Bipolar Disorder in the Geriatric Population

The Case

69 year old male history of Bipolar Disorder presents to the geriatric unit after being brought by his POA for worsening mania. On the unit patient was grandiose and hyperverbal, making sexual comments. Patient was tangential and expansive on interview. Made statements about how he spoke to God and his deceased grandfather in his mind.

Patient had a Valproic Acid level of 29.8 (ref range 50-100)

Psychiatric ROS

- Decreased need for sleep
- Increased energy
- Denies sadness
- Denies anhedonia
- Increases anxiety/agitation
- Grandiose delusions
- Denies history of compulsions
- Denies flashbacks
- Denies self-injurious behaviour

Home psychiatric medications

- Clonazepam 0.5 mg morning and at noon
- Clonazepam 1.5 mg nightly
- Divalproex 2000 mg daily
- Divalproex 2500 mg nightly

Psychiatric history

- Previous diagnosis: Bipolar
- 4 previous hospitalizations: 2 in 2013, 1 in 2017 and 1 for 2018. All for mania
- Previous medication trials: Depakote, ziprasidone, lorazepam, Haldol, lithium, Lexapro, vraylar, Latuda, Seroquel, navane
- No history of suicide attempts
- Family history: Paternal Aunt (bipolar), Cousin (schizophrenia), Maternal Aunt (Schizoaffective disorder)
- Substance: has a history of alcohol abuse, now drinks on average 2 beers monthly

Social History

- Grew up on a farm with married parents and siblings.
- Describes childhood as “great”
- HS graduate, went to work on the farm
- Is living in an apartment
- Is currently retired
- Divorced, married for 5 years in the 1980’s
- 2 children. One of the moved out of state, does not have relationship with the child living in state
- Primary support is sister, receives home health services

Mental Status Exam

- Appearance: Well-nourished elderly male, neat appearance
- Behavior: Boisterous. Essentially cooperative
- Psychomotor: No abnormal movements
- Eye contact: Intense eye contact
- Speech: Hyperverbal/expansive
- Mood: Labile
- Affect: Intense
- Thought Process: Tangential
- Thought Content: Focused on details of past. Agitation directed towards sister/son

Why is this so important?

· 25% of bipolar patients are elderly

· The number of geriatric bipolar patients is expected to rise in the next several decades

· Among geriatric pts in clinical settings, about 70-95% of them have cases with onset prior to age 50yrs that has persisted into later life

What does it look like?

- Most geriatric bipolar pts are female, whereas male to female ratio in young bipolar pts in 1:1
- European Mania in Bipolar Longitudinal Evaluation of Medication (EMBLEM) study: a 2-year prospective, observational study in 3459 bipolar patients. Found that in the eldery group:
  - There was more rapid cycling (especially with early onset bipolar pt)
  - Fewer suicide attempts
  - Less severe manic and psychotic symptoms but no difference in depressive symptoms
  - No difference in 12 week outcomes compared to younger group but late onset bipolar pts did recover faster than early onset patients

Treatment for Bipolar Mania

Lithium

a. Often started at 150mg daily or BID

b. Elderly pts generally require a smaller dose to reach therapeutic levels

c. Recommended serum levels based on guidelines from the International society for Bipolar Disorders:

i. •Patients 60 to 79 years old – 0.4 to 0.8 mEq/L (0.4 to 0.8 mmol/L)

ii. •Patients 80 years and older – 0.4 to 0.7 mEq/L (0.4 to 0.7 mmol/L)

d. Risk of hypothyroidism increases with age.

e. We also see more CKD in elderly pts on Li but that is likely moreso due to chronicity of Li exposure

Valproate

a. Usually start at 125 to 500 mg/day

b. Target dose of 500 to 1500mg/day

c. Like Li elderly population generally requires less than younger population to reach target serum levels

d. Side effects often seen in this pop are: GI distress, sedation, weight gain, and hand tremor

Olanzapine

a. Often started at 2.5 to 5 mg

b. Target dose of 5-15 mg /day even 20mg if no response to 15 and no SE

c. Metabolic side effects

d. Retrospective study in elderly veterans with bipolar d/o : “based upon potential confounding factors such as general medical and psychiatric comorbidity and use of concomitant medications, the analyses found that the mortality rate during the first six months of treatment was approximately two times greater in patients who received olanzapine or risperidone than valproic acid”

Quetiapine

a. Start at 12.5-25mg daily or BID

b. Target dose of 100-300mg, can even go up to 800 mg if no SE and response to 300mg

c. Commonly see sedation and orthostatic hypotension as a side effects as well as metabolic side effects

d. Be careful in pts who are already a fall risk

Treatment for Bipolar Depression

Lurasidone

- Start with 20mg daily in the evening
- Target dose of 20 to 120 mg
- GI side effects as well as somnolence, fatigue, and muscle spasms.
- 2nd generation antipsychotics have been known to increase mortality risk in patients with dementia related psychosis, it is suspected by some that this may also extend to late onset bipolar disorder

Quetiapine

- As in bipolar mania, target dose of 100-300mg
- Can go up to 600 mg if 300mg does not work
- Again keep in mind increased mortality risk in those with dementia related psychosis

Our patient cont.

- Initially patient was offered as needed quetiapine for his agitation. Patient felt that this made him feel worse and requested haloperidol instead and so a scheduled dose was provided.
- Over the course of his stay divalproex, haloperidol, and clonazepam were titrated
- As these meds were titrated his manic symptoms began to resolve. Patient's grandiose delusions also began to resolve as he started to deny hearing the voice of God or his deceased grandfather. Hyoersexual comments were still frequent but they lessened in frequency

Our patient cont.

- Patient continued to have difficulty with sleep. Encouraged better sleep hygiene but patient still had sleep difficulties.
- Patient continued to refuse quetiapine.
- Trial of low-dose thorazine was initiated
- This was effective, with patient being able to sleep through the night by discharge.
- By the time of discharge hypersexual comments also resolved. Patient seemed to have some insight into how his manic state contributed to his hospitalization and seemed to indicate that he will be compliant with medications. Increased services at home were set up for the patient.

References

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