Opinion

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Anorexia Nervosa and Obesity in Later Life have been Linked to Abnormal Growth in Childhood

James Luke*

Department of Psychiatry and Behavioral Sciences, Stanford University, USA

***Corresponding author:** James Luke, Department of Psychiatry and Behavioral Sciences, Stanford University, USA. E-mail: james_luke235@gmail.com

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Description

Anorexia of Aging (AA) is characterized by a decrease in the proportion of lean body mass and the basal metabolic rate, which results in a decrease in appetite and food intake. In addition to the "physiological" aspects of appetite, secondary factors like disabilities, medications, and acute or chronic illnesses can also have an impact on appetite. In spite of the fact that AA is underreported in the writing, its predominance is high across various settings, being around 22% in the populace and about 30 percent in long-term care facilities and 42 percent in a general hospital. According to Wilson et al., AA is a risk factor for malnutrition and weight loss 2005, which led to negative outcomes like sarcopenia, frailty, impaired physical function, disability, and death .The Simplified Nutritional Appetite Questionnaire (SNAQ) can be used to easily assess AA and poor appetite. However, there are few studies that evaluate AA due to secondary medical causes, particularly among geriatric outpatients, who are likely to have a high prevalence of AA. According to Luppa et al.'s meta-analysis, 7.2% of older people have a depressive disorder, and 17.1% even have clinically significant depressive symptoms. In the geriatric clinic, depression is also the most common mental illness. This is not surprising given that depression and other geriatric syndromes like AA, sarcopenia, and frailty share several pathophysiological mechanisms, such as chronic low-grade inflammation, dysfunction of the autonomic nervous system, and dysregulation of the hypothalamic-pituitary-adrenal axis. Depression typically accounts for 30% of the causes of weight loss among older outpatients (Wilson et al.,) and is characterized by decreased appetite and weight loss.

Significant Clinical Challenges

According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), one of the nine criteria for a major depressive episode is actually alterations in appetite or weight. The link between depression and anorexia can be explained in a number of ways. A higher concentration of corticotropin-releasing factor, a potent anorectic agent, and higher concentrations of serotonin after the stimulation of serotonin 5-HT2B and 5-HT2C receptors in depressed individuals can be linked to an increased release of ghrelin and appetite loss (Takeda et al., 2013). Anorexia can also be exacerbated clinically by psychosis, which is the belief that one has been poisoned, grief, constipation (leading to fullness), and the loss of one's social network. Although the connection between AA and depression seems obvious, it still presents significant clinical challenges. Anorexia and loss of appetite in late-life depression may be a sign of depression an independent comorbid condition (a patient with AA who develops depression), or both. Additionally, despite losing weight during a depressive episode, many depressed patients report normal appetite (an insight problem) (Simmons et al., 2020).Proxies for AA and depression were consistently linked in prior research. However, these studies were conducted in the general population, used screening scales to detect depression, and/or assessed weight loss or malnutrition rather than anorexia or changes in appetite (Cabrera, Mesas, Garcia, & de Andrade, 2007; Kimura and others,2012).According to our knowledge, no study has examined AA and depressive disorder in a clinical sample of elderly outpatients using DSM-IV criteria. Therefore, there is a lack of fundamental knowledge regarding the prevalence of AA in both depressed and non-depressed geriatric outpatients; however, such data are essential for raising awareness of this clinical issue, directing the creation of prevention strategies, and overcoming iatrogenic damage caused by unnecessary clinical examinations. The current study had three main objectives: (1) to determine the prevalence of AA in both depressed and non-depressed geriatric outpatients; (2) to investigate the relationship between AA, depressive symptomatology, and major depressive disorder (MDD); and (3) to determine the interaction between AA and MDD and their relationship to weight loss. We observed a 12.1% prevalence of AA among older patients attending a middle-income country's geriatric outpatient clinic. MDD patients had a prevalence that was nearly three times higher at 30.7%.After adjusting for a variety of potential confounders, MDD and depressive symptomatology remained significantly associated with AA and the SNAQ scoring.

Standard Deviation

This was true for both PHQ-9 and GDS-15.We used baseline data from the Multimorbidity and Mental Health Cohort Study in Frailty and Aging for our cross-sectional analysis in this study. The MiMiCS-FRAIL cohort's overarching objective is to understand the bidirectional relationship between depression, multimorbidity, and frailty in a geriatric outpatient sample accompanied by a multidisciplinary geriatric clinic (Aprahamian et al., 2020).In conclusion, regardless of weight loss, AA is strongly associated with depressive disorder in older MDD patients. The diagnosis of depression subtypes, therapeutic response to treatment, prevention of weight loss and adverse outcomes, and the identification of altered appetite in depressed patients can all benefit from this finding. AA should be evaluated prospectively in this population in future studies, as should alterations in anthropometry that could be related to AA. Anorexia nervosa (AN) and obesity in later life have been linked to abnormal growth in childhood. In this study, we investigated the connection between growth trajectories over the first two decades of life and polygenic scores (PGSs) for AN and BMI. A PGSs and BMI PGSs were determined for members of the Avon Longitudinal Investigation of Guardians and Kids. We linked PGSs to weight, height, Body Mass Index (BMI), Fat Mass Index (FMI), Lean Mass Index (LMI), and bone mineral density (BMD) trajectories by employing generalized (mixed) linear models. Between the ages of 6.5 and 24 years, female participants with an AN PGS of one Standard Deviation (SD) or higher experienced an average of 0.004% slower growth in BMI and 0.4 percent slower growth in BMD. Higher BMI PGSs were related with quicker development for BMI, FMI, LMI, BMD, and weight directions in the two genders over the course of growing up. Growth was slower in female participants with a high AN PGS and a low BMI PGS than in those with a low AN PGS and a low BMI PGS. We conclude that AN PGSs and BMI PGSs have discernible effects on growth trajectories that are gender-specific. Because their growth was slower than that of their peers who had high PGSs on both traits, female participants with a high AN PGS and a low BMI PGS probably belong to a group at high risk for AN. To better comprehend how the BMI PGS and AN PGS interact to influence childhood growth and whether a high BMI PGS can mitigate the effects of a high AN PGS, additional research is required.