INPATIENT PRACTICE

Diet Lessens Inpatient Weight Gain

The cardiovascular data collected during the Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study showed that 36% of men and 51% of women with schizophrenia have the metabolic syndrome, putting them at greatly increased risk for stroke, heart attack, and diabetes.

The onus that this type of information has imposed on psychiatrists to become more proficient in the practice of endocrinology and weight loss medicine has made many uncomfortable and feeling lost in an area they haven't needed to know before.

One psychiatrist, Dr. Charles Nguyen, found that the complexities of diet and nutrition had his patients as least as confused as his colleagues, so he greatly simplified the advice he was providing. It worked so well that he imposed his program on the entire acute psychiatric unit at the University of California, Irvine, Medical Center, with impressive results.

The fact that the diet permits only water and no sodas and restricts snack foods is important.

DR. NGUYEN

When he examined the weight gain experience of 143 patients with schizophrenia who were prescribed olanzapine (Zyprexa), he found that those hospitalized before the diet modification gained an average of 9 pounds before discharge, whereas those hospitalized after had gained only 4 pounds. The length of hospitalization was approximately 3 weeks in both groups.

Dr. Nguyen's diet, which he named the WIN Nguyen diet, includes just four basic instructions to patients on an antipsychotic regimen:

► No second servings at meals.
► No high-calorie snacks. Replace with fruits and vegetables.
► No desserts.
► Substitute water for sodas and juices.

Despite some reservations initially, more from staff than patients, Dr. Nguyen says his program has been well received and successful on his inpatient unit.

This month, CLINICAL PSYCHIATRY NEWS talks with Dr. Nguyen, director of the schizophrenia and bipolar inpatient unit at the University of California, Irvine, Medical Center, about his program and some of the rationale behind it.

Clinical Psychiatry News: Where did the motivation for developing your diet come from?

Dr. Nguyen: I initially became concerned about the weight gain that patients on antipsychotics experience when I was a third-year resident. Weight gain is one of the main reasons patients discontinue their medications.

I realized I had two choices. I could either use the less effective medications that cause less weight gain or I could use more effective medications like olanzapine and address weight gain.

I initially consulted with nutritionists and dietitians quite a bit, but, like my patients, I quickly became overwhelmed by all of the information. I was telling patients to keep their carbohydrate intake down to 30% of calories, and increase their protein above 20%, and to try to walk more and get their heart rate up. Patients could not follow it, especially when they already had to assimilate so much information about their treatment regimens.

Over time, my ideas evolved, and the components of the diet I recommend now are really simple.

I put the onus on the patients. I tell them that I can put them on a less effective drug, or I can put them on a more effective drug and a strict diet. I tell them that the medication is going to make them really hungry at first, but if they eat what they want they will gain weight.

I do not tell patients that this program needs to be followed forever. That is too intimidating. I say that they will have to be disciplined at first, and that eventually their intense appetite will abate. Usually, their exaggerated hunger goes away after 4-6 weeks.

Most importantly, I keep the requirements very simple.

CPN: Can you tell us more specifically how your ideas evolved?

Dr. Nguyen: I was finding that my directions to patients were too complicated, so I started simplifying, cutting one thing at a time. I knew that first-generation Asian patients I saw tended not to gain weight, whereas second-generation Asian patients did. That got me thinking about high-calorie snacks and sodas. You are just not going to gain much weight if your snack is a bowl of rice.

The fact that the diet permits only water and no sodas and restricts snack foods to fruits and vegetables is very important. With an extra 500 calories each day, you will gain a pound of weight every week. A big soda can be as much as 750 calories. If you drink two big sodas a day, you may gain 2 pounds a week.

The importance of these excess calories cannot be overstated. I used to tell patients to exercise to prevent weight gain, but you really can't burn off the calories of a big dessert.

CPN: You mentioned that there was resistance when you tried to implement the diet for everyone on your inpatient unit. How did you overcome that?

Dr. Nguyen: The resistance was mainly from the staff members, who saw this as a patient rights issue and didn't want to manage grumbling patients. I think they overcame their objections because they saw this as such a critical issue—psychiatric patients are two to three times more likely to have diabetes than the general population, and that is without drugs. I told the staff that we had to give patients options, and not just consign them to weight gain.

On our unit, patients can opt out and have a regular hospital diet, or they can get on our diet, with men getting 2,000 calories a day and women getting 1,800. The general hospital diet served in psychiatric wards provides about 2,900 calories a day, and then there is the snack shop for additional food.

Before the diet, we had patients who gained 40 pounds in 2 months. I think when the staff saw that our patients were not gaining weight on the diet, it helped to convince them that the diet is a good thing.

Our patients expect it, and we make sure families are very involved in discussions about the diet and the need for it.

CPN: Do you think you are having a long-term impact?

Dr. Nguyen: I think the information and direction we give our patients empowers them to have better control over their hunger. This should help them now and in the future.

CPN: You call the diet the WIN Nguyen diet. What does the acronym stand for?

Dr. Nguyen: The whole name concept of the diet started as sort of a joke, because there was the Atkins diet, and others named after people.

For a while we called it the WIN-WIN diet. The acronym was intended to remind the nurses and clinicians of their responsibilities. The W stands for "weigh the patient" at baseline and at every visit. The I stands for "initially," because you need to begin the weighing and the diet from the very start. And, the N was for "Nguyen."

CPN: Have you heard from people who are interested in using your diet in their institutions?

Dr. Nguyen: I have lectured on this topic many times, and one hospital is interested in implementing a similar diet program on its inpatient unit.

Many people I talk with are skeptical, but I always challenge them, saying that they don't know if it works until they try it.

We have a dangerous problem with our patients, and we have a choice to do something about it or not do something about it.

I use the diet not just for individuals who are on olanzapine and other second-generation antipsychotics, but for patients on divalproex (Depakote) and lithium too.

It's very effective. ■

By Timothy F. Kirn, Sacramento Bureau. Send your thoughts and suggestions to cpnews@elsevier.com.

Federal Action On Obesity Unlikely Soon

BY MARY ELLEN SCHNEIDER
New York Bureau

TORONTO — Political conditions still aren't ripe for significant U.S. government action on the obesity front, Michelle Mello, J.D., Ph.D., said at the annual meeting of the Endocrine Society.

Several highly active and influential public health groups support government action on obesity, but a well-funded lobby of food and beverage manufacturers and the restaurant industry has spent a lot of money trying to convince lawmakers that increased regulation of food products is unnecessary. "It's still a difficult row to hoe for a policy maker who would like to do something legally about obesity," said Dr. Mello of the Harvard School of Public Health, Boston.

Legal authority is another obstacle to action at the federal level. The federal government's authority over public health policy is actually relatively limited, she said. Most of that authority is granted to the states; in order to get involved, the federal government has to find a "jurisdictional hook" relating to interstate commerce or federal spending, she said.

Another likely reason why politicians aren't eager to pursue policy related to obesity is that the public support isn't there yet.

In a 2004 survey of more than 1,000 adults, which looked at the issue of childhood obesity, only 17% said the government has a lot of responsibility to reduce childhood obesity. The lion's share of the responsibility rests with parents, according to 91% of survey respondents. About 30% of those surveyed said that the schools bear a lot of responsibility, too (Am. J. Prev. Med. 2005;28:26-32).

"The findings don't demonstrate broad support for interventions outside of the schools," Dr. Mello said. Although the federal government has not taken action on obesity, there has been limited action at the state and local level. For example, some states have initiated financial disincentives by allowing some kinds of unhealthful foods to be taxable.

There have also been some attempts to condition the receipt of government benefits on individuals' making healthy lifestyle choices. In West Virginia, for example, the state Medicaid program offers an enhanced benefits package if beneficiaries sign a personal responsibility agreement. Food products are also being regulated directly in some places. Officials in New York City have banned the use of artificial trans fats in the city's restaurants after July 2008.

Dr. Mello predicted that future government actions regulating obesity are most likely to be supported if they focus on children.

"We can make all kinds of arguments about individual choice, but they make a lot less sense when we're talking about an 8-year-old than when we're talking about a 38-year-old," Dr. Mello said. ■