Elderly Bipolar Patients Need Careful Treatment

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CAMBRIDGE, MASS. — A broad differential diagnosis and careful drug selection are essential to successfully treating bipolar illness in geriatric patients, M. Cornelia Cremens, M.D., said at a meeting on bipolar disorder sponsored by Harvard Medical School.

But the dearth of evidence-based guidelines for managing older bipolar patients makes both objectives difficult to attain, the geriatric psychiatrist said.

"Bipolar patients represent approximately 5%-20% of patients who require acute treatment in geriatric psychiatry, but depression and mania can be secondary to many other psychiatric or medical illnesses," said Dr. Cremens of Massachusetts General Hospital, Boston.

"Psychotic symptoms are frequently associated with dementias of all types—delirium, depression, schizophrenia, and certain medical illnesses, such as Parkinson's disease," she said. In addition, symptoms of depression can be side effects of prescribed medications.

With respect to treatment, pharmacodynamic and pharmacokinetic changes in elderly patients alter prescribing patterns. "Elderly may respond to lower doses, and toxicity may occur earlier in treatment," said Dr. Cremens. "Pharmacokinetic changes in elderly can increase the time to reach steady state concentrations and possibly prolong clearance."

Hepatic function, renal clearance, and absorption may also be reduced in elderly patients, and increased distribution resulting from a higher fat-to-lean body mass ratio contributes to higher concentration of drug-to-dose ratio, she said. The medications prescribed for comorbid medical illness further complicate the treatment process.

When an accurate diagnosis of bipolar disorder is made, treatment selection and dosing should be guided by the tolerability of specific agents. Treatment should not be initiated until a thorough medication/disease history has been taken and the results of baseline clinical and laboratory studies, neurologic examinations, and cognitive assessments have been evaluated.

In the absence of contraindications, lithium is one treatment of choice for bipolar disease in older patients. "Lithium has been prescribed extensively in this population, and many patients have tolerated prolonged use of it; however, the risk of toxicity is greater with the addition of medications . . . such as diuretics, NSAIDs, ACE inhibitors, and others," Dr. Cremens said.

When prescribing lithium to elderly patients, initially target moderate concentration ranges, and gradually increase the dose. Be cognizant of conditions and treatments that might increase the concentration-to-dose ratio. In patients with comorbid brain disease, lithium dosing should be especially conservative, and patients should be watched for worsening of cognitive status, coarse tremor, and hypothyroidism.

In manic elderly patients, the anticonvulsant divalproex sodium can often be used as a first-line mood stabilizer. It's a reasonable alternative for patients who experience cognitive deterioration during lithium treatment. As with lithium, dosing should be conservative and gradually increased. Possible side effects include sedation and gait disturbance, as well as thrombocytopenia. The anticonvulsant carbamazepine is frequently used as second-line therapy for mania, but it carries a greater risk of hematologic toxicity than divalproex sodium, she said.

When initial mood stabilizing treatment is insufficient, adjunctive use of atypical antipsychotic medications has "been widely used for treatment of mania and, more recently, shown to improve symptoms of depression," said Dr. Cremens.

The latter consideration is important, because elderly patients diagnosed with bipolar illness are more often depressed than manic. In fact, "bipolar depression in elderly may have been misdiagnosed for many years as unipolar depression, because manic states may not be recognized," she said.

Aggressive treatment of the acute depressive state in elderly bipolar patients is critical, given the increased risk of suicide in this population, Dr. Cremens said.

Because there are no evidence-based guidelines for treatment duration in this population, maintenance pharmacotherapy or electroconvulsive therapy should be used indefinitely "unless a contraindication arises due to a medical or neurological problem," Dr. Cremens said. ■