Anorexia nervosa

- Akuta sjukdomsskedet och efter 30 år

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2026-04-27 Pedagogiskt perspektiv, Temakonferens Ätstörningar

Min bakgrund

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Disposition

- Diagnostiska kriterier anorexia nervosa
- Översikt behandling vid anorexia nervosa
- Neuropsykologi och neurokognition vid anorexia nervosa
- Sambanden mellan anorexia nervosa, autism och ADHD
- Anorexia nervosa i tonåren- hur har det gått efter 30 år?

DSM-5 Anorexia nervosa (AN)

A. Otillräckligt energiintag i förhållande till behoven, signifikant låg kroppsvikt med beaktande av ålder, kön, tillväxtkurva och kroppslig hälsa.

B. Intensiv rädsla för att gå upp i vikt eller bli tjock, eller ihållande beteende som motverkar viktökning, trots undervikt

C. Störd kroppsupplevelse med avseende på vikt eller form, självkänslan är överdrivet påverkad av kroppsvikt eller form, eller förnekelse av allvaret i den låga kroppsvikten.

Subtyp: med **självsvält**
med **hetsätning/självrensning**

Atypisk anorexia nervosa

Alla kriterier för anorexia nervosa är uppfyllda men personens kroppsvikt ligger inom eller över normalintervallet trots en betydande viktnedgång.

Anorexia nervosa

Incidens & Prevalens	• Incidens kvinnor: 120-270 per 100 000 person-år • Prevalens kvinnor: Ca 2% • Prevalens män: 0.0-0.3% *(Galmiche et al. 2019, Van Eden et al., 2021)*
Mortalitet	• Standardiserad mortalitets ratio: 5.2 *(Arcelus et al., 2011)*
Etiologi	• Multifaktoriell sjukdom: biologiska-, psykologiska- och sociokulturella faktorer
Genetik	• Heritabilitet: 0.48-0.74 *(Yilmaz et al., 2015)*
Samsjuklighet	• Ångest, depression, tvångssyndrom, neuropsykiatriska diagnoser, missbruk, personlighetssyndrom *(Marucci et al., 2018, Nickel et al., 2019, Nilsson et al., 1999)*

Behandling vid anorexia nervosa

Nationella riktlinjer	• I maj 2024 introducerade Socialstyrelsen nationella riktlinjer för behandling av ätstörningar *(Socialstyrelsen, 2024)*
Rekommendationer barn och ungdomar	• Erbjud familjebaserad terapi • Erbjud ätstörningsanpassad KBT om lämpligt utifrån mognad och familjesituation
Rekommendationer vuxna	• Erbjud ätstörningsanpassad KBT
Förstärkta insatser vid behov	• Dagvårdsbehandling (förstärkt öppenvård) • Heldygnsvård • 20-30% -förstärkt vård någon gång under sjukdomsförloppet (*Herpetz-Dahlmann, 2021*)

Familjebaserad terapi vid anorexia nervosa

Familjebaserad terapi (FBT) *(Lock & Le Grange 2013)*

- Inkluderar hela familjen
- Föräldrarna får en aktiv roll i att stödja barnets ätande och viktuppgång
- Tar hänsyn till familjens resurser och stärker deras förmåga att hjälpa sitt barn
- Behandlingen är strukturerad och uppdelad i faser

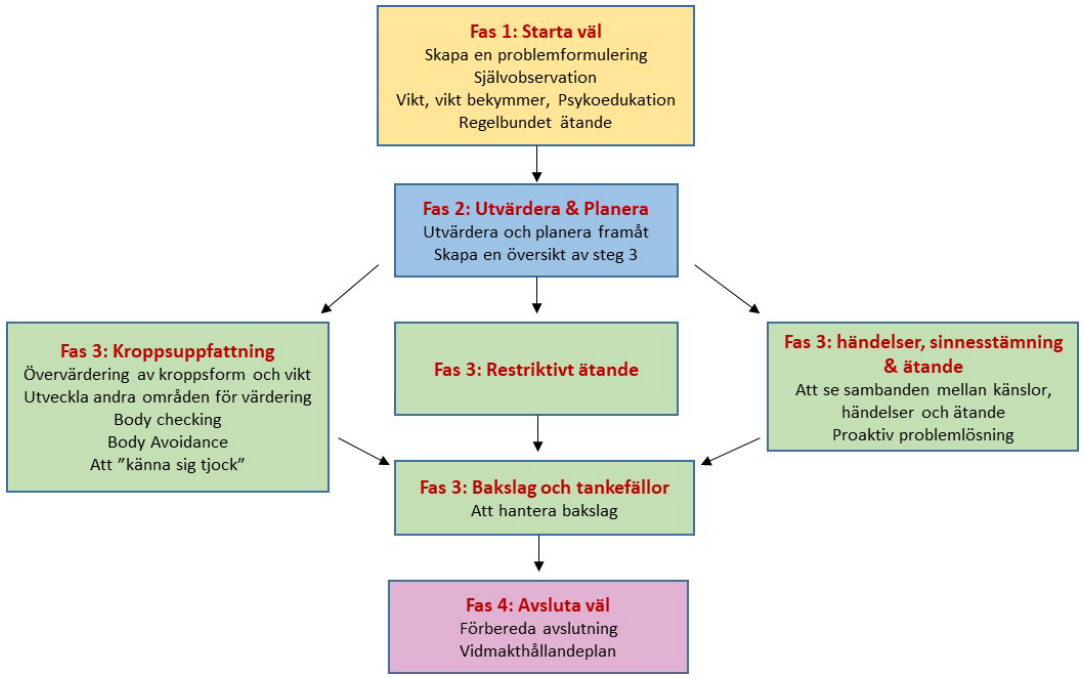
Fas 1	Fas 2	Fas 3
• Föräldrarna tar över ansvar för mat och måltider • Bryta svälten och normalisera ätande • Viktåterhämtning	• Bibehållen struktur och stöd måltider • Stegvis återgång till mer eget ansvar för barnet/ungdomen	• Fokus på livet utan ätstörningen • Identitet och utvecklingsområden • Planera för framtid, återfallsprevention

KBT-E vid anorexia nervosa

Enhanced cognitive behavioural therapy *(Fairburn, 2008)*

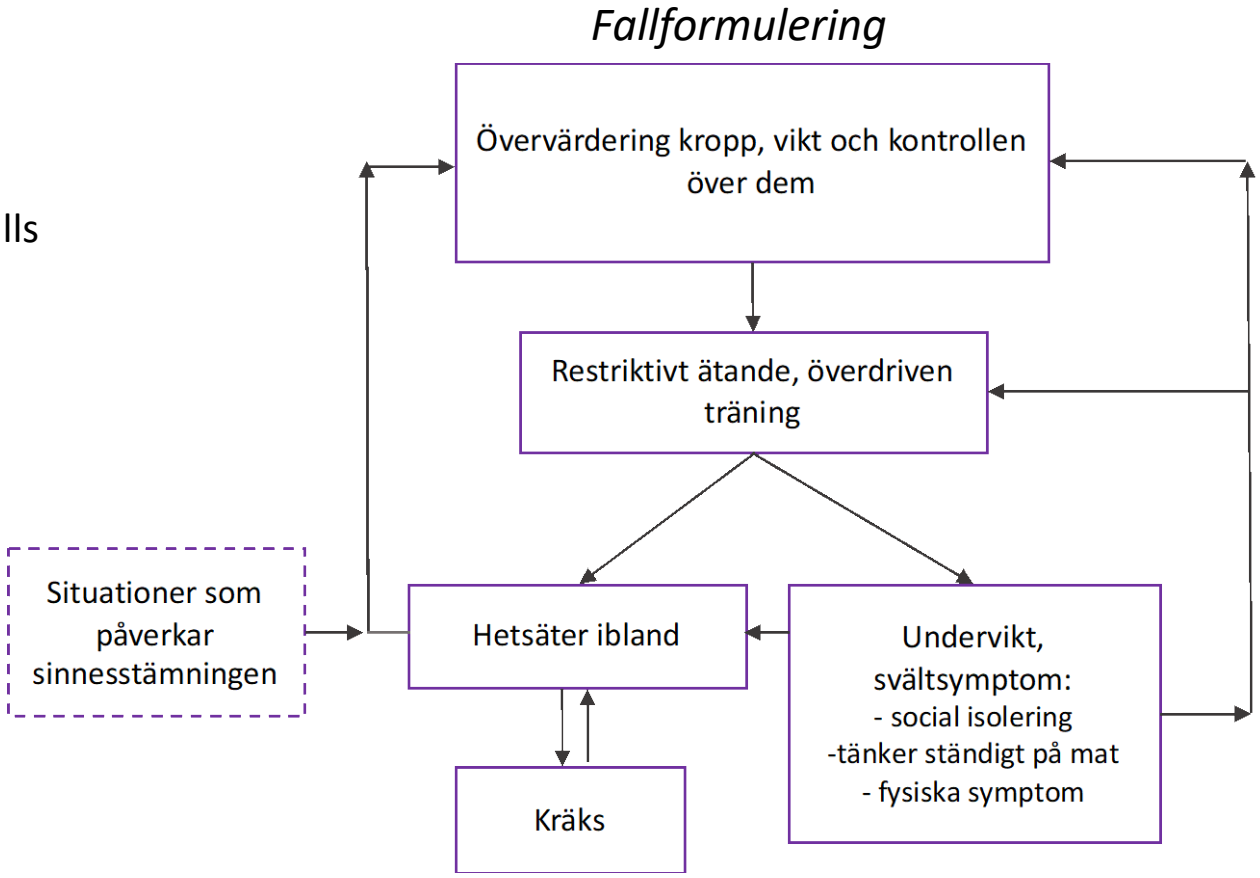
- Individuell, individanpassad behandling
- Identifiera och påverka de beteenden som vidmakthåller ätstörningen
- Normalisering av ätande centralt
- Viktåterhämtning integreras i behandlingen
- Aktivt samarbete mellan patient och terapeut
- Självmonitorering och hemuppgifter
- Strukturerad och tidsbegränsad behandling
  - 4 faser
  - 40 sessioner

Behandlingsstruktur



KBT-E vid anorexia nervosa

- Övervärdering av kropp, vikt och utseende – grundproblemet
- Fallformuleringen- *individuell karta* över hur den specifika individens ätproblem fungerar och vidmakthålls

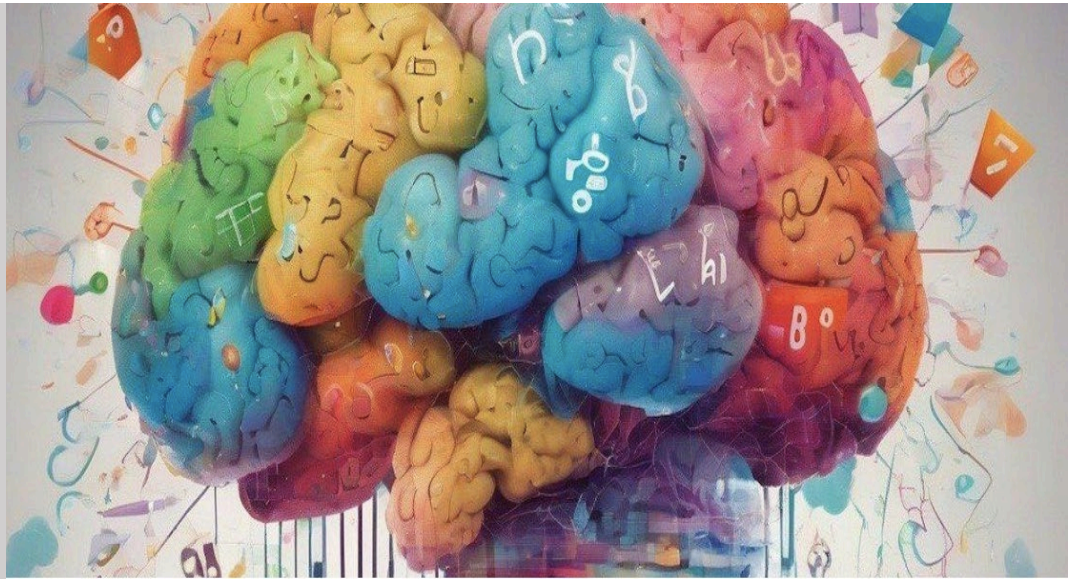


Motstridiga drivkrafter i sjukdomen

- Ambivalens och låg motivation
- Värderar beteenden som hör till sjukdomen högt
  - kontroll, perfektion, att klara av att hålla en sträng diet
- Bristande insikt i sjukdomens allvar
- Alla individer med AN söker inte behandling
  - en betydande andel (23-50%) fångas aldrig upp kliniskt
    (Keski-Rahkonen et al. 2007; Preti et al. 2007; Dobrescu et al. 2020)

Neuropsykologi och neurokognition vid anorexia nervosa

- ***Neuropsykologi:*** Studerar sambandet mellan hjärnans funktioner och människans beteende, tankar och känslor
- ***Neurokognition:*** hur vi tänker och förstår världen, kognitiva processer

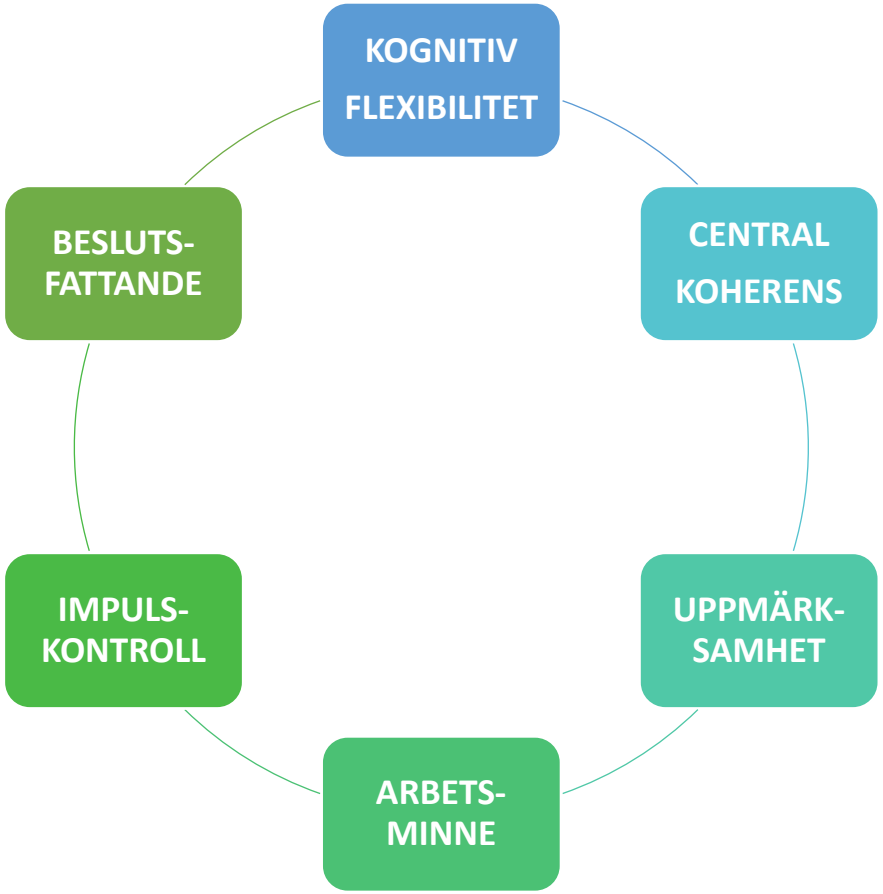


Hur mäts neurokognitiv funktion?

Neuropsykologiska tester:

- Generell kognitiv förmåga, IQ (WAIS/WISC)
- Exekutiva funktioner (D-KEFS)
- Wisconsin card sorting test (kognitiv flexibilitet)
- Rey Complex Figure test (central coherens)

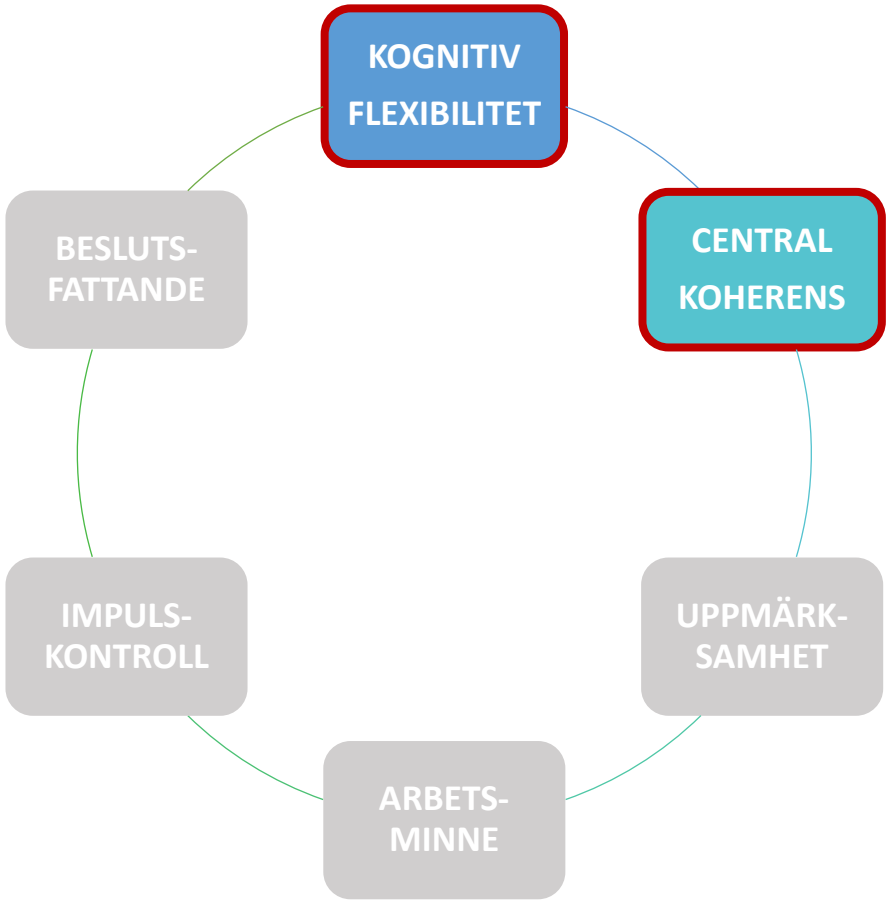
Neurokognitiv funktion Ätstörningar



Smith et al., 2018

Den neurokognitiva profilen vid anorexia nervosa

- Bristande kognitiv flexibilitet
- Svag central koherens



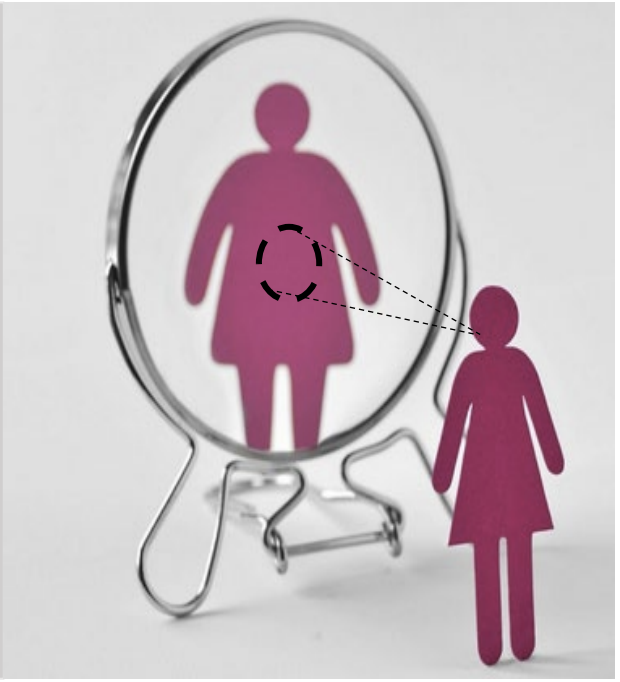
Central koherens

Central Koherens

Förmåga att se samband/helheter utan att fastna i delar/detaljer

Vid brister:

- Detaljfokus, missar ”the bigger picture”
- Kliniska exempel:
  - Överdrivet fokus mat och kropp
  - Fastnar i detaljer; matinnehåll, vikt, kalorier, delar av utseende
  - Svårt att se de mer övergripande tillfrisknandemålen i behandling



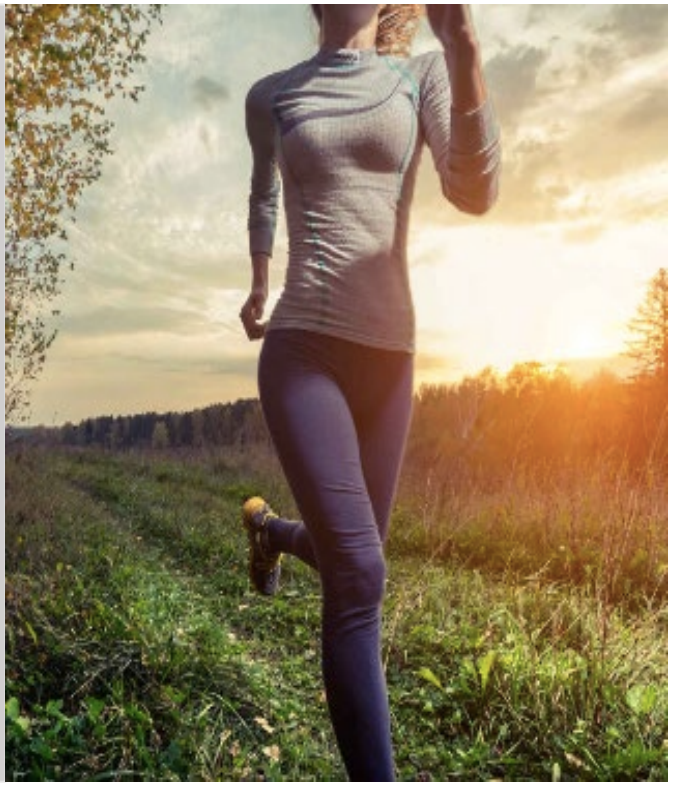
Kognitiv flexibilitet

Kognitiv flexibilitet

Kunna ändra och anpassa sitt beteende till vad situationen kräver

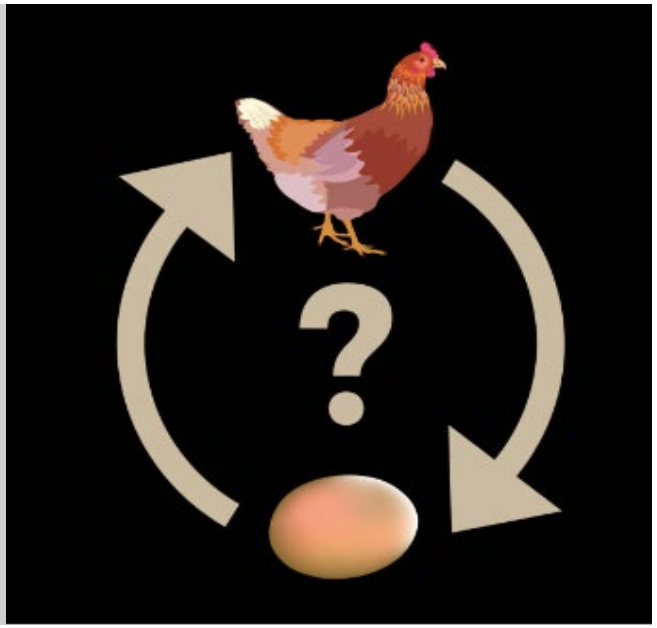
Vid brister:

- Svårt att skifta tankesätt eller beteende, t.ex. pröva en annan strategi
- Kliniska exempel:
  - Rigiditet
  - Svårt att utöka matrepertoaren
  - Tvångsmässiga beteenden



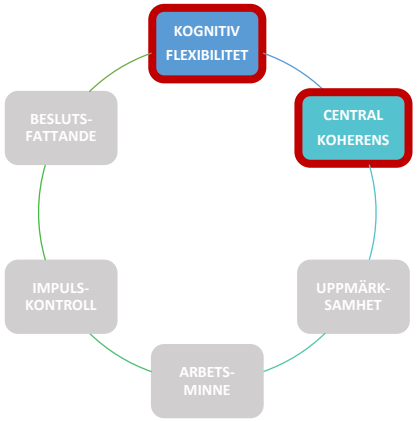
”State or trait” frågan

Orsakas de kognitiva nedsättningarna av ätstörningen eller har nedsättningarna funnits innan sjukdomsdebut?

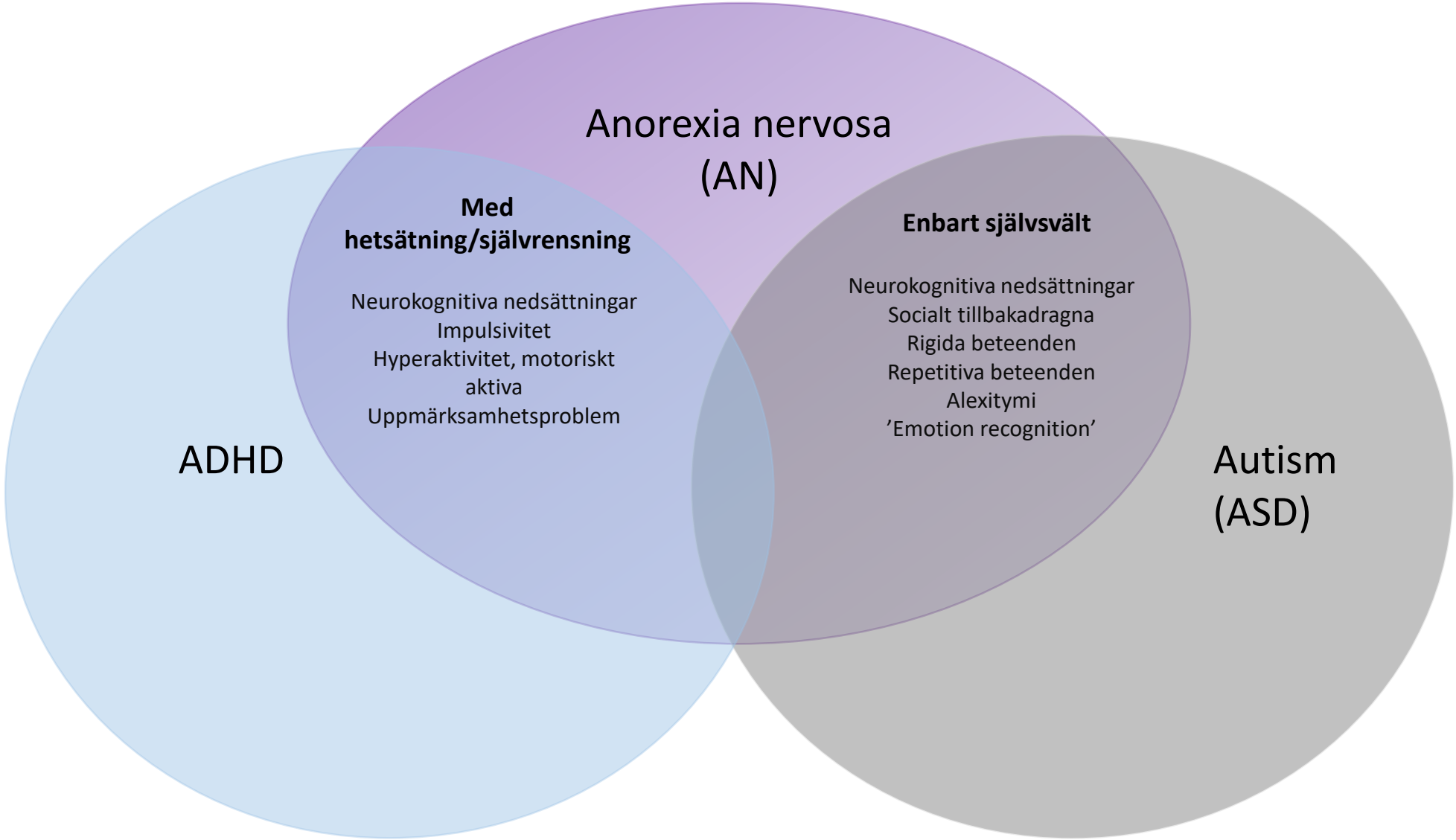


Den neurokognitiva profilen vid anorexia nervosa

- Alla patienter vi möter inom ätstörningsvården är till olika grad påverkade av kognitiva nedsättningar
- Den kognitiva profilen vid AN karaktäriseras av svag central koherens och bristande kognitiv flexibilitet, nedsättningarna kan påverka behandlingsprogress och utfall *(Holliday et al., 2005; Tenconi et al., 2010; Crane et al., 2007)*
- Ett mer långdraget förlopp av AN är associerat till mer uttalade brister avseende central coherence och kognitiv flexibilitet *(Saure et al., 2020)*
- Interventioner fokuserade på att förbättra kognitiv funktion
    - Cognitive remediation therapy, CRT *(Thanturia et al., 2017)*



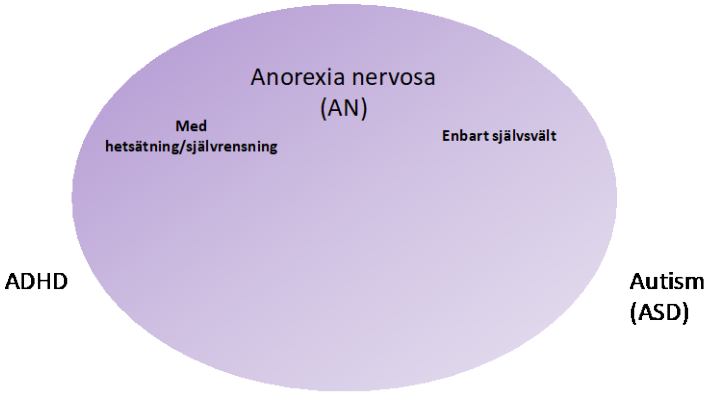
Sambanden mellan anorexia nervosa, autism & ADHD



Gillberg, 1983; Wentz et al., 2005; Westwood et al., 2016; Boltri & Sapuppo, 2021

Sambanden mellan anorexia nervosa & autism

- Sambanden mellan AN och autism uppmärksammades redan på 80-talet *(Gillberg, 1983)*
- Autistiska drag överrepresenterat hos individer med AN *(Anckarsäter et al., 2012; Westwood et al. 2016; Boltri & Sapuppo, 2021)*
    - 9-32% av vuxna individer med AN uppfyller kriterierna för autism
- Pseudoautistisk presentation eller underliggande autism?



Sambanden mellan anorexia nervosa & ADHD

- ADHD överrepresenterat vid ätstörningar

  Patienter med ätstörning (12-17 år), N=187:

  - Hetsätningsstörning: 31% hade ADHD
  - Bulimia nervosa: 19% hade ADHD
  - Anorexia nervosa**:** 9% hade ADHD *(Ruiz-Ramos et al., 2021)*

- Impulsivitet som länk mellan tillstånden
- Primärt samband med anorexia nervosa med hetsätning/självrensning
  (Svedlund et al., 2017; Nickel et al. 2019)

Vad har det för betydelse?

- Patienter med AN och autism har ett sämre behandlingsutfall och en ökad risk för ett långdraget förlopp av AN *(Saure et al. 2021; Nielsen et al. 2022)*
- Patienter med AN och autism har ökad risk för mer frekventa och längre slutenvårds inläggningar *(Nimbley et al. 2024; Zhang et al. 2022)*
- En hög grad av ADHD-symtom kan ha en negativ inverkan på tillfrisknande *(Svedlund et al., 2018)*
- Behov av anpassade interventioner vid AN och samsjuklighet med autism för att förbättra utfall

Anorexia nervosa i tonåren
- hur har det gått efter 30 år?

Bakgrund långtidsstudier anorexia nervosa

Långtids-uppföljningar AN

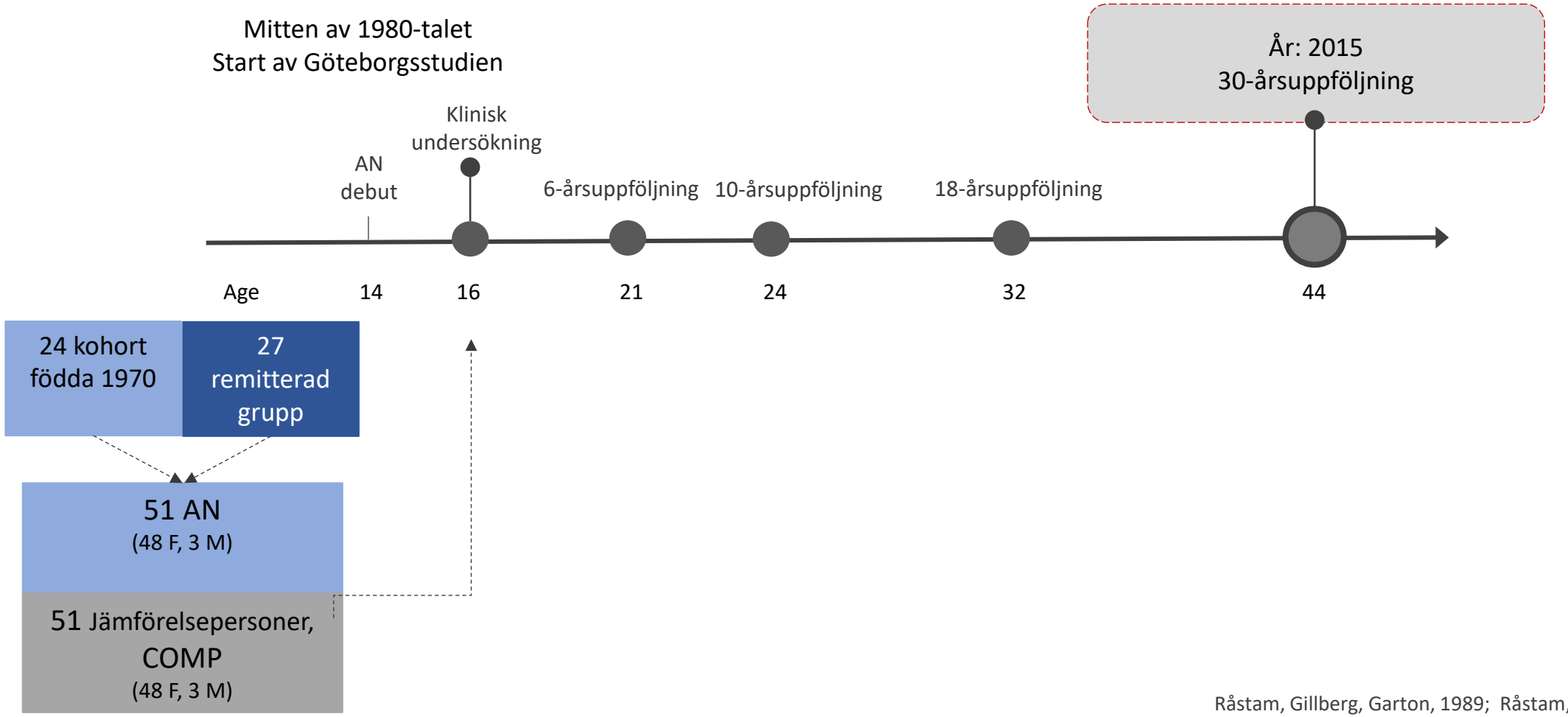
Få studier har följt upp individer med AN under mycket lång tid

- Review som sammanfattar långtidsutfall vid AN *(Steinhausen, 2002)*
  - Tillfrisknade individer: ca 50%
  - Kroniskt förlopp: 20%
  - Mortalitet: 5%

- Studier med mycket långa uppföljningsperioder, +20 *år (Theander, 1985; Eddy et al., 2017; Zipfel et al., 2000)*
  - Tillfrisknade individer: 51-76%
  - Mortalitet: 16-18%

Ringa kunskap om den psykiska och fysiska hälsan hos barn till individer med AN (Bulik et al., 1999; Linna et al., 2014; Micali & Treasure, 2009; Mantel, Hirschberg, Stephansson, 2019)

Göteborgsstudien
’The Gothenburg anorexia nervosa study’



Råstam, Gillberg, Garton, 1989; Råstam, 1992

Metod Göteborgsstudien

DELTAGARE

AN grupp
N=47

Medel ålder: 44 år

COMP grupp
N=51

Medel ålder: 44 år

MÄTNINGAR

Intervjuer
- MINI
- SDID-I Ätstörningsmodulen
- Morgan Russell Outcome assessment schedule

Självskattning
- SF-36, livskvalitet

Antropometriska mått & Blodprov
- Vikt, längd, BMI
- Blodprover- biomarkörer

Föräldraintervjuer
- SDQ
- DAWBA
- ADHD-RS

Registerdata
- Patientregistret
- Medicinska födelseregistret
- Läkemedelsregistret
- Ekonomiskt bistånd
- Försäkringskassans register

BJPsych | The British Journal of Psychiatry (2020) 216, 97–104. doi: 10.1192/bjp.2019.113

Anorexia nervosa: 30-year outcome

Sandra Rydberg Dobrescu*, Lisa Dinkler*, Carina Gillberg, Maria Råstam, Christopher Gillberg and Elisabet Wentz

Background

Little is known about the long-term outcome of anorexia nervosa.

Aims

To study the 30-year outcome of addescent-onset anorexia nervosa.

Method

All 4291 individuals born in 1970 and attending eighth grade in 1985 in Gothenburg, Sweden were screened for anorexia nervosa. A total of 24 individuals (age cohort for anorexia nervosa) were pooled with 27 individuals with anorexia nervosa (identified through community screening) who were born in 1969 and 1971–1974. The 51 individuals with anorexia nervosa and 51 school- and gender-matched controls were followed prospectively and examined at mean ages of 16, 21, 24, 32 and 44. Psychiatric disorders, health-related quality of life and general outcome were assessed.

Results

At the 30-year follow-up 96% of participants agreed to participate. There was no mortality. Of the participants, 19% had an eating disorder diagnosis (6% anorexia nervosa, 2% binge-eating disorder, 11% other specified feeding or eating disorder); 38% had other psychiatric diagnoses; and 64% had full eating disorder symptom recovery, i.e. free of all eating disorder criteria for 6 consecutive months. During the elapsed 30 years, participants had an eating disorder for 10 years, on average, and 23% did not receive psychiatric treatment. Good outcome was predicted by later age at onset among individuals with adolescent-onset anorexia nervosa and premorbid perfectionism.

Conclusions

This long-term follow-up study reflects the course of addescent-onset anorexia nervosa and has shown a favourable outcome regarding mortality and full symptom recovery. However, one in five had a chronic eating disorder.

Declaration of interest

None.

Keywords

Anorexia nervosa; outcome; population based; case-control.

Follow-up studies of anorexia nervosa have been conducted since the second half of the 20th century and were thoroughly reviewed in 2009 by Steinhausen.[1] According to the review, approximately half of all individuals with anorexia nervosa were classified as fully recovered, one in three had improved and one in five had a chronic course of the disorder. The crude mortality rate was 5%.[1] High mortality rates were also found in a meta-analysis reporting a standardised mortality ratio of six for anorexia nervosa.[2] According to Steinhausen, the outcome of adolescent-onset anorexia nervosa was more favourable in terms of mortality and chronicity than the outcome of anorexia nervosa with variable onset, including patients with adult onset.[1] All 119 patient series in the Steinhausen review[1] except two – the FinnTwin study[3] and the present study, i.e. the 'Gothenburg anorexia nervosa study',[4–7] – were based on clinical data.

Studies with exceptionally long observational periods

Three anorexia nervosa outcome studies (one from Germany,[8] one from the USA[9] and one from Sweden[10]) report exceptionally long observational periods of more than 20 years. All three studies included patients only. Recovery from anorexia nervosa was observed in 51% of patients after 21 years in the German study,[8] in 63% of patients after 22 years in the American study[9] and in 76% of patients after 33 years in the Swedish study.[10] Two of the studies reported crude mortality rate, corresponding to 16 and 18%, respectively.[8,10] The three outcome studies either performed personal interviews[8,10] or telephone interviews[9] at follow-up. Two of the studies had a prospective design.[8,9]

* These authors contributed equally to this article.

Since 1985, we have carried out a prospective, longitudinal, case–control study of individuals with adolescent-onset anorexia nervosa. The individuals have been examined on four previous occasions. The aims of the present study were as follows:

(a) to prospectively examine the very long-term outcomes of adolescent-onset anorexia nervosa, including full recovery from eating disorder symptoms, psychiatric morbidity, mortality, global functioning and health-related quality of life (HRQoL).
(b) to identify predictors of outcome to determine risk factors for developing anorexia nervosa.

For our study group we hypothesised that the outcomes of Global Assessment of Functioning (GAF), HRQoL, eating disorder outcome and psychiatric morbidity would be significantly worse than for the matched comparison group. We hypothesised that the outcomes within our study group would be better than the outcomes of the clinical, long-term studies due to this sample being partly community and population based and only including individuals with adolescent-onset anorexia nervosa.

Method

Study design and participants

The original study (study 1)

The anorexia nervosa group: In 1985, the so-called Gothenburg anorexia nervosa study was initiated by M.R. and C.G. All 4291 individuals born in 1970 and attending eighth grade in Gothenburg underwent a physical examination and completed an eating disorder symptom questionnaire. All 4291

Anorexia nervosa: 30-year outcome

Dobrescu et al. 2020

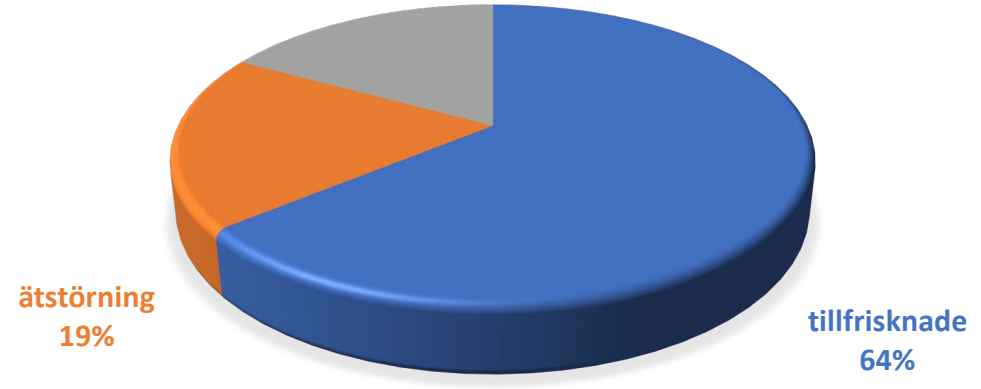
Resultat 30-årsuppföljning AN

Mortalitet

- **0%**

Utfall Ätstörning

- **19%** uppfyllde kriterierna för en ätstörning
- Medelduration AN: **4.9 år**
- Medelduration ätstörning: **10.2 år**
- **64%** var helt återställda



Utfall Ätstörning 2003-2015

- **17%** uppfyllde kriterier för AN
- **32%** uppfyllde kriterier för någon ätstörning

Psykiatrisk sjuklighet

- Psykiatrisk sjuklighet var överrepresenterat i AN-gruppen **(38%)** jämfört med COMP-gruppen **(12%)**
- **Ångestsyndrom** var den vanligaste diagnoskategorin

Resultat 30-årsuppföljning AN

Behandling

- 23% hade aldrig fått behandling för ätstörning
- Ätstörningsutfall var inte associerat med om personen hade fått behandling eller ej

God prognos

- Högre ålder vid insjuknande
- Premorbid perfektionism

Psykisk och fysisk hälsa hos barn till kvinnor med anorexia nervosa

European Child & Adolescent Psychiatry
https://doi.org/10.1007/s00787-024-02393-y

ORIGINAL CONTRIBUTION

Mental and physical health in children of women with a history of anorexia nervosa

Sandra Rydberg Dobrescu[1] · Lisa Dinkler[1,2] · Carina Gillberg[1] · Christopher Gillberg[1,3] · Maria Råstam[1,4] · Elisabet Wentz[5]

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Abstract
Few studies have investigated the offspring of women with anorexia nervosa (AN). The aim of this study was to examine perinatal status, mental and physical health in the offspring of mothers with a history of AN. Fifty-one individuals with adolescent-onset AN and 51 matched controls (COMP) have been followed prospectively. Presently, 30 years after AN onset, at a mean age of 44 years, female participants who had given birth ($n_{AN}=40$, $n_{COMP}=40$) were interviewed regarding psychiatric health in their offspring using the Developmental and Well-Being Assessment and the MINI International Neuropsychiatric Interview. In addition, information on the offspring's perinatal status, psychiatric- and physical health was obtained from the Swedish Medical Birth Register and The Swedish National Patient Register. Data regarding mental and physical health were available for 83 and 86 offspring in the AN and COMP groups, respectively. At birth, all of weight, length, head circumference and ponderal index were significantly reduced in the offspring of mothers with a history of AN. In adolescence, parental interviews indicated an overrepresentation of current psychiatric diagnoses in the offspring of mothers with AN. Compared with the offspring in the COMP group, endocrinological, immune and metabolic disorders were much more common in the offspring of the AN group. In conclusion, a history of AN increases the risk of worse perinatal outcome of the offspring. Later on, in childhood and adolescence, psychiatric and physical morbidity may be overrepresented in the offspring of women with AN.

Keywords Anorexia nervosa · Long-term follow-up · Offspring · Mental health · Physical health

Introduction

Anorexia nervosa (AN) is one of the most severe psychiatric disorders affecting women of reproductive age. In the acute phase of AN, amenorrhea and infertility are common [1]. According to some studies reproductive functions normalize after weight restoration and recovery from AN [2–4]. Some reports, however, indicate delays in reproduction and reduced fertility rates in individuals with a history of AN [5–7]. An elevated risk of birth and perinatal complications, including higher rates of preterm deliveries, lower birth weight, smaller head circumference, lower Apgar scores and perinatal mortality, compared with controls, has been reported for women with ongoing AN or a history of AN [8–14]. Results from previous studies are partly inconsistent with some studies reporting more favorable perinatal outcomes for women with a history of AN [15, 16].

Parental mental illness is known to be associated with a general increase in psychopathology in the offspring

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Dobrescu et al. 2024

Perinatal hälsa hos barn födda till kvinnor med AN

Hur många av deltagarna hade fött barn?

AN-gruppen n=48

40 (83%)

Jämförelsegruppen n=48

40 (83%)

PERINATAL HÄLSA

Födelsevikt och **längd**, **huvudomfång** och **ponderal index*** var **signifikant lägre** hos barnen födda till mödrar med tidigare AN.

* Mått på kroppsmassa hos nyfödda, kg/m^3

Resultat psykisk och fysisk hälsa hos barnen

Ätstörning

6 barn (7.2%) i AN-gruppen hade någonsin haft en ätstörning jämfört med 1 barn (1.2) i jämförelsegruppen (p=0.06)

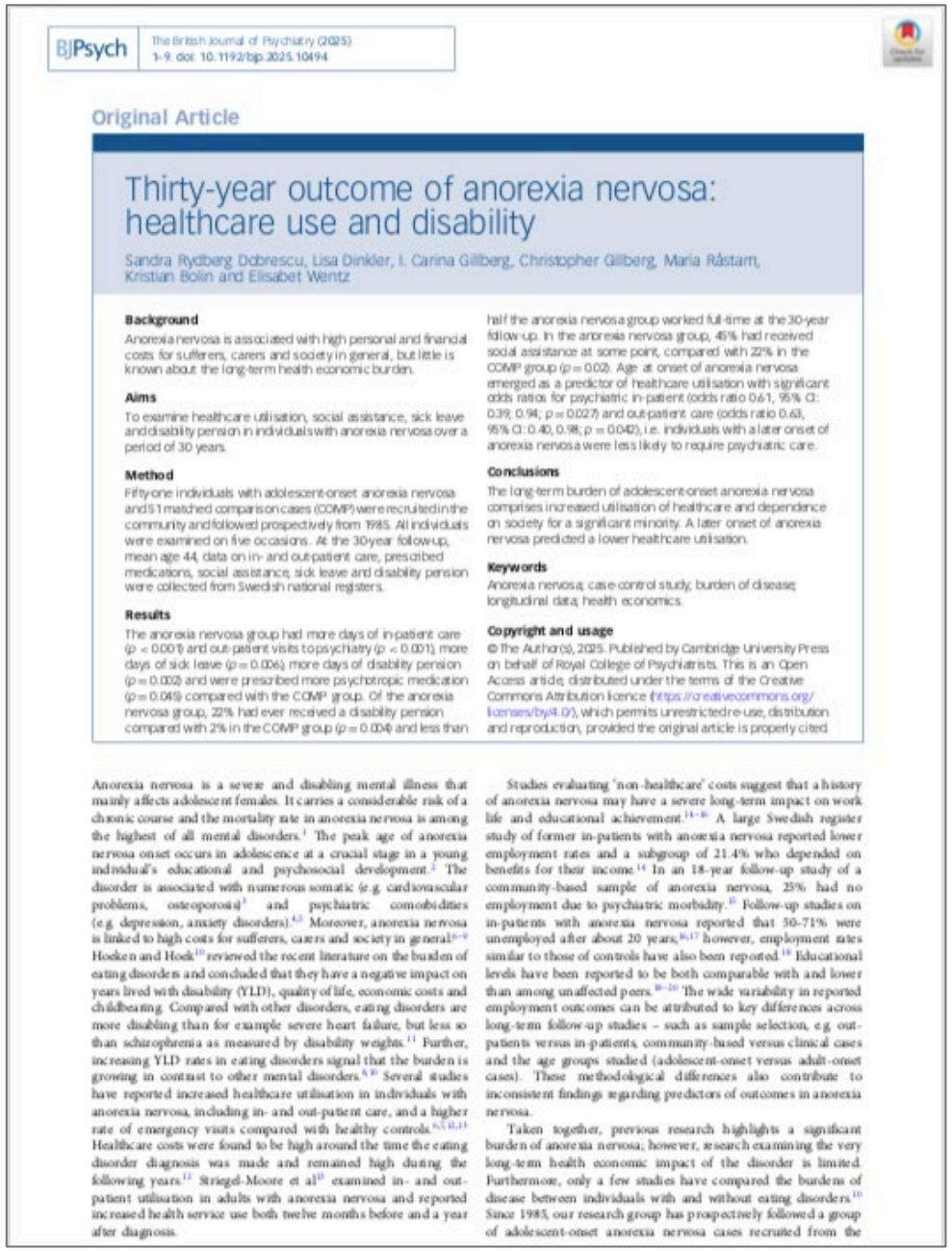
Psykiatriska diagnoser

Pågående psykiatrisk sjukdom var vanligare hos barn/ungdomar till mödrar i AN-gruppen jämfört med barnen i jämförelsegruppen (p=0.03)

- 10.2% hade ett **ångestsyndrom** jämfört med 1.4% hos barnen i jämförelsegruppen (p=0.076)

Somatisk sjukdom

Hos barnen i AN-gruppen var det vanligare med somatiska sjukdomar inom gruppen **endokrina, metabola och autoimmuna sjukdomar** (p=0.002) (hypotyreos, juvenil artrit, celiaki)



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Original Article

Thirty-year outcome of anorexia nervosa: healthcare use and disability

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Background

Anorexia nervosa is associated with high personal and financial costs for sufferers, carers and society in general, but little is known about the long-term health economic burden.

Aims

To examine healthcare utilisation, social assistance, sick leave and disability pension in individuals with anorexia nervosa over a period of 30 years.

Method

Fifty-one individuals with adolescent-onset anorexia nervosa and 51 matched comparison cases (COMP) were recruited in the community and followed prospectively from 1985. All individuals were examined on five occasions. At the 30-year follow-up, mean age 44, data on in- and out-patient care, prescribed medications, social assistance, sick leave and disability pension were collected from Swedish national registers.

Results

The anorexia nervosa group had more days of in-patient care ($p < 0.001$) and out-patient visits to psychiatry ($p < 0.001$), more days of sick leave ($p = 0.006$), more days of disability pension ($p = 0.002$) and were prescribed more psychotropic medication ($p = 0.045$) compared with the COMP group. Of the anorexia nervosa group, 22% had ever received a disability pension compared with 2% in the COMP group ($p = 0.004$) and less than half the anorexia nervosa group worked full-time at the 30-year follow-up. In the anorexia nervosa group, 45% had received social assistance at some point, compared with 22% in the COMP group ($p = 0.02$). Age at onset of anorexia nervosa emerged as a predictor of healthcare utilisation with significant odds ratios for psychiatric in-patient (odds ratio 0.61, 95% CI: 0.39, 0.94; $p = 0.027$) and out-patient care (odds ratio 0.63, 95% CI: 0.40, 0.98; $p = 0.042$), i.e. individuals with a later onset of anorexia nervosa were less likely to require psychiatric care.

Conclusions

The long-term burden of adolescent-onset anorexia nervosa comprises increased utilisation of healthcare and dependence on society for a significant minority. A later onset of anorexia nervosa predicted a lower healthcare utilisation.

Keywords

Anorexia nervosa; case-control study; burden of disease; longitudinal data; health economics.

Anorexia nervosa is a severe and disabling mental illness that mainly affects adolescent females. It carries a considerable risk of a chronic course and the mortality rate in anorexia nervosa is among the highest of all mental disorders.[1] The peak age of anorexia nervosa onset occurs in adolescence at a crucial stage in a young individual's educational and psychosocial development.[2] The disorder is associated with numerous somatic (e.g. cardiovascular problems, osteoporosis)[3] and psychiatric comorbidities (e.g. depression, anxiety disorders).[4,5] Moreover, anorexia nervosa is linked to high costs for sufferers, carers and society in general.[6–9] Hoeken and Hoek[10] reviewed the recent literature on the burden of eating disorders and concluded that they have a negative impact on years lived with disability (YLD), quality of life, economic costs and childbearing. Compared with other disorders, eating disorders are more disabling than for example severe heart failure, but less so than schizophrenia as measured by disability weights.[11] Further, increasing YLD rates in eating disorders signal that the burden is growing in contrast to other mental disorders.[8,10] Several studies have reported increased healthcare utilisation in individuals with anorexia nervosa, including in- and out-patient care, and a higher rate of emergency visits compared with healthy controls.[8,9,11,12] Healthcare costs were found to be high around the time the eating disorder diagnosis was made and remained high during the following years.[12] Striegel-Moore et al[13] examined in- and out-patient utilisation in adults with anorexia nervosa and reported increased health service use both twelve months before and a year after diagnosis.

Studies evaluating 'non-healthcare' costs suggest that a history of anorexia nervosa may have a severe long-term impact on work life and educational achievement.[14–16] A large Swedish register study of former in-patients with anorexia nervosa reported lower employment rates and a subgroup of 21.4% who depended on benefits for their income.[14] In an 18-year follow-up study of a community-based sample of anorexia nervosa, 25% had no employment due to psychiatric morbidity.[15] Follow-up studies on in-patients with anorexia nervosa reported that 50–71% were unemployed after about 20 years,[16,17] however, employment rates similar to those of controls have also been reported.[18] Educational levels have been reported to be both comparable with and lower than among unaffected peers.[16–20] The wide variability in reported employment outcomes can be attributed to key differences across long-term follow-up studies – such as sample selection, e.g. out-patients versus in-patients, community-based versus clinical cases and the age groups studied (adolescent-onset versus adult-onset cases). These methodological differences also contribute to inconsistent findings regarding predictors of outcomes in anorexia nervosa.

Taken together, previous research highlights a significant burden of anorexia nervosa; however, research examining the very long-term health economic impact of the disorder is limited. Furthermore, only a few studies have compared the burdens of disease between individuals with and without eating disorders.[10] Since 1985, our research group has prospectively followed a group of adolescent-onset anorexia nervosa cases recruited from the

Sjukvårdskonsumtion och arbetsförmåga efter 30 år

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Resultat arbetsförmåga och sjukpension

Sjukpension 1998-2015	AN N=51	COMP N=51	p
Någonsin fått sjukpension, N (%)	11 (22)	1 (2)	0.004
Antal dagar med sjukpension, medel (SD)	1175.3 (2524)	124.7 (890.9)	0.002

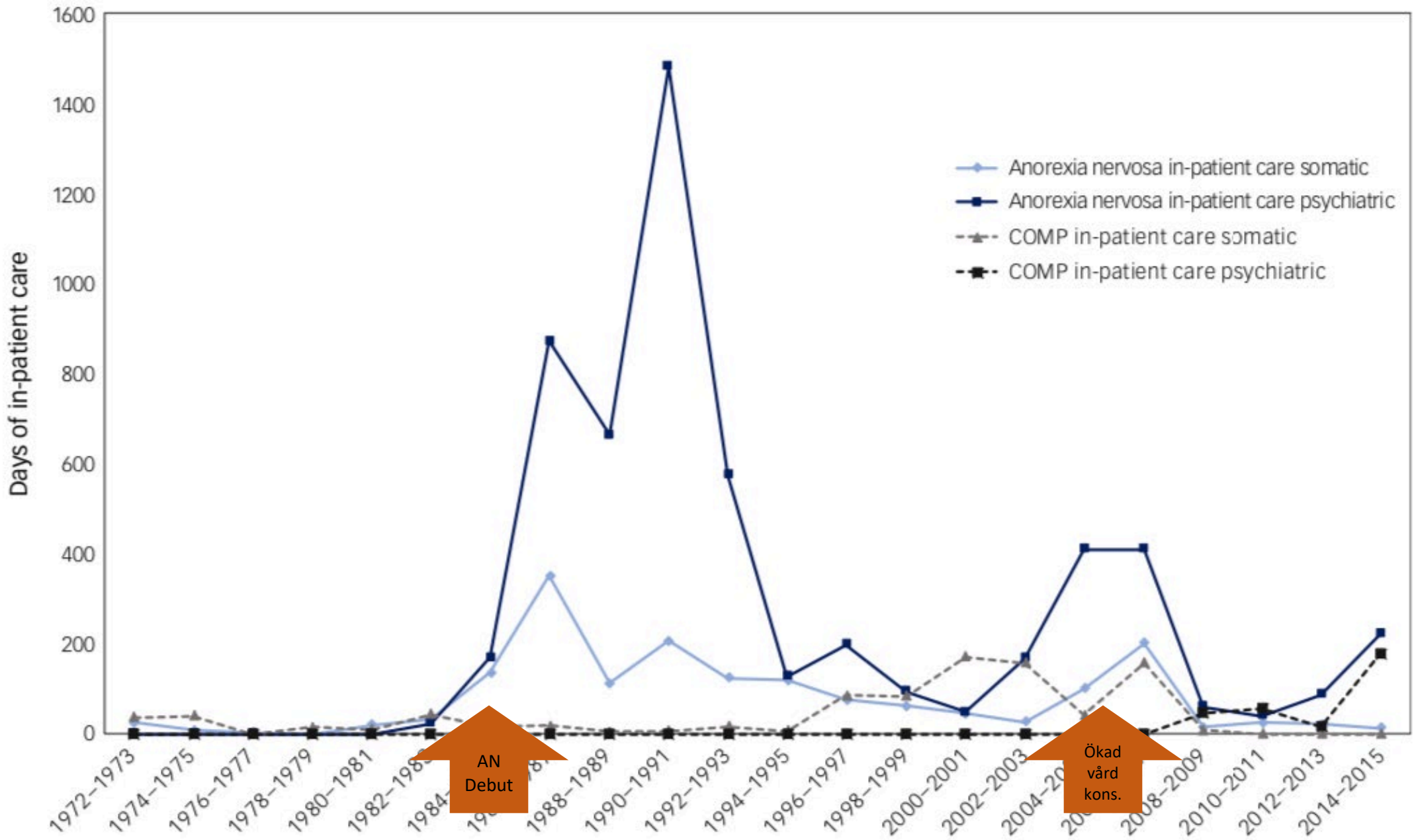

Fig. 1 Days of in-patient care on a timeline from 1972 to 2015, in the anorexia nervosa and COMP groups. The number of days per two years (e.g. 1972–1973) for psychiatric and somatic care, respectively, are displayed. COMP, Comparison.

Prediktorer för vårdkonsumtion

Ökat vårdbehov/vårdkonsumtion

Lägre debutålder för AN:
- ökat behov av psykiatrisk vård

Premorbid autism:
- fler antal dagar i psykiatrisk slutenvård
- fler dagar med sjukpension

Minskad vårdkonsumtion

Premorbid perfektionism:
- färre dagar i psykiatrisk heldygnsvård
- färre dagar med sjukpension

30 år efter AN, sammanfattning

30 år efter att ha insjuknat i AN i tonåren:

- Hade majoriteten tillfrisknat från ätstörningar och liknade sina jämförelsepersoner vad gäller utbildningsnivå och barnafödande
- Var femte individ hade en kvarstående ätstörning. Återfall inträffade även efter många år utan ätstörning
- En femtedel hade en tydligt nedsatt arbetsförmåga.
- Fann vi en sämre perinatal hälsa hos deras barn och viss ökad risk för att barnen skulle drabbas av psykisk och fysisk ohälsa

Take home message

- Anorexia nervosa är en allvarlig men behandlingsbar sjukdom. Tidig upptäckt och behandling ökar chanserna till fullt tillfrisknande.
- Kognitiva nedsättningar hänger samman med sjukdomsbilden vid anorexia nervosa och kan skapa hinder för att genomföra vissa delar av en behandling.
- Autism är överrepresenterat hos individer med anorexia nervosa och denna grupp svarar sämre på sedvanlig behandling och riskerar långdraget förlopp. Behov av anpassningar i behandlingen.
- Tre decennier efter insjuknande i anorexia nervosa med tonårs debut var utfallet gott för majoriteten.

Tack för uppmärksamheten

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