Long-term prognosis in anorexia nervosa: lessons from a 21-year follow-up study

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In a prospective long-term follow-up of 84 patients 21 years after first hospitalisation for anorexia nervosa, we found that 50·6% had achieved a full recovery, 10·4% still met full diagnostic criteria for anorexia nervosa, and 15·6% had died from causes related to anorexia nervosa. Predictors of outcome included physical, social, and psychological variables.

Anorexia nervosa is a serious illness known to be associated with a chronic course and high mortality. The outcome of this disease is difficult to predict. We did a long-term study to ascertain the influence of various medical, psychological, and social variables on prognosis.

A well-documented sample of 84 female patients with anorexia nervosa were followed-up after an average of 21·3 (SD 2·9) years following first inpatient treatment. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previously investigated after 3·6 and 11·7 years following first hospitalisation. This sample of patients had been previous...
Tolerability and side-effects of post-exposure prophylaxis for HIV infection

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A study of HIV post-exposure prophylaxis in 28 recipients showed that indinavir-containing regimens were poorly tolerated. This finding has implications for compliance and efficacy of the currently recommended combinations.

Post-exposure prophylaxis with antiretroviral drugs is offered to health-care workers exposed to HIV-1 through inoculation injuries. This practice is supported by a case-control study to health-care workers exposed to HIV-1 through inoculation.

Post-exposure prophylaxis with antiretroviral drugs is offered to health-care workers exposed to HIV-1 through inoculation injuries. This practice is supported by a case-control study showing at least single-agent resistance. 5 However, the increasing prevalence of antiviral resistance, led to UK guidelines in 1997 recommending a three-drug combination of zidovudine, lamivudine, and indinavir as standard post-exposure prophylaxis. 2 There are few data on the tolerability and safety of combination regimens in non-HIV-1-infected people. The consideration of provision of prophylaxis after sexual or non-occupational exposure for HIV-1 infection 3 increases the importance of reviewing experience.

We studied retrospectively the use of post-exposure prophylaxis for occupational HIV-1 exposure in three London Hospitals (St Bartholomew’s, the Royal London, and Homerton) from 1996 to January, 1999. 28 people had inoculation injuries from 27 patients. 24 of the source patients were proven HIV-1 positive, two (the source of three injuries) were later shown to be HIV-1 negative, and one was not tested for HIV-1. Most known HIV-1-infected sources (inoculation injuries) were later shown to be HIV-1 negative, and one was not tested for HIV-1. 2

For the purposes of this study we classified injuries as low (no break in the skin), high (break in the skin), or severe (involving mucous membranes). We investigated the frequency of side-effects and reasons for stopping or changing treatment regimens. Side-effects were: uncontrollable vomiting, nausea (despite antiemetics), or reflux (seven); urticaria temporally related to indinavir (one); and galactorrhoea with hyperprolactinaemia (one).

In our experience, post-exposure prophylaxis regimens that include indinavir are poorly tolerated, which affects adherence; persistent vomiting may lessen the effect of other drugs in the regimen or individuals may be forced to stop drugs because of the severity of side-effects, some of which are potentially serious. The costs of providing medical support because of staff absence due to side-effects are substantial, as are the personal costs to those who have such injuries. Although any multidrug combination is likely to cause adverse effects, it seems timely to question the routine use of indinavir in prophylaxis if our findings are common. Other protease inhibitors and non-nucleoside analogues may be better tolerated. The question of whether multiple agents are necessary in post-exposure prophylaxis remains outstanding. Viral resistance is an issue that may favour combination therapy. Our data show that the source of an HIV-1-inoculation injury is increasingly likely to have experienced antiretroviral treatment. 9% of sexually transmitted infections have been shown to be with viruses showing at least single-agent resistance. However, the mechanism by which prophylactic treatment works to prevent infection may be different to that involved in controlling continuing infection, and the amount of virus involved is generally low. The balance needs to be struck between giving complex therapies that may lead to poor adherence and giving adequate therapy to protect the individual. In addition, we need to continue to monitor what further actions can be taken to prevent inoculation injuries in the first place.