Geriatric Behavioral Health Conference

Management of OCD in the Geriatric Population

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DISCLOSURE

- **I do not have any financial relationships with commercial interest companies to disclose.**
- **I will be discussing off-label use of a commercial product.**

Learning Objectives

- Treatment of OCD in geriatric population
- Management of benzodiazepines in geriatric population

Initial presentation

- 80 year old male with long history of OCD
- Had been stable on clomipramine and clonazepam since 1987, recently discontinued due to loss of effectiveness and financial constraints.
- Cross titrated from clomipramine to fluoxetine by a different provider.
- He described worsening of symptoms of anxiety on fluoxetine.

Psychiatric ROS

- Quite anxious. Complaining of muscle twitching, restless legs. Visibly anxious, pacing throughout the visit.
- Worried about “everything.” Wife has been increasingly concerned about his symptoms.
- Denied panic attacks.
- Symptoms of depression, hallucinations, mania grossly negative.

Past Psychiatric History

- Diagnoses: OCD diagnosed by psych testing, social anxiety disorder, GAD, dysthymia
- Therapy: multiple trials in the past, claims he was told “You are healed”
- No hospitalizations, suicide attemps
- Current meds: fluoxetine 40 mg daily, clonazepam 1 mg TID
- Past meds: clomipramine-effective for years, valium, nefazadone-effective, hydroxyzine-effective
- “When Mayo diagnosed me with OCD they said CLOMIPRAMINE, CLOMIPRAMINE, CLOMPIRAMINE.”

Past medical history

- Parkinson’s disease-followed by neurology
- Essential tremor-s/p thalmotomy
- Narcolepsy

Social history

- Married
- Retired
- Master’s degree
- Drinks 1 beer daily, no history of abuse
- No history of illicit substance use

Family psychiatric history

- No diagnoses, hospitalizations, suicide attempts

Initial management

- Discontinued fluoxetine due to side effects-restlessness and increased anxiety.
- Hold off on other SSRI given long half life of fluoxetine.
- Discussed risks of benzos.
- Recommended therapy.

2 week follow-up

- Restlessness resolved, much more comfortable overall.
- He described worsening obsessions and compulsions.
- Difficulty sleeping.
- Wife present for the visit, described that he historically does not engage in therapy.
- She had some concern over his short term memory. Had some deficits found on neuropsych testing in the last year.

2 week follow-up

- Recommended follow-up neuropsych testing for memory.
- Held off on SSRI given long half life of fluoxetine.
- Initiated trazodone 50 mg at night for insomnia.

4 week follow-up

- Ongoing anxiety.
- No changes with insomnia.
- Wife describes him alphabetizing spices in the cabinet, checking to ensure belongings are in place around the house multiple times daily.
- Taking 3-4 tablets of clonazepam per week.

4 week follow-up

- Increased trazodone to 100 mg at bedtime.
- Started fluvoxamine 50 mg at bedtime, increase to 50 mg twice daily after 1 week.

Fluvoxamine trial

- Tolerating the medication well 4 weeks in. No improvement in anxiety.
- Fluvoxamine had again been increased to 50 mg daily and 150 mg at bedtime.
- Patient informed myself that he increased clonazepam to 1 mg daily.

Fluvoxamine trial

- Fluvoxamine continued to be titrated to FDA recommended max of 300 mg in split doses.
- Patient noted increased fatigue, dosing was shifted to nighttime only.
- Anxiety did seem improved subjectively, though he continued to describe only minimal relief.
- Continued to use clonazepam 1 mg 4 times per week.

Fluvoxamine trial

- Plan was made to decrease dose of clonazepam as tolerated.
- Initial plan was to decrease to 0.5 mg doses for 2 weeks then discontinue.
- Started on hydroxyzine 25 mg twice daily as needed, previously had relief from this medication.

Fluvoxamine trial

- Through duration of trial anxiety did improve, though he continued to describe anxiety being largely unchanged.
- Each office visit required significant education on expectations for both medications and overall treatment of anxiety.
- Patient frequently asked for medication to be cross titrated. He was given reassurance.
- Continually refused therapy.
- Frequently called the office after visits with questions/concerns.

Fluvoxamine trial

- Hydroxyzine was increased to total of 100 twice daily with ongoing anxiety.
- After 12 weeks at max dose of fluvoxamine he did elect for cross titration.
- Of note, neuropsych testing was repeated and found to be normal for age, education level.

Adjunct treatment

- Hydroxyzine was deemed ineffective by patient.
- Elected to proceed with trial of propranolol 10 mg twice daily for panic symptoms.
- After discontinuation of clonazepam, symptoms of REM sleep behavior disorder did emerge. Neurologist restarted clonazepam 0.25 mg at bedtime, which resolved symptoms.

REM sleep behavior disorder

- Characterized by loss of atonia during REM sleep. Can present as range of symptoms from simple movement of extremities to violent thrashing.
- Relatively low prevalence in the general population, though it is much more common in Parkinson's disease, multiple systems atrophy, and lewy body dementia.
- Can be exacerbated by serotonergic agents.
- Treatment options include melatonin, clonazepam, cholinergic agents.

1. UpToDate-REM sleep behavior disorder

Choosing a new serotonergic agent

- Only previous trials of SSRIs-fluvoxamine and fluoxetine.
- Opted to start trial of sertraline with plan for relatively rapid titration.

Sertraline trial

- Sertraline was titrated to dose of 100 mg daily after two weeks.
- Patient and his wife both described worsening of symptoms.
- Blood pressure much more elevated, as high as SBP 180. This would return to SBP 130 after the visit.
- Experiencing panic symptoms throughout the day and night.
- Sertraline increased to 150 mg daily.
- Propranolol increased to 20 mg three times daily.

Sertraline trial

- Sertraline 150 mg daily did seem to improve OCD symptoms overall, though combination with propranolol caused increased sedation.
- Ongoing panic symptoms multiple times daily.
- Requested retrial of clonazepam at a low dose of 0.5 mg daily as needed and discontinuation of propranolol, which was approved.
- Sertraline increased to 200 mg daily.

Sertraline trial

- Sertraline 200 mg and as needed clonazepam did not adequately address panic symptoms after two weeks.
- Patient was requesting increased dose of clonazepam. Reviewed potential risks and alternative options.
- He was in agreement with trial of quetiapine 25 mg twice daily as needed for anxiety.
- Reviewed risks of quetiapine including metabolic side effects, qtc prolongation, black box warning in elderly, risk to worsen PD symptoms.

Use of antipsychotics in PD

- PD and DLB patients are much more sensitive to side effects from this class of medications.
- Generally, quetiapine, pimavanserin, and clozapine are best tolerated, though still carry risk.
- Anxiety is off label use, though quetiapine doses up to 300 mg have found to be effective in some patients.

2. UpToDate-Prognosis and Treatment of Dementia with Lewy Bodies

3. UpToDate- Quetiapine drug infromation

Sertraline trial

- Patient did notice some relief with quetiapine, though continues to have break through panic symptoms.
- Sertraline increased to 250 mg daily.
- Quetiapine increased to 50 mg twice daily as needed.

Treating OCD/Anxiety

- In general, OCD requires higher doses of serotonergic agents in comparison to other psychiatric illnesses.
- Benefits of high dose SSRI/SNRI often offset by tolerability.
- Doses above FDA recommended max are controversial, though have shown benefit in some studies.

4. Bloch, 2009

Conclusions

- Treatment of OCD often requires high dose serotonergic agents.
- It is important to stick to the treatment plan.
- Adjunct therapy should be strongly encouraged.
- Objective measures including GAD-7, PHQ-9, Y-BOCS are helpful in tracking symptoms over time.
- PD, DLB patients are can be extremely sensitive to medications.
- It is important to have an adequate trial of the medication before concluding failure of an agent.

Conclusions

- Anti-anxiety agents have many negative side effects, particularly in the geriatric population.
  - Hydroxyzine- sedation
  - Propranolol- sedation, hypotension
  - Benzodiazepines- sedation, increased risk of falls, worsening cognitive symptoms, dependence
  - Antipsychotics- increased risk of death, sedation, qtc prolongation, EPS, TD

Citations

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