Effects of long-term treatment with antipsychotics on serum leptin levels

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Background Abnormal regulation of the adipocyte-derived hormone leptin could play a role in body weight gain induced by antipsychotics.

Aims To study the effects of long-term antipsychotic treatment on leptin levels in patients with schizophrenia.

Method Serum leptin levels were determined in 59 out-patients with chronic schizophrenia and in the same number of healthy subjects controlled by gender, age and body mass index.

Results Leptin levels did not differ between patients and controls. Leptin levels in patients with schizophrenia correlated with weight gain, even after controlling for current weight, but did not show any association with clinical variables. Antipsychotic class tended to exert different effects over leptin levels (among atypical, olanzapine induced a greater increase).

Conclusions Elevation of leptin levels induced by chronic antipsychotic treatment can be attributed to weight gain, but other mechanisms could be involved.

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Body weight gain is a common side-effect of antipsychotics that affects up to 50% of the patients under chronic treatment with these drugs (Allison et al, 1999; Baptist, 1999; Ganguli, 1999). The factors influencing body weight regulation are rather complex (Yanovski & Yanovski, 1999), but a major advance was the discovery of the adipocyte-derived hormone leptin (Zhang et al, 1994). The level of this hormone is correlated positively with body fat. Leptin acts by binding to specific receptors in the hypothalamus; this decreases food intake and increases energy expenditure (Friedman & Halaas, 1998). Clozapine and olanzapine (Bromel et al, 1998; Kraus et al, 1999) have been shown to increase the levels of leptin over short-term treatment, but the effects of long-term treatment are unknown. Our aim has been to study serum leptin levels in out-patients with chronic schizophrenia, to determine the effects of long-term treatment with different antipsychotics on this hormone and to test if clinical symptoms are associated with leptin levels.

METHOD

Subjects All out-patients treated at one department in Santander (a city in the North of Spain), and fitting DSM-IV criteria of schizophrenia (American Psychiatric Association, 1994) by agreement of two senior psychiatrists were asked to participate in the study. In addition, patients were evaluated with the Item Group Checklist section of the Schedules for Clinical Assessment in Neuropsychiatry (SCAN; Wing et al, 1990; Vázquez-Barquero et al, 1994) in order to confirm the diagnosis. Exclusion criteria were acute or chronic illnesses known to affect the immune, endocrine or metabolic systems. From the initial sample of 81 patients, 12 patients were excluded because of not fitting schizophrenia criteria and 4 were excluded because of physical reasons (two patients with diabetes mellitus, one with AIDS and one pregnant). In addition, three patients were not accessible when the study was performed and three did not give informed consent. Thus 22 patients were excluded from the initial sample, leaving 59 patients entered in the study. This sample has been analysed previously in other reports (Herrán et al, 1999; 2000a,b).

Fifty-nine healthy subjects without current or past psychiatric disorder and controlled by gender and age were selected as controls. In addition, they were matched by the current body mass index (BMI) of the patients. Exclusionary criteria were the same as for patients. Neither patients nor controls had dietary restriction or evidence of clinical malnutrition. After a complete description of the study, all patients and healthy controls gave informed consent to participate in the investigation.

Clinical data were obtained from the patients and blood samples were obtained from patients and controls.

Clinical measures Demographic, social and medical antecedent variables were assessed using a specifically created questionnaire. Clinical information included DSM-IV schizophrenia subtype and the Spanish version of the Positive and Negative Syndrome Scale (PANSS; Peralta & Cuesta, 1994; for English version see Kay et al, 1987). Additional data regarding clinical evolution and treatment were derived from the clinical records.

Chlorpromazine equivalents were calculated according to commonly used equivalent doses (American Psychiatric Association, 1997). All patients had been on treatment with their current antipsychotic for at least 6 months. Patients (n=5) on treatment with fluphenazine depot and another antipsychotic drug were considered as taking only phenothiazines. Four patients were treated exclusively with behavioural psychotherapy and were not taking antipsychotic medication.

Height and weight were assessed immediately before blood sample extraction. For patients, weight at the onset of the illness was derived from clinical records. The BMI was expressed in kg/m².

Serum measures Fasting blood samples were withdrawn from an antecubital vein between 08.00 and 09.00 h. Samples were centrifuged
immediately and serum was stored at \(-40^\circ C\) until assayed. Samples were obtained simultaneously for patients and controls within a 6-month period to avoid seasonality.

Serum leptin levels were determined by radioimmunoassay (RIA) from Linco (Linco Research Inc., St Charles, MO, USA). Precisions within and between assay variation were 4.9 and 4.5%, respectively. Normal values are: <10 ng/ml for males and <20 ng/ml for females, with BMI <25 kg/m\(^2\).

**Analysis**

Data were analysed with the Statistical Package for the Social Sciences (SPSS) version 8.0. Given the skewed distribution of leptin levels, a base-10 logarithm transformation was used for analysis. Comparisons between schizophrenia and control groups were made by t-test. Group mean differences among schizophrenia subtypes (clinical, treatment) were checked by means of t-test or analysis of variance (ANOVA). The General Linear Model (Factorial) command of the SPSS was used when controlling for covariates. For the relationship between leptin levels, weight and BMI, Pearson’s correlation was used (and partial correlation when controlling for the effects of other additional variables). For the relationship with clinical (ordinal) variables, Spearman’s correlation was used.

**RESULTS**

Fifty-nine patients with schizophrenia and the same number of healthy subjects entered the study (32 males and 27 females in each group). Patients and controls were controlled for age (mean=38.2 years and s.d.=11.2 \(\mu\) mean=38.1 years and s.d.=9.6, respectively), and BMI (mean=26.4 kg/m\(^2\) and s.d.=4.2 \(\mu\) mean=25.7 kg/m\(^2\) and s.d.=4.0, respectively).

**Sample description**

The sample consisted of patients with chronic schizophrenia, with a mean of 13.7 years of evolution of the illness (s.d.=11.1). There was a predominance of patients with residual schizophrenia. Clinical subtypes were as follows: paranoid, 19 (32.3%); disorganised, 7 (11.9%); undifferentiated, 9 (15.5%); and residual schizophrenia, 24 (40.7%). Mean scores on the PANSS scale reflect a moderate severity of the illness and a predominance of negative symptoms. Mean scores were: positive sub-scale, 10.9 (s.d.=4.9); negative sub-scale, 17.6 (s.d.=7.3); general sub-scale, 27.4 (s.d.=9.9); and total PANSS score, 55.8 (s.d.=18.3). Mean weight gain in patients since the onset of the illness was 10.6 kg (s.d.=9.3) and mean BMI gain was 3.8 kg/m\(^2\) (s.d.=3.3).

Mean antipsychotic dose (as chlorpromazine equivalents) was 317.8 mg/day (s.d.=206.8). Seventeen patients (30.9% of those taking antipsychotic treatment) were taking long-acting depot neuroleptics and the same number of patients were on atypical antipsychotics. Twenty-six patients were on treatment with phenothiazines (perphenazine, fluphenazine, trifluoperazine), eight with haloperidol, two with zuclopenthixol, one with loxapine, one with pimozide, five with risperidone, five with clozapine and seven with olanzapine. Some of the patients also received benzodiazepines and/or anticholinergic drugs, but none received antidepressants or mood stabilisers.

**Serum leptin levels**

Serum leptin levels did not differ significantly between patients and controls, either in the total sample (t=0.150; d.f.=116; \(P=0.8\)) or when they were compared by gender. Levels were higher in females than in males, both in patients (t=−5.602; d.f.=57; \(P=0.000\)) and control groups (t=−5.968; d.f.=57; \(P=0.000\) (Table 1). The BMI did not differ significantly between male and female groups. Age did not correlate with leptin levels.

Relationships between leptin levels and weight, BMI, gain in weight and gain in BMI are shown in Table 2. In both patients and controls, leptin showed a strong correlation with BMI, and in the case of patients leptin also correlated with weight gain and BMI gain. Because weight gain correlated strongly with current weight (r=−0.740; \(P=0.000\)) and BMI gain correlated with current BMI (r=0.767; \(P=0.000\)), the effects of weight and BMI gain were controlled for current weight and BMI. Leptin levels in patients with schizophrenia correlated significantly with weight gain and showed a trend for an association with BMI gain.

Neither clinical variables (age at the onset of the illness, years of evolution, PANSS scores) nor schizophrenia subtype (F=0.048; d.f.=3; \(P=0.9\)) exerted any effect over leptin levels. Also, antipsychotic dosage and mode of treatment (oral \(\mu\) depot) did not show any association with leptin levels. Patients on typical antipsychotic treatment did not differ from those on atypical drugs (clozapine, olanzapine, risperidone) (t=−0.572; d.f.=53; \(P=0.5\)). Serum leptin levels, weight and BMI according to antipsychotic class are shown in Table 3. Patients taking clozapine and olanzapine tended to show a higher BMI than patients taking other antipsychotic drugs.

Serum leptin levels did not differ among patients taking different antipsychotics when controlling for current BMI. When comparing patients taking atypical drugs (clozapine, olanzapine, risperidone) the differences in leptin levels were significant (F=4.442; d.f.=2; \(P=0.03\)). Patients on treatment with olanzapine had the highest leptin levels, patients on risperidone had the lowest and patients taking clozapine...
had intermediate values. The difference in leptin levels between patients taking olanzapine and risperidone remained at the limit of statistical significance, even after controlling for BMI (F = 4.877; d.f. = 1; P = 0.05).

**DISCUSSION**

This is the first study analysing the effects of chronic antipsychotic medication on serum leptin levels. In addition, we assessed an unselected, representative sample of outpatients with schizophrenia. Given the prevalence of weight gain in patients taking antipsychotics, and its impact over patients’ health and quality of life, the knowledge of the physiological basis of the weight gain is an essential area of research.

The present study focused on the relationship between leptin levels and psychopathology, the effects of chronic treatment with antipsychotic drugs on weight and serum leptin levels and the differential effects of antipsychotic subgroups (particularly the newer atypical ones) over this hormone. The main findings were: serum leptin levels do not differ between patients with schizophrenia taking chronic antipsychotic medication and healthy subjects controlled by gender, age and BMI; leptin levels in patients with schizophrenia correlated with weight gain; leptin levels did not show any association with clinical variables; and among atypical antipsychotics olanzapine appeared to induce a greater increase in leptin independently of weight gain.

There are a number of limitations to the present study. First, given the transverse design of the study, we must be cautious with the conclusions: correlation does not imply causal association. In addition, we cannot exclude a number of confounding factors, such as other pharmacological treatments (anticholinergic drugs, etc.), and we did not assess the patients’ eating behaviour. Additionally, there was a limited number of patients in each group (clinical and treatment groups).

**Leptin and antipsychotic treatment**

Leptin levels did not differ between patients and healthy subjects matched by BMI. At least two studies have analysed the behaviour of leptin over short-term antipsychotic treatment. Bromel et al. (1998) found that leptin increased in a 1-week period of treatment with clozapine. Kraus et al. (1999) found an increase in leptin levels in patients taking clozapine or olanzapine over 4 weeks, but not in patients taking haloperidol. Both groups suggested that the most probable reasons for these increases in leptin levels were overeating and weight gain, which induce increased leptin secretion. Our results of unchanged levels in a sample of long-term treated patients compared with BMI-matched controls support this hypothesis. However, the difference in leptin levels between patients on olanzapine and those on risperidone is intriguing. Perhaps most of the effect of antipsychotics on leptin levels could be attributed to weight gain, but other mechanisms could be involved. Leptin is known to be affected by several neurotransmitters, such as histamine (Morimoto et al. 1999) and serotonin (Yamada et al., 1999). The serotonin receptor inhibitor fluoxetine decreased plasma leptin levels in rats (Dryden et al., 1999). It is possible that, given the different pharmacological profile of antipsychotics (including the atypical ones) over these receptors (Moore, 1999), diverse drugs could exert differential effects over leptin levels irrespective of induced weight gain. This could support the hypothesis of Baptista (1999) regarding different ways in which antipsychotics, it would be correlated with clinical measures.

**Table 3** Serum leptin levels, weight, weight gain, body mass index (BMI) and BMI gain by drug class

<table>
<thead>
<tr>
<th>Antipsychotic</th>
<th>Leptin (ng/ml)</th>
<th>Weight (kg)</th>
<th>Weight gain (kg)</th>
<th>BMI (kg/m²)</th>
<th>BMI gain (kg/m²)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>Mean ± s.d.</td>
<td>n</td>
<td>Mean ± s.d.</td>
<td>n</td>
</tr>
<tr>
<td>Phenothiazines</td>
<td>26</td>
<td>71.12 ± 14.25</td>
<td>23</td>
<td>10.22 ± 10.36</td>
<td>26</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>8</td>
<td>78.50 ± 10.90</td>
<td>8</td>
<td>7.75 ± 7.59</td>
<td>8</td>
</tr>
<tr>
<td>Clozapine</td>
<td>5</td>
<td>81.00 ± 7.52</td>
<td>5</td>
<td>15.60 ± 8.50</td>
<td>5</td>
</tr>
<tr>
<td>Olanzapine</td>
<td>7</td>
<td>80.57 ± 16.31</td>
<td>7</td>
<td>14.71 ± 11.46</td>
<td>7</td>
</tr>
<tr>
<td>Risperidone</td>
<td>5</td>
<td>73.60 ± 6.23</td>
<td>5</td>
<td>7.40 ± 5.55</td>
<td>5</td>
</tr>
</tbody>
</table>

ANOVA: F = 2.316; P = 0.07

1. Patients taking loxapine (n = 1), pimozide (n = 1) and zuclopenthixol (n = 2) are not shown.

2. Differences are calculated with log-transformed leptin levels.

3. When controlling for current BMI: F = 1.442; P = 0.2.
antipsychotics induce weight gain: olanzapine, for example, could exert some direct effect over leptin. None the less, given that the main finding of the present study is that the leptin levels are raised in association with body weight, we must keep in mind the limitations discussed about the weight gain of patients on risperidone (low number of patients, not sufficiently long taking this drug). Prospective studies with larger samples are necessary to elucidate these issues.

REFERENCES


CLINICAL IMPLICATIONS

- Body weight gain is a common side-effect of antipsychotics that could contribute to the increased morbidity and mortality in schizophrenia.
- Leptin levels did not differ between patients and healthy subjects matched by body mass index.
- Most of the effect of antipsychotics on leptin levels could be attributed to weight gain, although diverse drugs could exert differential effects over leptin.

LIMITATIONS

- Given the transverse design of the study, conclusions should be treated with caution.
- In the present work the patients’ eating behaviour was not assessed.
- The number of patients was relatively low for assessing differences between groups of antipsychotics.

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62
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