizzate principalmente da convinzioni distorte e preoccupazioni esasperate circa la forma e il peso corporeo

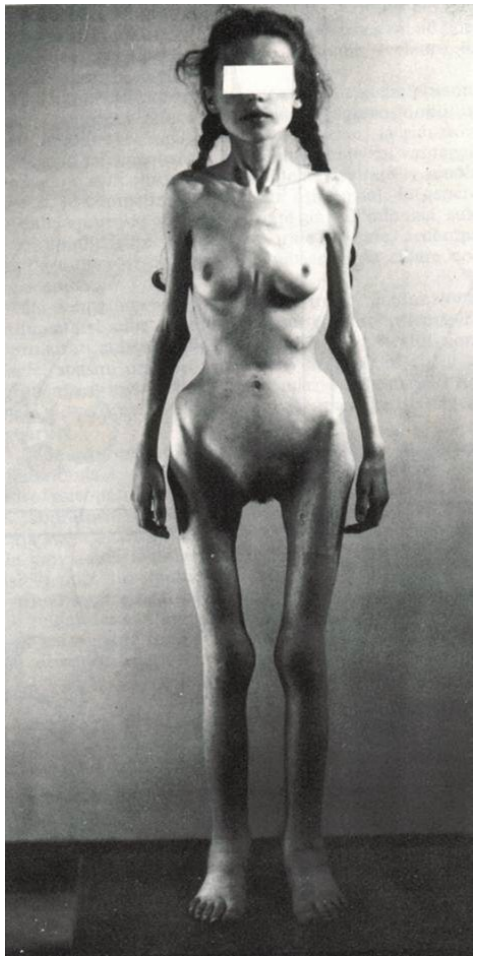
-Determinano una persistente alterazione del comportamento alimentare e delle condotte connesse con il cibo, con una ricerca costante di ridurre l'apporto calorico

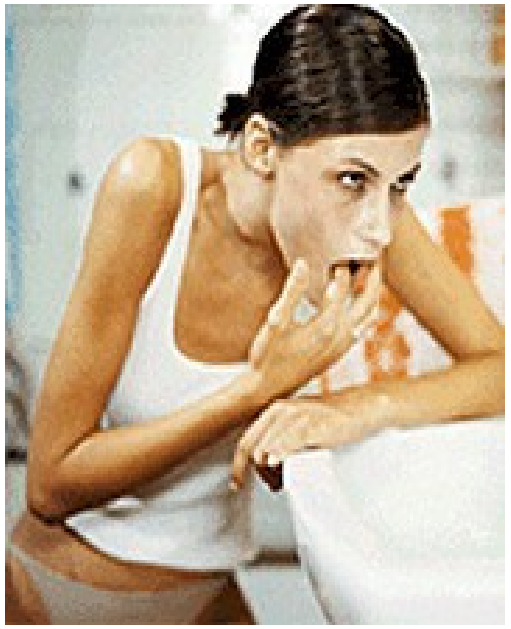
-Non causate da patologie internistiche o da altri disturbi psichici

-Compromissione significativa del benessere psicofisico e del funzionamento sociale del paziente

(Fairburn, 2008)

PROTOTIPI DI DCA





Prevalence of eating disorders over the 2000–2018 period: a systematic literature review

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ABSTRACT

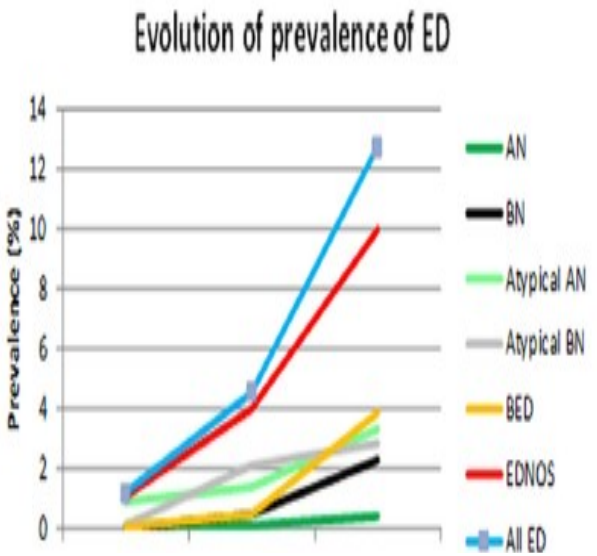
Background: Eating disorders (EDs) lead to multiple psychiatric and somatic complications and thus constitute a major public health concern.

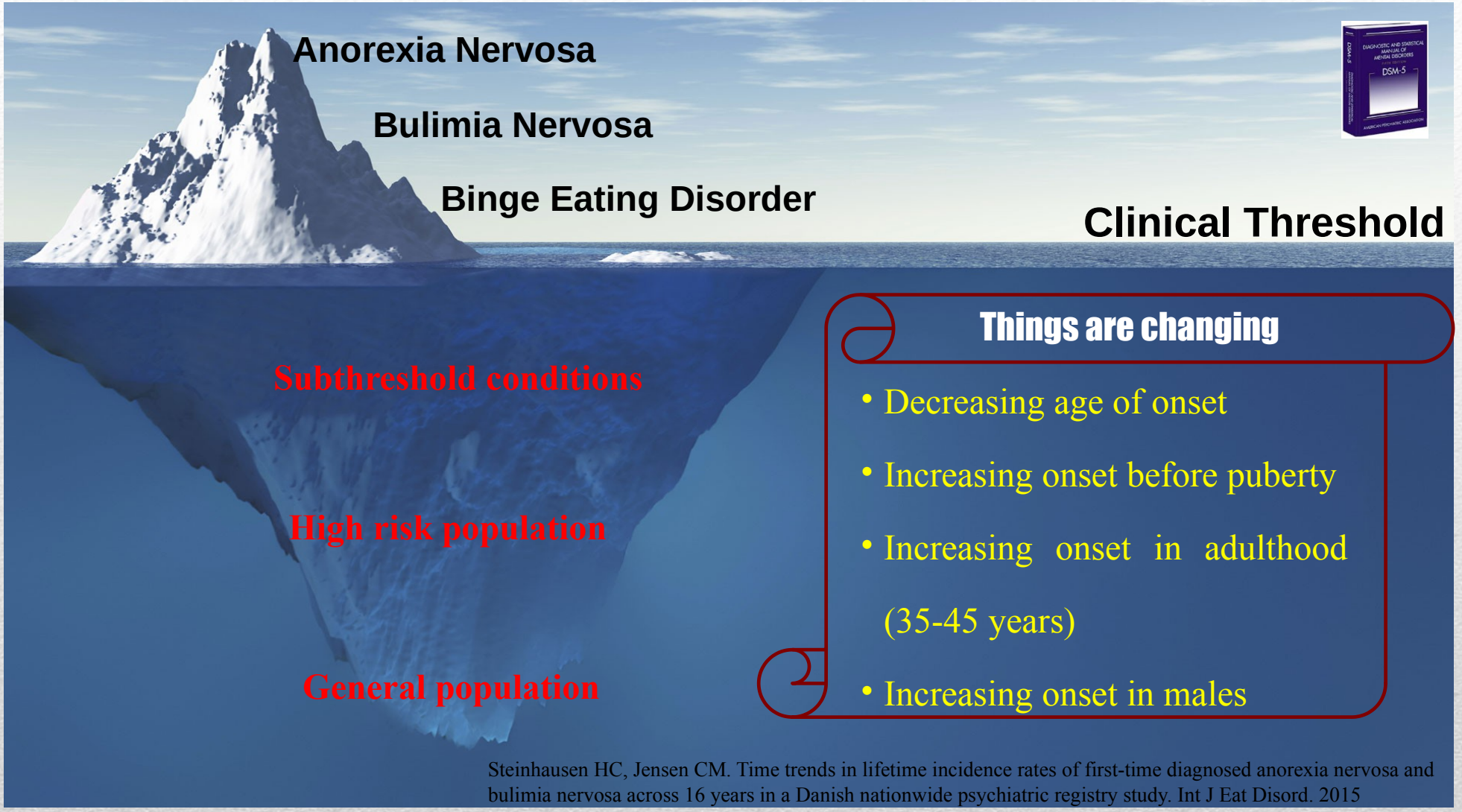
Objectives: The aim of this study was to give an exhaustive view of the studies reporting the prevalence of the different EDs or total EDs and to study their evolution.

Methods: A literature search following PRISMA Guidelines and limited to studies in English or French published between 2000 and 2018 was performed and relevant studies were included in this systematic review on the prevalence of EDs. The literature search revealed 94 studies with accurate ED diagnosis and 27 with broad

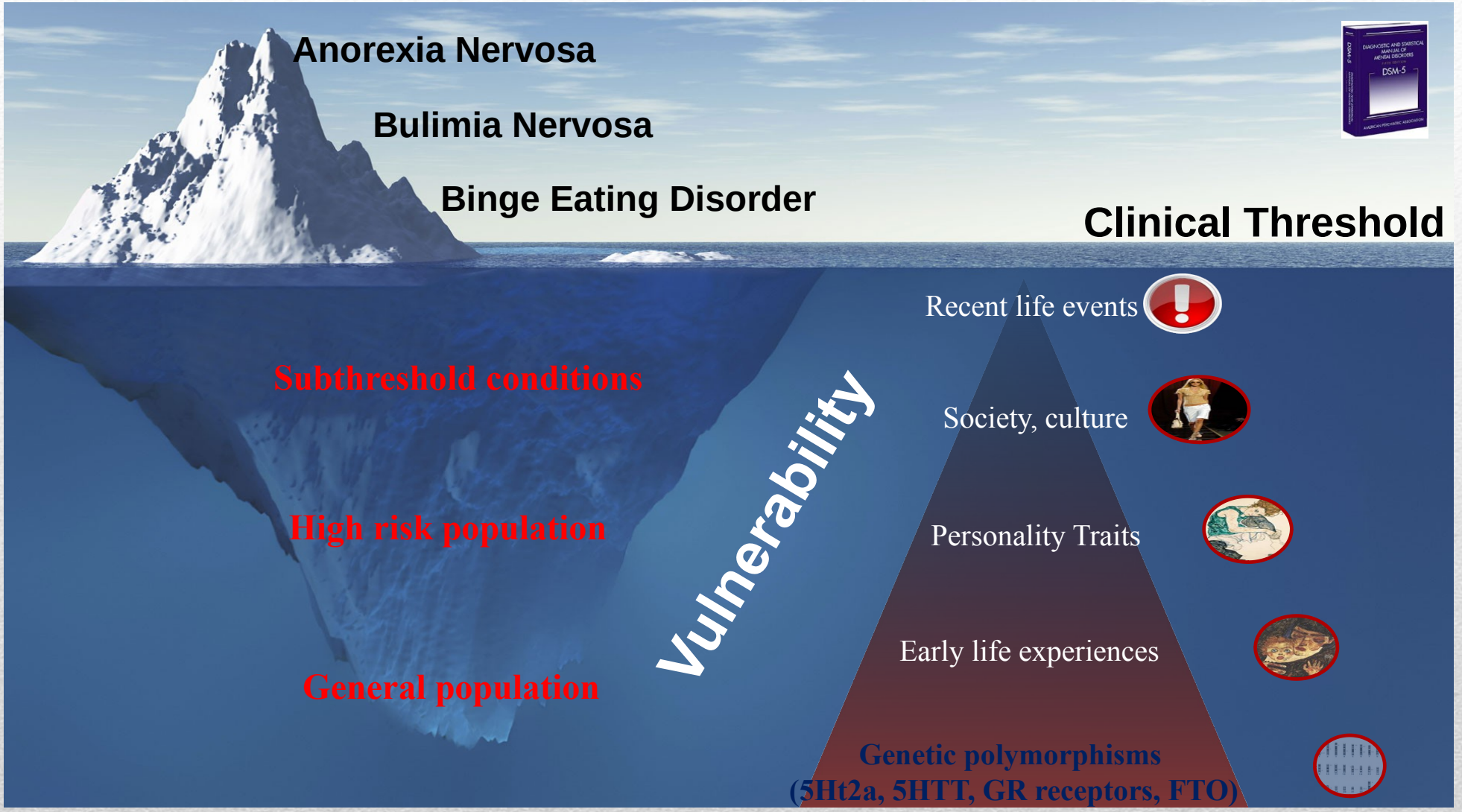
Results: In 94 studies with accurate ED diagnosis, the weighted means (ranges) of lifetime ED were 8.4% (3.3–18.6%) for women and 2.2% (0.8–6.5%) for men. The weighted means (ranges) of 12-month ED prevalence were 2.2% (0.8–13.1%) for women and 0.7% (0.3–0.9%) for men. The weighted means (ranges) of point prevalence were 5.7% (0.9–13.5%) for women and 2.2% (0.2–7.3%) for men. According to continents, the weighted means (ranges) of point prevalence were 4.6% (2.0–13.5%) in America, 2.2% (0.2–13.1%) in Europe, and 3.5% (0.6–7.8%) in Asia. In addition to the former, 27 other studies reported the prevalence of EDs as broad categories resulting in weighted means (ranges) of total point prevalence of any EDs of 19.4% (6.5–36.0%) for women and 13.8% (3.6–27.1%) for men.

Conclusions: Despite the complexity of integrating all ED prevalence data, the most recent studies confirm that EDs are highly prevalent worldwide, especially in women. Moreover, the weighted means of point ED prevalence increased over the study period from 3.5% for the 2000–2006 period to 7.8% for the 2013–2018 period. This highlights a real challenge for public health and healthcare providers. *Am J Clin Nutr* 2019;109:1402–1413.





Steinhausen HC, Jensen CM. Time trends in lifetime incidence rates of first-time diagnosed anorexia nervosa and bulimia nervosa across 16 years in a Danish nationwide psychiatric registry study. Int J Eat Disord. 2015


Anorexia Nervosa
Bulimia Nervosa
Binge Eating Disorder
DSM-5
Clinical Threshold
Subthreshold conditions
High risk population
General population
Vulnerability
Recent life events
Society, culture
Personality Traits
Early life experiences
Genetic polymorphisms
(5Ht2a, 5HTT, GR receptors, FTO)

Review of the burden of eating disorders: mortality, disability, costs, quality of life, and family burden

Daphne van Hoeken[a] *and Hans W. Hoek*[a,b,c]

Purpose of review
To review the recent literature on the burden of eating disorders in terms of mortality, disability, quality of life, economic cost, and family burden, compared with people without an eating disorder.

Recent findings
Estimates are that yearly over 3.3 million healthy life years worldwide are lost because of eating disorders. In contrast to other mental disorders, in anorexia nervosa and bulimia nervosa years lived with disability (YLDs) have increased. Despite treatment advances, mortality rates of anorexia nervosa and bulimia nervosa remain very high: those who have received inpatient treatment for anorexia nervosa still have a more than five times increased mortality risk. Mortality risks for bulimia nervosa, and for anorexia nervosa treated outside the hospital, are lower but still about twice those of controls. In people with an eating disorder, quality of life is reduced, yearly healthcare costs are 48% higher than in the general population, the presence of mental health comorbidity is associated with 48% lower yearly earnings, the number of offspring is reduced, and risks for adverse pregnancy and neonatal outcomes are increased.

Summary
People with a current or former eating disorder are at risk of increased mortality, high YLD rates, a reduced quality of life, increased costs, and problems with childbearing.

Keywords
eating disorders, economic cost, mortality, quality of life, years lived with disability

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WILEY

ORIGINAL ARTICLE

International Journal of EATING DISORDERS

Long-term outcome of anorexia nervosa: Results from a large clinical longitudinal study

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This article was published online on 23 June 2017. Errors were subsequently identified in the author line. This notice is included in the online and print versions to

Abstract

Objective: Assessment of the long-term outcome of anorexia nervosa (AN) in a very large sample of inpatients ($N = 1,693$) and identification of predictors for poor outcome.

Method: Over 25 years (mean 10 years), consecutively admitted inpatients of a specialized hospital were followed. A subsample of 112 patients with 20-year follow-up was defined. Bivariate comparisons and logistic regression analysis identified risk factors of poor outcome.

Results: Body mass index (BMI) increased during the follow-up period. Eating behavior as well as general psychopathology improved but did not reach the level of healthy controls. Remission was found in 30% (total sample) and in 40% (20-year follow-up subsample). Crossover from AN to [illegible] lower BMI at admission; a higher score on the Eating Disorder Inventory Maturity Fears subscale at admission; fewer follow-up years; and higher age at admission. The main diagnostic crossover occurred from AN to eating disorder not otherwise specified. Motherhood was related to better outcome.

Discussion: Many patients with very severe AN recover from their illness but AN also shows considerable long-term negative consequences. Over long time periods, survivors show improvement but better treatments for severe cases are still needed. Predictors of outcome included symptom severity, chronicity, and length of follow-up but not psychiatric comorbidity.

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ORIGINAL ARTICLE

International Journal of EATING DISORDERS WILEY

Long-term outcome of inpatients with bulimia nervosa—Results from the Christina Barz Study

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Funding information
Christina Barz-Stiftung, Grant/Award Number: none

Abstract

Objective: To assess the long-term outcome and identify outcome predictors in a very large sample of inpatients treated for bulimia nervosa (BN).

Method: Out of a total of 2,033 patients admitted consecutively to specialized treatment, 1,351 patients (mean age at treatment 25.94) were assessed for follow-up on average 11 (*SD* 6) years after admission. Also a very long-term (21 years) subsample (*N* = 147; mean age 25.92) was defined. Bivariate and logistic regression analyses identified predictors of poor outcome.

Results: For more than 70% of the patients follow-up information could be gathered. Severity of eating disorder (ED) and other symptoms decreased over time but remained higher than in healthy controls, using published normative data. Remission rate was 38% after 11 years and 42% in the subsample after 21 years. Out of the total sample of *N* = 2,033 patients, 49 had died (2.4%). Persistent BN was found in 14.2% and the most frequent crossover was to ED not otherwise specified. Predictors of poor outcome were fewer follow-up years, higher drive for thinness, higher age at treatment, and less global functioning.

Discussion: Based on clinical indicators, patients presented with a high level of ED and psychiatric symptomatology. With less than half of the patients remitted after 22 years, efforts are needed to improve treatment outcome.

Eating disorders

Janet Treasure, Tiago Antunes Duarte, Ulrike Schmidt

Eating disorders are disabling, deadly, and costly mental disorders that considerably impair physical health and disrupt psychosocial functioning. Disturbed attitudes towards weight, body shape, and eating play a key role in the origin and maintenance of eating disorders. Eating disorders have been increasing over the past 50 years and changes in the food environment have been implicated. All health-care providers should routinely enquire about eating habits as a component of overall health assessment. Six main feeding and eating disorders are now recognised in diagnostic systems: anorexia nervosa, bulimia nervosa, binge eating disorder, avoidant-restrictive food intake disorder, pica, and rumination disorder. The presentation form of eating disorders might vary for men versus women, for example. As eating disorders are under-researched, there is a great deal of uncertainty as to their pathophysiology, treatment, and management. Future challenges, emerging treatments, and outstanding research questions are addressed.

Lancet 2020; 395: 899–911

See Editorial page 840

Institute of Psychiatry, Psychology and Neuroscience, King's College London, London, UK (Prof J Treasure MD, T A Duarte MD, Prof U Schmidt MD); South London and Maudsley NHS Foundation Trust, London, UK (Prof U Schmidt); and Serviço de

Panel: Physical findings in the main eating disorders

Anorexia nervosa*

All systems of the body are affected by starvation, and the damage accumulates over time. Also, if there are additional purging behaviours, the risk of the following conditions is increased:

- Cardiovascular: hypotension, bradycardia, prolonged QT, arrhythmias, cardiomyopathy
- Dermatological: dry scaly skin and brittle hair (hair loss), lanugo (ie, fine downy body hair)
- Endocrine and metabolic: hypoglycaemia, hypokalaemia, hyponatraemia, hypothermia, altered thyroid function, hypercortisolaemia, amenorrhoea, delay in puberty, arrested growth, osteoporosis
- Gastrointestinal: prolonged gastrointestinal transit (delayed gastric emptying, altered antral motility, gastric atrophy, decreased intestinal mobility), constipation
- Haematologic: anaemia, leukopenia, thrombocytopenia
- Neurological: peripheral neuropathy, loss of brain volume: ventricular enlargement, sulcal widening, cerebral atrophy (pseudoatrophy—corrects with weight gain)
- Oral: dental caries
- Skeletal: osteopenia
- Renal: renal calculi, acute kidney injury (from dehydration and purging)
- Liver: transaminitis, liver failure
- Reproductive: amenorrhoea, infertility, low birthweight infant

Bulimia nervosa and binge eating disorder

Physical findings mainly due to the effects of starvation or vomiting:

- Often similar to anorexia nervosa, but less severe
- Specific problems related to purging include:
  - Cardiovascular: arrhythmias, cardiac failure (sudden death)
  - Endocrine and metabolic: electrolyte disturbances (K^+, Na^+, Cl^-, metabolic acidosis [laxatives] or alkalosis [vomiting])
  - Gastrointestinal: constipation or steatorrhoea, gastric or duodenal ulcers, pancreatitis, oesophageal or gastric erosions or perforation
  - Haematological: leukopenia or lymphocytosis
  - Oral: dental erosion
  - Renal: acute renal injury

K–Potassium. Na–Sodium. Cl–Chlorine. * It is beyond the scope of this Seminar to detail a full medical assessment and management. For the most part, these anomalies are linked to symptomatic behaviours and resolve when these behaviours are reduced. Further details are available in the Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) guidelines, which are regularly updated.[75] [76]

REVIEW ARTICLE

Cardiac complications of malnutrition in adolescent patients: A narrative review of contemporary literature

Joseph Burns[1], Caroline Shank[1], Madhusudan Ganigara[2], Nadia Saldanha[3], Arushi Dhar[2]

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ABSTRACT

Eating disorders are common. Between 1% and 2% of adolescent females and 0.5% of males suffer from anorexia nervosa, bulimia nervosa, and binge eating disorder. Although suicide represents nearly half of the mortality in patients with eating disorders, a majority of the remainder is cardiac arrest, likely secondary to cardiovascular complications of eating disorders such as bradycardia, hypotension, QT interval changes, structural heart disease, and pericardial effusion. Bradycardia is suspected to be secondary to increased vagal tone and is a common finding in patients admitted with disordered eating. Similarly, hypotension and orthostatic abnormalities are common complications due to atrophy of peripheral muscles. Descriptive studies report prolongation of the corrected QT interval (QTc) in these patients relative to controls, albeit within the normal reference range. Structural heart disease is also common, with left ventricular mass reported as lower than predicted in several studies compared to healthy controls. Pericardial effusion is also commonly described, although it is possible that this is underestimated, as not all patients with eating disorders undergo echocardiograms. Further, refeeding syndrome as a result of treatment of eating disorders carries its own cardiac risks. Cardiac complications of malnutrition are common but reversible with appropriate management and recovery. It is imperative that providers are aware of the epidemiology of these complications, as it is only with a high clinical suspicion that proper evaluation including a thorough history and physical examination, electrocardiogram, and when necessary echocardiogram can be performed.

ORIGINAL ARTICLE

Mortality in Eating Disorders - Results of a Large Prospective Clinical Longitudinal Study

Manfred Maximilian Fichter, MD, Dipl.-Psych.[1,2]*
Norbert Quadflieg, Dipl.-Psych.[1]*

ABSTRACT

Objective: To report on long-term mortality in anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED), and eating disorder not otherwise specified (ED-NOS), causes of death, and predictors of early death.

Method: A large sample of consecutively admitted inpatients ($N = 5,839$) was followed-up on vital status through the German civil registry office. Of these patients 1,639 were treated for AN, 1,930 for BN, 363 for BED, and 1,907 for ED-NOS. Data from the main inpatient hospital treatment were applied to bivariate and multivariate Cox regression analyses on survival time from onset of eating disorder to death or end of observation. Standardized mortality ratios (SMR) were computed matched for age, gender, and person-years.

Results: SMR were 5.35 for AN, 1.49 for BN, 1.50 for BED, 2.39 for narrowly defined ED-NOS, and 1.70 for widely defined ED-NOS. Patients with AN died earlier than patients with BN, BED, or ED-NOS who did not differ. A diagnosis of AN, chronicity, later age of onset, not living in a relationship, and an irregular type of discharge from index inpatient treatment were major predictors of a shorter time to death. Suicidality was a univariate predictor of a shorter time to death in BN only. AN patients mostly died from natural causes related to their eating disorder.

Discussion: Mortality in AN is excessive and considerably higher than in BN, BED, and ED-NOS.

Keywords: eating disorders; anorexia nervosa; bulimia nervosa; binge eating disorder; ED-NOS; death; mortality; standardized mortality ratio

(Int J Eat Disord 2016; 49:391–401)

BJPsych | The British Journal of Psychiatry (2021)
219, 487–493. doi: 10.1192/bjp.2020.197

Excess mortality associated with eating disorders: population-based cohort study

Tomisin Iwajomo, Susan J. Bondy, Claire de Oliveira, Patricia Colton, Kathryn Trottier and Paul Kurdyak

Background

Individuals with eating disorders have a high mortality risk. Few population-based studies have estimated this risk in eating disorders other than anorexia nervosa.

Aims

To investigate all-cause mortality in a population-based cohort of individuals who received hospital-based care for an eating disorder (anorexia nervosa, bulimia nervosa or eating disorder not otherwise specified) in Ontario, Canada.

Method

We conducted a retrospective cohort study of 19 041 individuals with an eating disorder from 1 January 1990 to 31 December 2013 using administrative healthcare data. The outcome of interest was death. Excess mortality was assessed using standardised mortality ratios (SMRs) and potential years of life lost (PYLL). Cox proportional hazards regression models were used to examine sociodemographic and medical comorbidities associated with greater mortality risk.

Results

The cohort had 17 108 females (89.9%) and 1933 males (10.1%). The all-cause mortality for the entire cohort was five times higher than expected compared with the Ontario population (SMR = 5.06; 95% CI 4.82–5.30). SMRs were higher for males (SMR = 7.24; 95% CI 6.58–7.96) relative to females (SMR = 4.59; 95% CI 4.34–4.85) overall, and in all age groups in the cohort. For both genders, the cohort PYLL was more than six times higher than the expected PYLL in the Ontario population.

Conclusions

Patients with eating disorders diagnosed in hospital settings experience five to seven times higher mortality rates compared with the overall population. There is an urgent need to understand the mortality risk factors to improve health outcomes among individuals with eating disorders.

Keywords:

Eating disorders; anorexia nervosa; bulimia nervosa; EDNOS; mortality.

Available online at www.sciencedirect.com
ScienceDirect
Current Opinion in Psychology

Eating disorders and suicidality: what we know, what we don't know, and suggestions for future research

April R Smith[1], Kelly L Zuromski[2] and Dorian R Dodd[1]

Suicide is the second leading cause of death among individuals with anorexia nervosa (AN), and suicidal behavior is elevated in bulimia nervosa (BN) and binge eating disorder (BED) relative to the general population. This paper reviews the suicidality literature within each ED, as well as theoretical explanations for

Approximately one-quarter to one-third of people with AN, BN, or BED have thought about suicide, and one-quarter to one-third of people with AN and BN have attempted suicide. Relative to gender and aged matched comparison groups, individuals with AN are 18 times more likely to die by suicide, and individuals with BN are seven times more likely to die by suicide. However, the majority of the research in this area is cross-sectional or retrospective, which leaves the timing of the mortality risk unclear. Longitudinal work that is designed to examine dynamic and acute fluctuations in suicidality among ED samples is needed in order to determine meaningful risk factors.

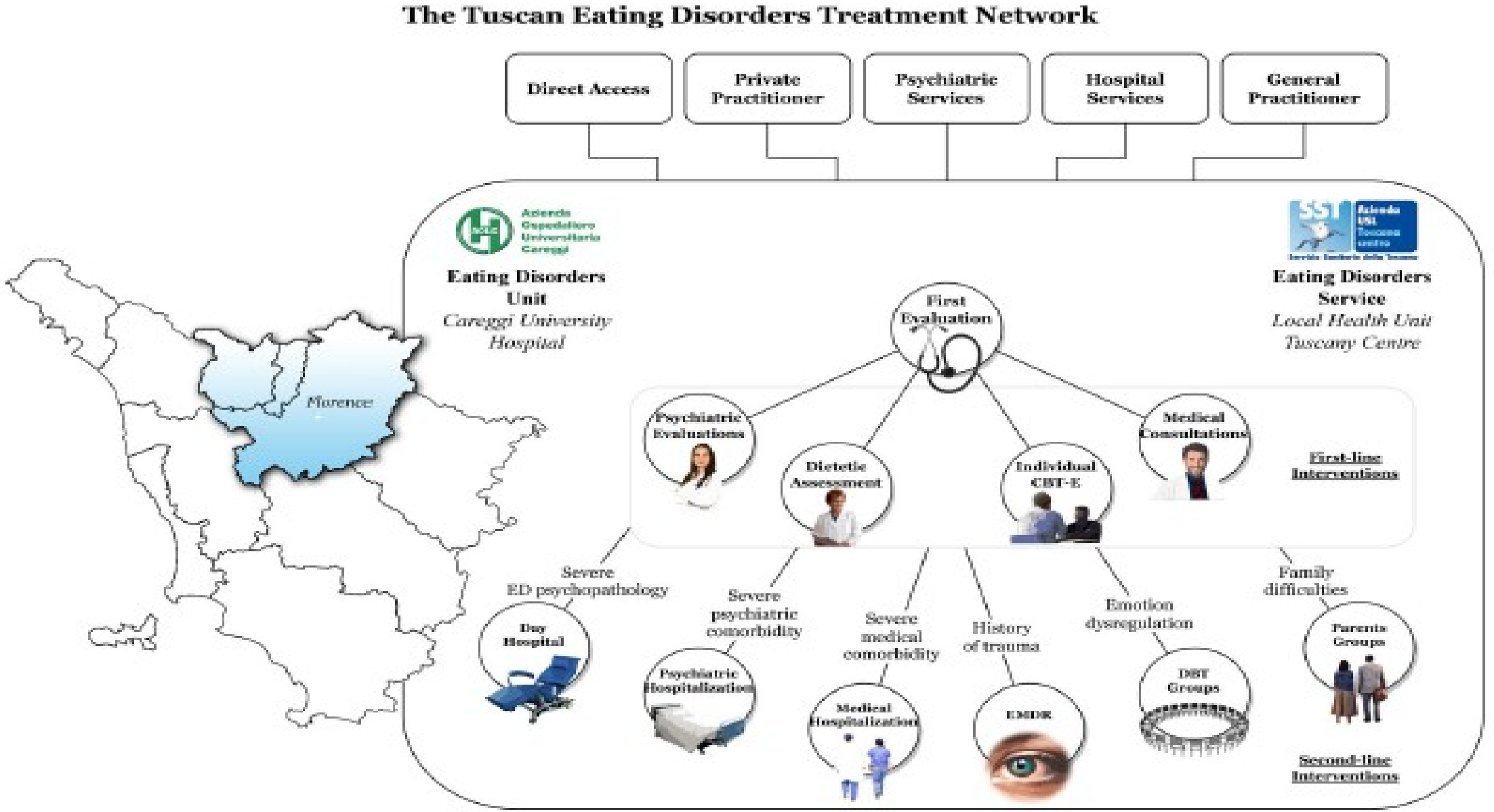


FIGURE 1 Illustration of the Tuscan eating disorders treatment network services

Figura 2

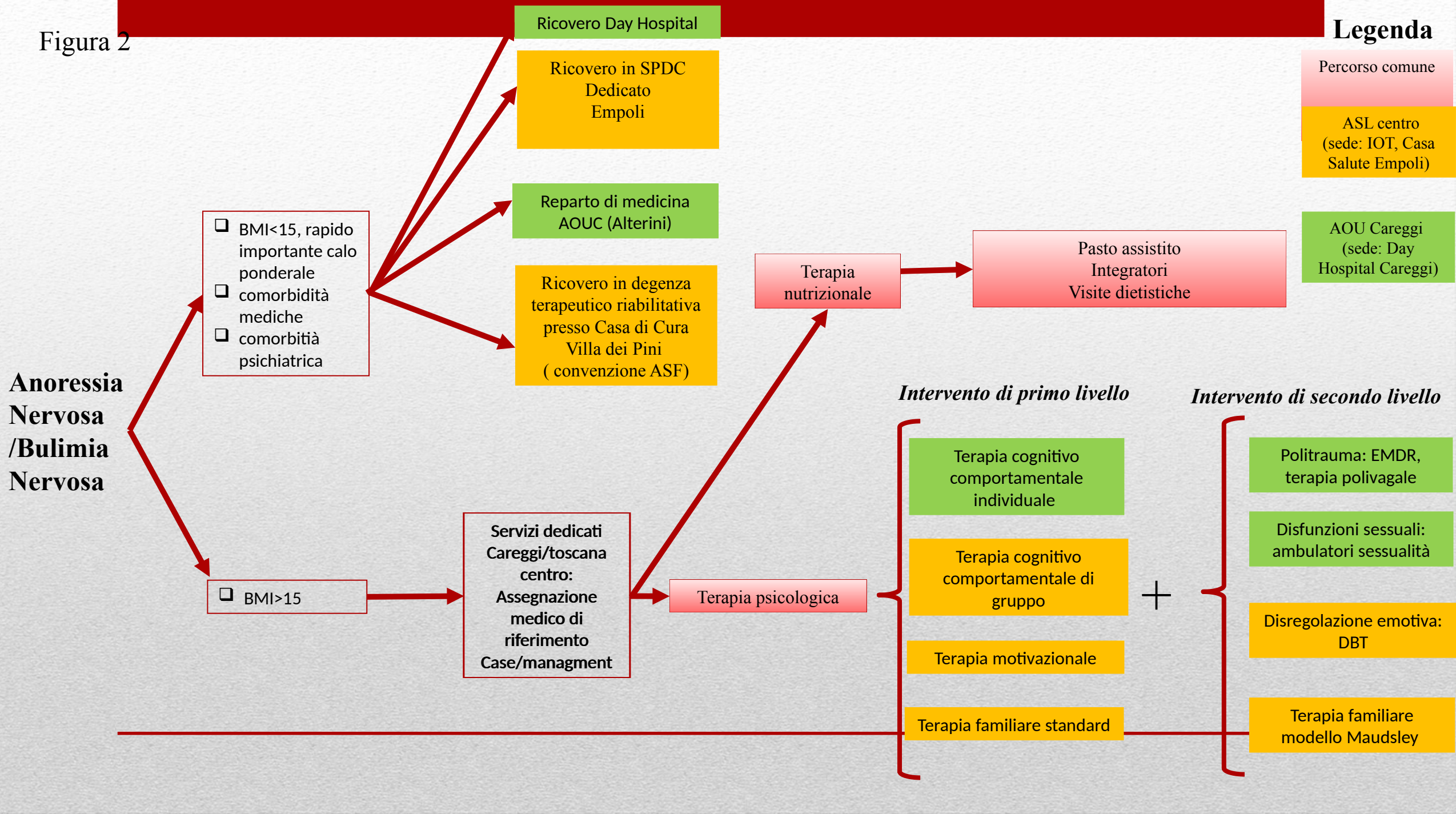
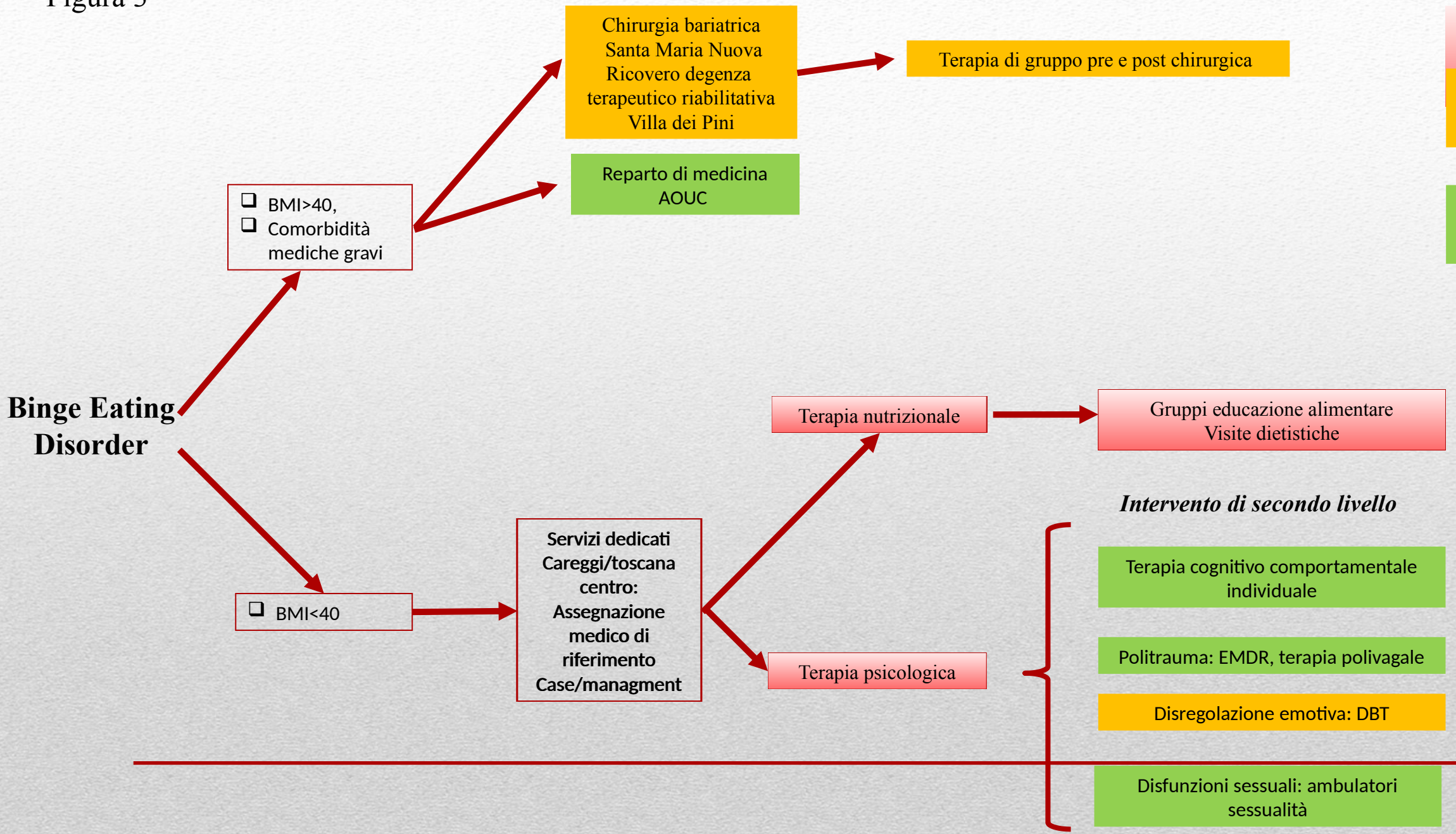

Legenda
Percorso comune
ASL centro (sede: IOT, Casa Salute Empoli)
AOU Careggi (sede: Day Hospital Careggi)
Anoressia Nervosa /Bulimia Nervosa
BMI<15, rapido importante calo ponderale
comorbidità mediche
comorbitià psichiatrica
Ricovero Day Hospital
Ricovero in SPDC Dedicato Empoli
Reparto di medicina AOUC (Alterini)
Ricovero in degenza terapeutico riabilitativa presso Casa di Cura Villa dei Pini (convenzione ASF)
Terapia nutrizionale
Pasto assistito
Integratori
Visite dietistiche
BMI>15
Servizi dedicati Careggi/toscana centro: Assegnazione medico di riferimento Case/managment
Terapia psicologica
Intervento di primo livello
Terapia cognitivo comportamentale individuale
Terapia cognitivo comportamentale di gruppo
Terapia motivazionale
Terapia familiare standard
Intervento di secondo livello
Politrauma: EMDR, terapia polivagale
Disfunzioni sessuali: ambulatori sessualità
Disregolazione emotiva: DBT
Terapia familiare modello Maudsley

Figura 3


Legenda
Percorso comune
ASL centro (sede: IOT, Casa Salute Empoli)
AOUC (sede: Day Hospital Careggi)
Binge Eating Disorder
BMI>40,
Comorbidità mediche gravi
Chirurgia bariatrica Santa Maria Nuova Ricovero degenza terapeutico riabilitativa Villa dei Pini
Reparto di medicina AOUC
Terapia di gruppo pre e post chirurgica
BMI<40
Servizi dedicati Careggi/toscana centro: Assegnazione medico di riferimento Case/managment
Terapia nutrizionale
Gruppi educazione alimentare Visite dietistiche
Terapia psicologica
Intervento di secondo livello
Terapia cognitivo comportamentale individuale
Politrauma: EMDR, terapia polivagale
Disregolazione emotiva: DBT
Disfunzioni sessuali: ambulatori sessualità

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ORIGINAL ARTICLE

Acta Psychiatrica Scandinavica WILEY

Mortality and care of eating disorders

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Abstract

Introduction: Eating disorders (EDs) are considered serious mental illnesses, with one of the highest lethality among psychiatric disorders, even though the issue of mortality due to these conditions is still controversial. The present study was aimed at comparing the mortality rate in a cohort of ED patients representative of the geographic area with that of the age and gender-matched general population of central Italy.

Methods: Patients were enrolled between 1994 and 2018, among those attending the eating disorders treatment network of the Florence area (EDTN), which is a regional multidisciplinary treatment reference center for EDs covering the clinical population of the metropolitan Florence area (Italy). The life status of participants was determined through linkage with the Regional Mortality Registry.

Results: A total of 1277 individuals with EDs were included, including 368 with Anorexia Nervosa (AN), 312 with Bulimia Nervosa (BN), and 597 individuals with Binge Eating Disorder (BED). Twenty-two patients (1.72%) died, during a median follow-up of 7.4 years. The mortality rates among ED patients did not significantly differ from that of the general population of the same age and sex with a Standardized Mortality Ratio (SMR) of 1.19, 95% CI 0.79–1.81. Only among BN patients, the mortality was significantly increased after 10 years from clinical evaluation (SMR 11.24, 95% CI 3.62–34.84).

Conclusion: The low mortality in EDs, compared to published studies, might be due to the EDTN treatment strategy, based on a large network which makes an integrated multidisciplinary team available for almost all the patients with EDs of the geographical area.

KEYWORDS
anorexia nervosa, binge eating disorder, bulimia nervosa, eating disorders, standardized mortality ratio

TABLE 1 Cause of deaths of the 22 individuals with eating disorders included in the analyses who died during follow-up

Eating disorder type	Sex	Age at death	Years between clinical evaluation and death	Cause of death (ICD-10 classification)		
				Code(s)	Chapter	Detail
AN	Female	35.3	11.6	T50 + X44	XIX—Injury, poisoning and certain other consequences of external causes	Poisoning by diuretics and other and unspecified drugs, medicaments and biological substances, accidental
	Female	56.8	0.4	C34	II—Neoplasms	Malignant neoplasm of bronchus or lung
	Female	64.3	6.2	E83	IV—Endocrine, nutritional and metabolic diseases	Disorders of mineral metabolism
BN	Female	48.9	10.6	C71	II—Neoplasms	Malignant neoplasm of brain
	Female	71.5	11.8	I26	IX—Diseases of the circulatory system	Pulmonary embolism
	Female	82.2	10.8	C64	II—Neoplasms	Malignant neoplasm of kidney
BED	Female	40.4	0.4	S02 + S14	XIX—Injury, poisoning and certain other consequences of external causes	Fracture of skull and facial bones + Injury of nerves and spinal cord at neck level
	Female	47.1	4.2	C92	II—Neoplasms	Myeloid leukemia
	Female	50.6	7.1	E66	IV—Endocrine, nutritional and metabolic diseases	Obesity
	Female	54.0	8.7	C25	II—Neoplasms	Malignant neoplasm of pancreas
	Female	54.8	1.5	C55	II—Neoplasms	Malignant neoplasm of uterus (part unspecified)
	Female	59.6	11.9	I24	IX—Diseases of the circulatory system	Other acute ischemic heart diseases
	Male	63.9	11.7	I11	IX—Diseases of the circulatory system	Hypertensive heart disease
	Female	64.0	6.4	C19	II—Neoplasms	Malignant neoplasm of rectosigmoid junction
	Female	64.6	9.6	I61	IX—Diseases of the circulatory system	Intracerebral hemorrhage
	Female	66.0	2.8	J42	X—Disease of the respiratory system	Chronic bronchitis, unspecified
	Male	66.3	9.7	I25	IX—Diseases of the circulatory system	Chronic ischemic heart disease
	Female	67.2	7.8	C55	II—Neoplasms	Malignant neoplasm of uterus (part unspecified)
	Female	69.7	8.5	I25	IX—Diseases of the circulatory system	Chronic ischemic heart disease
	Male	69.9	10.5	C18	II—Neoplasms	Malignant neoplasm of colon
	Female	74.7	9.8	C67	II—Neoplasms	Malignant neoplasm of bladder
	Female	75.5	1.5	C25	II—Neoplasms	Malignant neoplasm of pancreas

Significant outcomes

- Twenty-two patients (1.72%) died, during a median follow-up of 7.4 years.
- The mortality rates among ED patients did not significantly differ from that of the general population of the same age and sex with a Standardized Mortality Ratio (SMR) of 1.19, 95% CI 0.79–1.81.
- Only among BN patients, the mortality was significantly increased after 10 years from clinical evaluation (SMR 11.24, 95% CI 3.62–34.84).

Limitations

- The present study did not include patients relying on private care services, therefore the calculated SMRs may not be applicable to this subgroup.
- The SMRs were calculated considering gender, age group, and calendar time; future studies should consider additional factors, such as clinical characteristics, type and duration of treatment.

Considerazioni alla base dei risultati ottenuti (1)

1) La rete assistenziale che si è costituita permette una integrazione di competenze, con interventi mirati in grado di fare fronte a esigenze cliniche molto diversificate. E' un esempio, fra i tanti, di come il Sistema Sanitario Pubblico Toscano può ottenere eccellenti risultati clinici.

2) Essi sono riconducibili:

-alla disponibilità numerica di personale che, formato nella Scuola di Specializzazione in Psichiatria, è sufficientemente competente ed in numero tale da garantire una assistenza continua, con visite e monitoraggi frequenti.

- a conoscenze psichiatriche e psicoterapeutiche condivise, con una impostazione diagnostica e terapeutica sufficientemente omogenea.

Considerazioni alla base dei risultati ottenuti (2)

- All’elevato grado di competenza dei colleghi internisti coinvolti nella rete assistenziale, capaci di gestire situazioni particolarmente complesse in modo tale da evitare complicanze mediche fatali.

- Alla possibilità di utilizzare setting di cura diversificati (ambulatorio, day hospital, degenza in medicina interna, degenza psichiatrica prolungata terapeutico riabilitativa, Servizio di Diagnosi e Cura) e funzionali ai vari quadri clinici delle pazienti.

Considerazioni alla base dei risultati ottenuti (3)

- Alle conoscenze che si sono sviluppate e consolidate nel gruppo di lavoro dopo circa 30 anni di esperienza clinica, condivise tra le varie figure professionali coinvolte.

- Alla presenza di una costante attività di ricerca clinica di livello internazionale , che permette una continua elaborazione critica dei dati derivanti dai protocolli terapeutici, utilizzati per migliorare costantemente gli esiti dei vari trattamenti.

Conclusioni

La salute mentale è un bene prezioso, che richiede capacità terapeutiche, organizzative e risorse economiche non indifferenti.

E’ necessario destinare risorse adeguate a pazienti con patologie gravi, che comportano livelli di sofferenza individuale e familiare particolarmente elevati.

E’ possibile ottenere risultati clinici ottimali quando la struttura pubblica riesce a dotarsi di un sistema assistenziale ben organizzato, con personale adeguato per competenze e numerosità, che condivida strategie, strumenti e obiettivi terapeutici.