Geri psych case presentation: Bipolar I Disorder

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I have no financial relationships but will discuss off-label use of a commercial product.

DSM IV & V

DSM-IV Criteria	DSM-5 Criteria
Manic episode	Manic episode
A. A distinct period of abnormal, persistent, elevated/expansive/irritable mood, lasts at least 1 week (or any duration if hospitalization is necessary).	A. A distinct period of abnormal, persistent, elevated/expansive/irritable mood, lasts at least 1 week (or any duration if hospitalization is necessary) + increased goal directed activity/energy
B. three (or more) of the following symptoms have persisted (four if the mood is only irritable)	B. three (or more) of the following symptoms have persisted (four if the mood is only irritable)
1. Inflated self-esteem or grandiosity	1. Same
2. Decreased need for sleep (e.g., feels rested after only 3 hours of sleep)	2. Same
3. More talkative than usual or pressure to keep talking	3. Same
4. Flight of ideas or subjective experience that thoughts are racing	4. Same
5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)	5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli), as reported or observed.
6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation	6. Same
7. Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)	7. Excessive involvement in activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).
C. The symptoms do not meet criteria for a mixed episode.	Dropped
D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.	C. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
E.not due to substances or other medical condition	E.not due to substances or other medical condition
Note: Manic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of bipolar I disorder.	Note: A full manic episode that emerges during antidepressant treatment (e.g., medication, electroconvulsive therapy) but persists at fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a manic episode and therefore a bipolar I diagnosis.

HPI

- 70 y/o M with Hx of mixed hyperlipidemia, hypertension, bipolar I disorder, and EtOH use disorder presents to the ED for breakthrough symptoms of mania. Wife is present at bedside and provides collateral. Recently trialed on desvenlafaxine for treatment of depressive symptoms.

-decreased need for sleep 2-3 hrs a night for several nights

-increased goal oriented activity

-grandiosity

FDA approved medications for bipolar depression

- Olanzapine-fluoxetine
- Quetiapine
- Lurasidone
- Cariprazine
- Lumateperone

Past Psych Hx

- Diagnoses: Bipolar I disorder, EtOH use disorder
- Hospitalizations: multiple none recently
- Home medications: quetiapine, clonazepam, *desvenlafaxine, Zaleplon*
- Medication trials: lithium, sertraline, trazodone, aripiprazole, olanzapine
- Suicide attempts: one remote prior attempt via CO poisoning
- Self harm: denies
- History of Violence: denies
- N.b. had hyper-religious delusions during past manic episode

Social Hx

- Financial: retired
- Housing: stable
- Relationship: married
- Children: estranged
- Substances: denies (Hx of EtOH use disorder)
- Access to firearms: denies

Family Psychiatric Hx

- Aunt: schizophrenia
- Several family members with bipolar disorder
- Grandfather completed suicide

Labs & Imaging

- CBC: nml
- CMP: low Na, Cl. Increased BUN. Decreased osmolality.
- UDS: negative
- UA: trace protein
- TSH: nml

MSE

- Appearance: appears as old as stated, dressed in blue hospital scrubs, appropriate to environment, fair grooming
- Behavior: forthcoming, psychomotor agitation present (constant pacing)
- Speech: appropriate volume, elevated rate and amount, pressured, and appropriate tone
- Mood: “I’m manic"
- Affect: mood congruent; elevated
- Thought process: disorganized, flight of ideas
- Thought content: denies SI/HI/NSSH, delusions
- Perception: denies A/V hallucination, not overtly attending to internal stimulus.
- Sensorium: Grossly intact
- Cognition: Estimated as average
- Insight: impaired; fair
- Judgment: impaired; poor

Hospital course

Home medications were restarted

- quetiapine 50 mg daily and 400 mg nightly
- clonazepam 0.5 mg nightly
- Trial of lithium 300 BID initiated

FDA approved medications for bipolar mania

- Lithium
- Aripiprazole
- Asenapine
- Cariprazine
- Olanzapine
- Quetiapine
- Risperidone
- Ziprasidone
- Carbamazepine
- divalproex

FDA approved medications for bipolar mixed episodes

- Aripiprazole
- Asenapine
- Olanzapine
- Risperidone
- Ziprasidone
- Carbamazepine
- Divalproex

Hospital course

- Kidneys did not tolerate
- Stopped lithium
- Trial of divalproex
- Titrated home quetiapine

Hospital course

Stabilized on

- divalproex 250 mg nightly
- clonazepam 0.5 mg nightly
- quetiapine 200 mg daily and 600 mg nightly

FDA approved medications for bipolar maintenance

- Lithium
- Aripiprazole
- Olanzapine
- Lamotrigine
- LAI risperidone

Outpatient regimen

- divalproex was cross-titrated to lamotrigine 200 mg daily
- clonazepam 0.5 mg nightly
- quetiapine was tapered to 200 mg nightly
- lurasidone initiated at 20 mg daily with meals

Hospital course 2.0

- Presented with breakthrough mania
- Psychogenic polydipsia
- Grandiose delusions
- Hypersexual content

Hospital course 2.0

- Initially titrated lurasidone without improvement
- Restarted quetiapine and divalproex and titrated to maximum dose
- Improvement but side effects

Hospital course 2.0

Stabilized on

- divalproex 1000 mg nightly
- clonazepam 0.5 mg nightly
- quetiapine 600 mg nightly

Considerations for older adults

- Drug induced movement disorders
- Orthostasis – fall risk
- Sedation – confusion, fall risk, and aspiration
- Thrombocytopenia – divalproex and other early antiepileptics
- Cardiovascular
- Renal
- Hepatic

Question 1

Which medication choice has the lowest risk of inducing orthostatic hypotension?

a. quetiapine

b. risperidone

c. olanzapine

d. aripiprazole

Question 2

Which medication choice has the highest risk of drug induced parkinsonism?

a. quetiapine

b. risperidone

c. clozapine

d. aripiprazole

Sources

- Stahl’s essential psychopharmacology
- Stahl’s prescribers guide
- Kaplan and Sadock's synopsis of psychiatry 10th edition
- Kaplan and Sadock's synopsis of psychiatry 12th edition
- Epocrates online