Management of Bipolar Disease in the Elderly

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Sunday August 3, 2008
9:00 - 9:50 am

Concerns of Older Adults

- Quality of life
  - Mental and physical health fundamental to a more meaningful life
  - Many more issues in late life
  - How to avoid – early treatment/prevention
  - Increasing numbers struggling with mental health issues
Good news

- Most seniors enjoy good mental health
  - Psychiatric illness is not part of normal aging
  - NIMH 1:5 diagnosed with mental illness
- Growing population mentally ill
  - 65+ 20 million in 1970 (7 million)
  - 65+ predicted 70 million in 2030 (15 million)

Mental Health Issues in Aging

Most common psychiatric disorders in late-life
- Anxiety (includes phobias and OCD)
- Cognitive impairment and delirium (Alzheimer’s disease)
- Mood disorders (depression and bipolar)
- Range of severity from problematic-severe
  - Suicide highest in this age group
Older Adults Avoid Psychiatrists

- Mental health services underutilized
  - Stigma
  - Denial
  - Lack of services, access outreach
  - Poor coordination of services and follow-up

Psychiatric Evaluation of Older Adults

- Psychiatric assessment
  - Rule out pre-morbid psychiatric illness
  - Rule out co-morbid medical illness
- Functional Assessment
  - ADLs
    - mobility, dressing, hygiene, feeding and toileting
  - IADLs
    - independent living, shopping, cooking, telephone, housekeeping (light), medications, finances, transportation
- Evaluation
  - Complete history
  - Psychiatric, medical, neurological
What is different in evaluation?

- Evaluation
  - Complete history,
    - Prior clinicians, medical records, medications
    - often need family to give history
  - Psychiatric, medical, neurological

- Psychiatric assessment
  - Rule out pre-morbid psychiatric illness
  - Rule out co-morbid medical illness

Evaluation of Function

- Functional assessment
  - Activities of daily living
    - Feeding, Bathing, Dressing, Transferring, Toileting
  - Instrumental activities of daily living
    - Finances, Telephone, Medications, Shopping, Cooking
    - Housework, Ambulating, Laundry
Presentation of Illness

- Often atypical may present as
  - Falls
  - Behavioral changes
  - Behavioral changes
  - Cognitive deficits
  - Functional losses
    - incontinence
  - Non-specific signs and symptoms

Evaluation of Older Patients

- Cognition
  - Assessment Mini-Mental State Exam (Folstein)
- Affect
  - Sleep Interest Guilt Energy
  - Concentration Appetite
  - Psychomotor activity
  - Suicide
- Psychosis
Medications, get a list

- Bring the bottles in to appointment
- Current list
- Names of prescribers
- Dates on bottles
- Over the counter
- Herbal
- Borrowed from a friend
- Old medications, saved

Most commonly prescribed

- Cardiovascular
  - Diuretic
  - Antihypertensive
  - Vasodilator
  - Digoxin
- Psychotropic
- Analgesic
  - narcotic
  - antiarthritic
- Laxative
  - antispasmodic
Common culprits

- Over the counter sleeping pills
  - PM combinations
- Allergy medications, antihistamines
- Cough syrup, alcohol or dextromethorphan
- Cold preparations, pseudoephedrine
- Narcotics
- Illicit drugs, cocaine, MJ
- Alcohol, intoxication or withdrawal

More culprits, prescribed

- Any medication or substance
- Dopaminergic medications
- Steroids
- Stimulants
- Benzodiazapines
- Cardiac medications
- Herbal preparations
Psychosis

- Common Types of Psychosis
  - Delirium
  - Dementia
  - Depression
  - Mania

Psychosis

- DSM-IV definition one or more of:
  - Hallucinations
  - Delusions
  - Disorganized speech
  - Disorganized or catatonic behavior
Psychosis

- Dementia
- Delusional disorder
- Charles Bonnet Syndrome
  - confused with psychosis
  - poor response to medications
- Rule out
  - alcoholism
  - substance abuse
- Prescribed drugs
- Illicit drugs

Demographics of Bipolar Illness in the elderly population

- Epidemiology
  - Underreported or not diagnosed
- Prevalence
  - 1% general population
  - 1.2-1.3% 1-year community based
## Bipolar Illness

- Bipolar illness - onset often early in life
- 10% of patient with BPI onset >50 years
- First onset of mania or hypomania is rare in the elderly
- Patient often presents with depression first
- Not usually hypomania or mania

## Bipolar Illness

- Associated with or complicated by
  - cognitive impairment
  - substance abuse
  - co-morbid illness
  - history of depression
- Secondary mania due to medical conditions or neurological disorders is diagnosed more frequently especially with dementia
Bipolar Illness

- Symptoms of mania or hypomania the elderly
  - > anger or irritability - aggressive behavior
  - less grandiosity or euphoria
  - longer episodes of mania
  - cycling may be more rapid
  - pervasive delusions and paranoia
  - inconsistent treatment response

Definitions

- Syndrome of 1 or more manic episodes accompanied by 1 or more depressive
- Seasonal patterns
- Mixed states have significant dysphoria in manic states
- Secondary mania, symptoms in the context of delirium, dementia, MCI or toxic
Diagnosis of BPI

- Correct diagnosis is key to treatment
- Hypomania can be easily missed
- Depressive states more disabling
- Usually first episode of BPI is depressive
- Clinical course most salient clinical feature rather than characteristic of individual episode

BPI is difficult to diagnose

- Manic symptoms establish diagnosis
- Absence of manic symptoms - not ruled out
- Misdiagnosis of unipolar depression
- Diagnosis of manic symptoms, historic
  - establish diagnosis
- Irritability vs euphoria
- Family or third party informer
Mnemonic useful in diagnosis

- Distractability
- Impulsivity, indiscretions
- Grandiose
- Flight of Ideas
- Activity increased
- Sleep decreased
- Talkative, pressured speech
  - devised by Dr William Falk at MGH

Diagnosis of Bipolar Depression

- Subtlety in interview style
- Inability of patient to recognize symptoms
- Lack of insight
- Depressive symptoms bring patient in
- Poor memory of manic symptoms
- Greater stigma than diagnosis of depression
Predictors of Suicide

- age
- male sex
- isolated, divorced or separated
- debilitating illness
- widowed
- alcohol

Other causes to consider

- Medical disorders
  - Metabolic, Uremia
  - Thyroid disorder
  - Infection or delirium
  - Neurologic lesions, seizures
- Medications
- Deficiencies –
  - vitamin B12
  - Niacin
Confused with Dementia

- Alzheimer’s disease
- Vascular dementia
- Dementia due to trauma
- Lewy body disease
- Frontal lobe dementia, Pick’s disease
- Parkinson’s related dementia
- Prion disease

Psychosis in Dementia

- high prevalence and incidence
- episodic or persistent
- can appear early or late
- Categories of psychosis in dementia
  - Delusions
  - Hallucinations
  - Misconceptions
Behavioral Psychological Symptoms of Dementia (BPSD)

- Psychological
  - Disorganized or illogical thought process
  - Perceptual disturbances: hallucinations/illusions
  - Delusions or thought content not reality-based

- Behavioral
  - Agitation and anxiety
  - Aggression, hostility, uncooperativeness
  - Apathy
  - Wandering

Involuntary Emotional Expressive Disorder (IEED)

- Damage brain areas control emotional output
- Also referred to as:
  - Pseudobulbar affect
  - Emotional incontinence
  - Affective or emotional lability
  - Pathologic laughing or crying
Anxiety common comorbidity

- Must be addressed
- Benzodiazepines may cause confusion
- Antidepressants may precipitate mania
- Psychotherapy, individual or CBT

Sleep Disorders in the Elderly related to BPI

- Evaluate and treat psychiatric or medical illness
- Rule out sleep apnea
- Medications, including OTC medications
- Alcohol
- Other substances, especially stimulants
Alcoholism

- Mimics many medical and psychiatric illnesses
- Treatment program essential for refractory disease
- May need medications when sober (antidepressants)
- Hospitalization required for detoxification
- Suicide risk - greatest in this group

Alcoholism

- Life long pattern of drinking every day
  ♦ even small amounts every day – problem
  ♦ withdrawal life threatening
- Symptoms include
  ♦ insomnia
  ♦ memory loss
  ♦ confusion
  ♦ anxiety and/or depression
  ♦ somatic complaints mimic medical illness
Elder Abuse

- Subtle presentation
  - Not responding to medications
  - Fearful or increased startle
  - Delusional
- Family/caregivers may be overwhelmed
- Hotlines in every state

Treatments

- Psychopharmacologic therapy
- Individual psychotherapy
- Supportive psychotherapy
- Cognitive behavioral therapy
- Group therapy
- Family therapy
- Caregiver support group therapy
Treatment

- Evidence-based research minimal
- Elderly not usually recruited
- Increase in older participants mostly healthy
- Too much for frail - not enough for robust
- Trials should include those who will benefit
- Difficulty in assessing the health status

Treatment of Mania and Depression

- Complete differential diagnosis including medical issues
- Assess suicide risk and potential adverse effects of treatment
- Careful individualization of treatment choice
- Education of patient, family, caregivers and support system
- Adequate treatment and adherence
- Attentive monitoring and follow up
- Use of individual or combined somatic therapies in combination, when appropriate, with psychotherapy
Treatment - medications

- Polypharmacy nature of symptoms
- Lithium
- Anticonvulsants
- Antipsychotics
- Antidepressants

FDA approved for mania

- Lithium
- Divalproex
- Carbamazepine
- Lomtrigine
- Aripirazole
- Olanzapine
- Quetiapine
- Risperidone
- Ziprazodone
Atypical Antipsychotics

- Less dopamine blockade and significant 5-HT 2A
- Less depressionogenic effect
- First generation antipsychotics
  - Increase antidepressive episodes
- Second generation
  - Reduce both acute and ongoing depressive symptoms and syndromes

Mortality and antipsychotics

- Atypical antipsychotics black box warning
- First generation not established
- Mortality associated with mania
- Mortality associated with depression
Treatment

- Lithium treatment for mania begin low
- Lithium carbonate 150-900 mg/d
  - Underlying medical conditions or medications can preclude its use
  - Lithium can be toxic at low levels in elderly
    - risk of fluid shifts
    - dehydration
    - toxicity
- Anticonvulsants more suitable
  - lower side effect profile
  - increased efficacy
- Antipsychotic especially the atypicals good response
  - Minimal side effects

Antipsychotics

Atypical anti-psychotics
- clozapine 6.25-100 mg  WBC weekly, excessive drooling, hypotension
- risperidone 0.25-3 mg  significant EPS
- olanzapine 1.25-10 mg  weight gain, diabetes
- quetiapine 6.25-300 mg  sedation, hypotension
- aripiprazole 10-30 mg  insomnia, agitation
- ziprazidone 20-160 mg  cardiac issues related to increased QTc
Anticonvulsants

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carbamazepine</td>
<td>50-600 mg/d</td>
<td>drug interactions, ataxia</td>
</tr>
<tr>
<td>Valproic acid</td>
<td>125-1500 mg/d</td>
<td>weight gain, sedation</td>
</tr>
<tr>
<td>Gabapentin</td>
<td>100-1800 mg/d</td>
<td>ataxia, sedation</td>
</tr>
<tr>
<td>Lomotrigine</td>
<td>5-400 mg/d</td>
<td>rash, TENS, Stevens-Johnson</td>
</tr>
</tbody>
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Table 1. Clinical Pharmacology of Agents Useful for Reducing the Signs of Dementia.‡

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Donepezil</th>
<th>Rivastigmine</th>
<th>Galantamine</th>
<th>Memantine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time to maximal serum concentration (hr)</td>
<td>3-5</td>
<td>0.5-2</td>
<td>0.5-1</td>
<td>3-7</td>
</tr>
<tr>
<td>Absorption affected by food</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Serum half-life (hr)</td>
<td>70-80</td>
<td>2γ</td>
<td>5-7</td>
<td>60-80</td>
</tr>
<tr>
<td>Protein binding (%)</td>
<td>96</td>
<td>40</td>
<td>0-20</td>
<td>45</td>
</tr>
<tr>
<td>Metabolism</td>
<td>CYP2D6, CYP3A4</td>
<td>Nonhepatic</td>
<td>CYP2D6, CYP3A4</td>
<td>Nonhepatic</td>
</tr>
<tr>
<td>Dose (initial/maximal)</td>
<td>5 mg daily/10 mg daily</td>
<td>1.5 mg twice daily/6 mg twice daily</td>
<td>4 mg twice daily/12 mg twice daily</td>
<td>5 mg daily/10 mg twice daily</td>
</tr>
<tr>
<td>Mechanism of action</td>
<td>Cholinesterase inhibitor</td>
<td>Cholinesterase inhibitor</td>
<td>Cholinesterase inhibitor</td>
<td>NMDA-receptor antagonist</td>
</tr>
</tbody>
</table>

‡ CYP2D6 denotes cytochrome P450 enzyme 2D6, CYP3A4 cytochrome P450 enzyme 3A4, and NMDA N-methyl-d-aspartate.
† Rivastigmine is a pseudo-reversible acetylcholinesterase inhibitor that has an eight-hour half-life for the inhibition of acetylcholinesterase in the brain.
Adverse side effects to medications

- Lithium
  - neurological, renal and thyroid problems
  - polydypsia, polyuria, edema weight gain and EKG changes
- Divalproex
  - Sedation, tremor, gait disturbance
- Atypical antipsychotics
  - metabolic syndrome EPS, weight gain, EKG changes, increased mortality

Electroconvulsive Therapy

- Resistant to treatment with medications
- Intolerant of side effects from medications
- Due to worsening medical illness
- Psychosis associated with depression
  - Severity of depression
  - Risk of suicide
  - 20-45% older patients are psychotic
Family Education

- Discuss with family and if possible patient
- Outline findings and probable diagnosis
- Support services
  - Companions
  - Day programs
  - Drivers
  - Support groups and networks

Caregivers need care

- Caregivers are often older and frail
- Need to care for health of caregiver
- Care can be sad, depressing and overwhelming
- Caregivers may blame themselves
- Seek help especially through tough times
  - Support groups and time for self
“In diseases of the mind... it is an art of no little importance to administer medicines properly; but, it is an art of much greater importance and more difficult acquisition to know when to suspend or altogether omit them.”

Phillipe Pinel, physician 1806
Resources

- American Association of Geriatric Psychiatrist
  - www.aagpgpa.org
- Family Caregiver Alliance
  - www.caregiver.org
- National Institute of Aging
  - www.nih.gov.nia

Resources

- Alzheimer’s Association
  - www.alz.org
- MGH Senior Health
  - www.massgeneral/seniorhealthweb
Thank you

Contact me with questions
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