

Response to the Editorial from Micali and Herle on the research article entitled ‘Mortality and Care of Eating Disorders’

We are pleased to note that our study entitled ‘Mortality and Care of Eating Disorders’¹ received attention from other researchers and stimulated the debate in the field of clinical management of Eating Disorders (EDs).

In their editorial entitled ‘Gone too soon: Studying mortality in eating disorders’, Micali and Herle highlighted the importance of studying mortality in EDs, given the number of psychiatric and medical comorbidities of these disorders, as well as their increasing burden.² Furthermore, the authors considered possible explanations for the discrepancy of our study's low standardised mortality ratios compared with previous observations.²

First, the authors considered methodological differences between our study and that of Plana-Ripoll et al.,³ which analysed data from the entire Danish population (7,378,598 individuals) between 2000 and 2018. Plana-Ripoll found that EDs were associated with 3.8-fold increased mortality compared to age and sex-matched populations.³ These findings were coherent with several other observations demonstrating increased mortality in patients with EDs.⁴

Indeed, the mentioned study was based on a larger population with a longer follow-up period. As highlighted by Micali and Herle, sample compositions might account for discrepancies between studies in this field. Indeed, our study included patients from a clinical population, specifically those who were under treatment within the Tuscan Eating Disorder Treatment Network (EDTN); thus, the sample was not comparable to those derived from national registries, nor to those including only hospitalised patients (which obviously showed greater mortality rate as compared to our more heterogeneous sample). Patients included in our study were all under the same protocol of treatment, while subjects included in a national registry refer to heterogeneous settings of care.

While it is true that the average follow-up duration in our study was not long, as compared to other studies, this does not imply that the results are not valid. In particular, our finding that mortality rates are not increased in the first years upon clinical diagnosis is robust, and

uncertainty is limited to long-term risk of death. Regarding the sample composition, our study was based on a population-based sample of patients, not selected based on severity (as it is often the case in hospital-based studies), as a further demonstration of the Tuscan health system's inclusiveness. Studies with large samples based on national registries are obviously important; however, these studies do not focus on treatment strategies and clinical management and often pool patients from different care services. Undoubtedly, a larger sample size and a longer follow-up would have ensured larger statistical power, less uncertainty, and eventually more confidence in the results (which is valid for all studies). However, what is essential in epidemiology is also the representativeness of the study sample regarding the question that is addressed. Concerning the criticism raised by Micali and Herle, it must be emphasised that the sample included in our study is likely to be representative of the entire population of patients with EDs in Tuscany.

Finally, the inclusion of patients with Binge Eating Disorder should be considered as a strength of the study, rather than a bias for interpretation of mortality rates, considering the high cross-over rates between these patients and those with Bulimia Nervosa.

We believe that different approaches should not be considered merely in a quantitative manner; rather, they reflect different specific aims of the studies. Indeed, the primary purpose of our study was not to compare mortality in the Tuscan region with the one obtained from larger datasets in other countries. Instead, we wanted to stimulate the analysis of factors associated with public health services that possibly influence the mortality of EDs. We realise that a relevant part of the message we wanted to promote with our study was not completely understood, and comprehensibly Micali and Herle were against a conclusion which might sound like ‘EDs are not as dangerous as previous studies reported’.

Apart from the methodological differences, Micali and Herle hypothesised that low mortality rates in our study could be explained by the multidisciplinary approach or by socio-demographic peculiarities of the

Tuscan region (e.g., social support in small towns). However, beginning from the title, the manuscript was not limited to the issue of mortality, rather it included the concept of care. Indeed, the authors of the editorial did not seem to have considered what was the primary explanation provided in the article: in accordance with other authors,⁵ we believe that the decreased mortality was due to improved care organisation, which in this case was due to the integration of public services in the EDTN. This is not limited to the multidisciplinary approach of the EDTN but concerns all pathways to care for help-seeking behaviour of people with chronic illnesses. As reported in the article, since 1978 the Italian psychiatric context has had peculiarities which could have exerted significant effects on psychiatric care in general and, in particular for EDs.¹ For example, the treatment of chronic conditions in the EDTN approach is not based on long-term hospitalisation, but rather on an extensive network which makes multidisciplinary care available for almost all patients with EDs in the geographical area. Thus, homogenous strategies are adopted by an integrated network, including general practitioners, emergency room staff, and the multidisciplinary team. Therefore, the main message from our study was that a robust national health system with a well-implemented integration between services might be protective against worse outcomes of severe mental disorders. A well-organised public health network might have a significant impact on EDs treatment outcomes, from different perspectives: it allows constant communication between different services, joint strategies for assessments and prevention of relapses, and sharing of the same clinical language among caregivers. In other words, regarding mortality, a public health network means that patients are never left alone, even if they are not compliant with treatments.

Micali and Herle highlighted the need to foster and fund research that addresses the burden and impact of EDs.² Even though we obviously agree with this position, it is also time to shift the attention of epidemiological studies to what could account for differences in outcomes, considering factors associated with the whole healthcare process in EDs.

As demonstrated by the mentioned meta-analysis by Arcelus et al.,⁶ there are many studies already highlighting the burden and impact of EDs. However, given that death is a modifiable outcome in these patients, as reported by Micali and Herle, there is a need for studies providing evidence of a more efficacious approach to the clinical management of EDs. This effort should not be limited to research regarding novel psychological techniques or biological treatment; instead, it should also focus on the organisation of

public services devoted to long-term assessments and treatment.

Indeed, the main aim of the present study was to stress the importance of building a network between the specialised multidisciplinary team, general practitioners, and emergency services. Thus, we thank Micali and Herle for giving us the opportunity to clarify this point.

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None.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

PEER REVIEW

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DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

Giovanni Castellini^{1,2} 

Saverio Caini³

Emanuele Cassioli¹ 

Eleonora Rossi¹ 

Giorgia Marchesoni¹

Francesco Rotella²

Nora De Bonfioli Cavalcabo³

Miriam Fontana⁴

Barbara Mezzani⁵

Brunetto Alterini⁶

Stefano Lucarelli⁷

Valdo Ricca^{1,2}

¹Psychiatry Unit, Department of Health Sciences, University of Florence, Florence, Italy

²Psychiatry Unit, Careggi University Hospital, Florence, Italy

³Cancer Risk Factors and Lifestyle Epidemiology Unit, Institute for Cancer Research, Prevention and Clinical Network (ISPRO), Florence, Italy

⁴Clinical Epidemiology Unit, Institute for Cancer Research, Prevention and Clinical Network (ISPRO), Florence, Italy

⁵Casa di cura "Villa dei Pini", Florence, Italy

⁶Division of Cardiovascular and Perioperative Medicine, Careggi University Hospital, Florence, Italy

⁷UFS Eating Disorders ASL Toscana Centro, Florence, Italy

Correspondence

Giovanni Castellini, Psychiatry Unit, Department of Health Sciences, University of Florence, Florence, Italy.

Email: giovanni.castellini@unifi.it

ORCID

Giovanni Castellini  <https://orcid.org/0000-0003-1265-491X>

Emanuele Cassioli  <https://orcid.org/0000-0003-3623-7096>

Eleonora Rossi  <https://orcid.org/0000-0003-4755-3879>

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