Schizophrenia shortens life, e.g. through suicide and obesity-related diseases such as type 2 diabetes mellitus. It is assumed that medications play a major role, but most of the evidence for this comes from studies poorly controlled for variables such as lifestyle and medication status.

Aims To determine whether schizophrenia is associated (independently of medication) with the development of certain metabolic disturbances and whether these might be explained by stress axis dysfunction.

Method Literature review.

Results Most studies did not control for confounding factors such as previous usage of medication, lifestyle, age and ethnicity. A few conducted in drug-naïve patients with first-episode schizophrenia appear to indicate that these patients have higher than expected rates of visceral obesity and impaired fasting glucose concentrations, which may be related to a subtle disturbance of the hypothalamic–pituitary–adrenal axis.

Conclusions Schizophrenia is independently associated with physical illnesses that have a metabolic signature. Therefore, patients need to have a thorough physical assessment at diagnosis and at regular intervals thereafter. Metabolic disturbances have been found in drug-naïve patients with first-episode illness and may be an inherent part of the illness.

Declaration of interest J.H.T. is supported by a grant from Eli Lilly & Co.

Schizophrenia is a life-shortening disease (Brown, 1997). Premature death is common, with life expectancy reduced by over 20%. Although suicide remains the single largest cause of death at 28%, the lifetime risk of suicide has been adjusted from 10% to 4% because most of the deaths occur within the first year following diagnosis (Inskip et al., 1998). Over 60% of the deaths in schizophrenia are accounted for by natural causes such as cardiovascular illness; the standardised mortality ratios for cardiovascular illness in schizophrenia are twice as high as those for the general population (Brown et al., 2000). Predisposing factors for cardiovascular illness include non-modifiable factors such as age, gender and family history, and modifiable risk factors such as lifestyle and various biochemical parameters, of which obesity is one (Goldboult & Neufeld, 1988; Wood et al., 1998).

METHOD

The topics of obesity, type 2 diabetes mellitus and hypothalamic–pituitary–adrenal (HPA) axis, and schizophrenia, were reviewed using an electronic database (Medline) and a manual search of papers published before 1966. In addition, studies conducted by J.H.T. pertaining to these issues are described.

RESULTS

Obesity and schizophrenia: location, location, location?

Obesity is a worldwide epidemic and it is estimated that 300 million people are obese, defined as having a body mass index (BMI) in excess of 30 kg/m² (for review, see Hill et al., 2003). A meta-analysis (Allison et al., 1999b) and review (Taylor & McAskill, 2000) have suggested that antipsychotic drugs – in particular, certain atypical antipsychotic agents – are associated with this weight gain, and schizophrenia has been associated with obesity (Bruha et al., 1989; Kendrick, 1996; Allison et al., 1999a). Certain illnesses such as type 2 diabetes mellitus, insulin resistance, dyslipidaemias and cardiovascular disorders, together with obesity, have been termed the metabolic syndrome (Reaven, 1988) and appear to occur more frequently in people with schizophrenia, as has been shown by a recent study conducted in Finland (Heiskanen et al., 2003). It is believed that obesity-related illnesses may be associated particularly with an increase in visceral fat, the most metabolically active constituent of abdominal obesity (Ryan & Thakore, 2002).

In order to control for the confounding effects of medication, we measured visceral fat distribution using computed tomography in 15 patients with schizophrenia and matched them with healthy controls in terms of age, exercise, diet, smoking habits and alcohol intake (Thakore et al., 2002). Seven patients were drug-naïve and the rest had not taken any oral neuroleptic preparation for at least 6 weeks and had had no intramuscular preparation for 6 months; none of the patients had been taking any form of atypical neuroleptic agent prior to entering the study. Patients with schizophrenia had a higher mean BMI than the control group: 26.7 (s.d. = 1.1) kg/m² v. 22.8 (s.d. = 0.5) kg/m². Patients and controls had similar amounts of total body fat and subcutaneous fat, but the patients had over 3.4 times more intra-abdominal fat than the normal controls: 13,232.0 (s.d. = 2666.5) mm² v. 3879.9 (s.d. = 571.9) mm². However, there was no difference in intra-abdominal fat distribution between patients who were drug-naïve and those who were drug-free: 12,442.4 (s.d. = 9762.6) mm² v. 14,133.9 (s.d. = 11,656.8) mm².

An increase in visceral fat is not merely a ‘mass effect’ of a raised BMI; Enzi et al. (1986) found that healthy volunteers with BMI values ≥ 26 had less intra-abdominal fat (4650 mm²) than the patients in our study (13,232 mm²). Chronically elevated levels of cortisol, also seen in our study, may provide an explanation for the increase in intra-abdominal fat, as density of glucocorticoid receptors (cytosolic signal transducers for steroids such as cortisol) and the concentrations of the lipogenic enzyme lipoprotein lipase (a key enzyme in fat deposition) are higher in visceral fat than in subcutaneous fat (Ottoson et al., 1994; Pedersen et al., 1994).
Hyperglycaemia, insulin resistance and schizophrenia: an illness effect?

Even though the higher rates of type 2 diabetes mellitus observed in people with schizophrenia have been attributed to the use of antipsychotic medications – in particular, atypical agents – this is by no means a universally accepted finding. For instance, Mukherjee et al. (1996) studied a cohort of patients with schizophrenia (n=95), and observed that the prevalence of diabetes was age-dependent and greater in those taking conventional neuroleptic medications. Subramaniam et al. (2003) reported a rate of undiagnosed diabetes mellitus of 16% and a rate of impaired glucose tolerance of just over 30% in a cohort of residential patients with schizophrenia, none of whom had ever received an atypical neuroleptic drug; yet the rate of type 2 diabetes mellitus in the general population of a similar age was over 22%, indicating that patients with schizophrenia are less likely to have their diabetes diagnosed than their counterparts without mental illness.

The introduction of atypical neuroleptics has added to this debate, although most of the evidence implicating these compounds is based on case reports and various cross-sectional epidemiological studies (Liebzeit et al., 2001; Sernyak et al., 2002). In contrast to these findings, Lieberman et al. (2003) conducted a prospective study in a Chinese population, comparing chlorpromazine with clozapine in drug-naive patients with first-episode schizophrenia over a 52-week period, and showed that despite significant increases in weight (which were equal between the two compounds in question), there was no significant increase in fasting plasma glucose levels at the end of the study period. However, the study did not have a normal control group as a reference population. This is important, because the rates of obesity and type 2 diabetes mellitus in this population are lower than those found in North America, or indeed in Europe. Furthermore, lifestyle issues such as diet and exercise were not discussed either before or during the treatment period.

Is it possible that a mechanism other than medication might be responsible for such findings? A number of papers from the era before the use of antipsychotic drugs add credence to this hypothesis, although problems with diagnosis, small size of study group and other methodological issues make it difficult to interpret the significance of these valuable earlier studies (Lorenz, 1922; Braceland et al., 1945; Freeman, 1946; Langfeld, 1952). It is notable that a family study found that up to 19% of first-degree relatives of patients with schizophrenia had type 2 diabetes mellitus, which indicates that this endocrine condition and schizophrenia might have a genetic association (Mukherjee et al., 1989).

In an attempt to determine whether schizophrenia is associated with abnormal glucose metabolism, we compared fasting levels of plasma glucose, insulin, lipids and cortisol measures in a group of hospitalised, drug-naive patients with first-episode schizophrenia (n=26) with those of a healthy volunteer group matched in terms of age, ethnicity, exercise, diet, smoking habits and alcohol intake (Ryan et al., 2003). Anthropometric and lifestyle data indicated that the only significant difference between the two groups was that patients had a higher saturated fat intake than did controls. Over 15% of patients with schizophrenia had impaired fasting glucose levels – compared with none in the control group – as defined by the American Diabetes Association (1997) criteria. Patients with schizophrenia, compared with the control group, had significantly higher plasma levels of fasting glucose (s.d.=0.9 mmol/l vs. 4.8 (s.d.=0.3) mmol/l), insulin (68.2 (s.d.=64.6) pmol/l vs. 55.2 (s.d.=26.5) pmol/l) and cortisol (499.4 (s.d.=161.4) nmol/l vs. 303.2 (s.d.=10.5) nmol/l), and were more insulin-resistant: 2.3 (s.d.=1.0) vs. 1.7 (s.d.=0.7). Both the control and the patient groups had similar levels of lipids. Finally, there was no significant association between severity of symptoms and plasma levels of glucose, indicating that the ‘stress of hospitalisation’ was an unlikely cause of the hyperglycaemia.

The rate of impaired fasting glucose concentration observed in our group of patients (>15%) is greater than that found in a recent European study (8.5%, Gourdy et al., 2001). Type 2 diabetes mellitus and vascular complications occur in a third of those with impaired fasting glucose levels (Alberti, 1996). Medication, age, ethnicity, physical inactivity and smoking are unlikely to explain our findings (King & WHO Ad Hoc Reporting Group, 1993; Shaten et al., 1993). Although our patients consumed more saturated fat, studies do not indicate a positive association between a high intake of saturated fat and hyperglycaemia (Colditz et al., 1992; Salmeron et al., 1997, 2001), however, patients with schizophrenia did have higher levels of cortisol than did normal controls.

Are patients with schizophrenia biologically stressed?

A common endocrine reaction to stress involves activation of the hypothalamic–pituitary–adrenal (HPA) axis (Axelrod & Reisine, 1984). As in Cushing’s syndrome and melancholic depression (Wajchenberg et al., 1995; Condren & Thakore, 2001; Thakore et al., 2002), a dysregulated HPA axis can lead to abnormal glucose metabolism and visceral obesity (Rosmond & Bjortorp, 2002). Schizophrenia is associated with abnormalities of this axis (Altamura et al., 1989; Coryell & Tsuang, 1992; Kaneko et al., 1992; Lammers et al., 1995), and we have confirmed this using a rather crude indicator of HPA axis activity in two studies (Thakore et al., 2002; Ryan et al., 2003).

To date, HPA axis disturbance has been less consistently reported in schizophrenia than in depression (Holboel, 1998; Cotter & Pariente, 2002). With respect to schizophrenia, adrenocorticotropic hormone (ACTH) and cortisol responses to corticotrophin-releasing hormone (CRH) are indistinguishable from controls, although pre-treatment with dexamethasone results in an exaggerated CRH-induced pituitary–adrenal response in patients (Roy et al., 1986; Lammers et al., 1995). Most (but not all) studies have shown that dexamethasone suppresses plasma levels of cortisol in patients with schizophrenia (Dewan et al., 1982; Tandon et al., 1991). Equally discordant findings have been reported in terms of basal activity of the HPA axis as measured by serum cortisol levels (Gil-Ad et al., 1986; Roy et al., 1986; Whalley et al., 1989; Van Cauter et al., 1991; Breier & Buchanan, 1992; Rao et al., 1995; Elman et al., 1998; Kaneda et al., 2002). Methodological problems may partly explain the differences observed between the studies quoted. For instance, the effects of medication on HPA axis activity are unclear (Hellewell, 1999), and often a single sample of cortisol has been used to determine HPA activity although it is not clear whether this accurately represents an estimate of mean 24 h activity (Muller & von Werder, 1989).

As mean or integrated measures, such as area under the curve (AUC), of plasma cortisol between 13.00 h and 16.00 h can be used to detect hypercortisolism
(Halbreich et al., 1982), we decided to determine cortisol, ACTH and arginine vasopressin (AVP) levels in drug-naive patients with first-episode schizophrenia and compare them with a group of volunteers matched for age and gender (Ryan et al., 2004). Baseline levels of cortisol and AVP were indistinguishable between patients and controls, although patients had higher ACTH levels. Patients with schizophrenia had a higher mean AUC of ACTH (26.3 (s.d.=6.2) nmol/l v. 13.9 (s.d.=3.0) nmol/l) and cortisol (279.4 (s.d.=26.0) nmol/l v. 213.1 (s.d.=18.4) nmol/l) but had a lower mean AUC of AVP (0.87 (s.d.=0.24) pmol/l v. 1.42 (s.d.=0.34) pmol/l) than controls. A positive correlation between plasma levels of AVP and cortisol, and higher levels of plasma ACTH during the test period, indicate that the pituitary–adrenal axis was more sensitive to vasopressin-mediated stimulation in our patients with schizophrenia. This may be due first to the fact that vasopressin can directly stimulate the release of cortisol from the adrenal cortex (Guillon et al., 1995), and second, to the fact that glucocorticoid-induced inhibition of AVP gene transcription may be overcome, thereby allowing this hypothalamic neuropeptide to stimulate the pituitary–adrenal axis (Rivier & Vale, 1983; Kovacs & Sawchenko, 1996; Aguilera & Rabadán-Diehl, 2000; Aguilera et al., 2000), leading to a relative hypocortisolaeemia with all its consequent effects.

**DISCUSSION**

Conclusions are difficult to draw, either from the literature at large or even from this short paper. However, there are indications that schizophrenia is associated with not only an increase in visceral fat distribution but also impaired fasting glucose levels independently of medication, possibly due to a dysfunctional HPA axis. To clarify matters we need prospective studies examining the effects of medication on drug-naive patients with first-episode schizophrenia. Second, all patients with schizophrenia require regular physical examinations and need to have their blood glucose and lipids measured on a regular basis by either their primary care doctor or (if necessary) their psychiatrist.

**REFERENCES**


Abnormal dexamethasone suppression test


Metabolic disturbance in first-episode schizophrenia
Jogin H. Thakore
BJP 2004, 184:s76-s79.
Access the most recent version at DOI: 10.1192/bjp.184.47.s76

References
This article cites 62 articles, 16 of which you can access for free at:
http://bjp.rcpsych.org/content/184/47/s76#BIBL

Reprints/permissions
To obtain reprints or permission to reproduce material from this paper, please
write to permissions@rcpsych.ac.uk

You can respond to this article at
/letters/submit/bjprcpsych;184/47/s76

Downloaded from
http://bjp.rcpsych.org/ on June 26, 2017
Published by The Royal College of Psychiatrists

To subscribe to The British Journal of Psychiatry go to:
http://bjp.rcpsych.org/site/subscriptions/