Bipolar Elderly Need Careful Treatment

BY DIANA MAHONEY
New England Bureau

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, she 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.

Bipolar depression in the elderly may be misdiagnosed for many years as unipolar depression, because manic states may not be recognized.

"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.

Pharmacodynamic and pharmacokinetic changes in elderly patients alter prescribing patterns. "Elderly may respond to lower doses, and toxicity may occur earlier in treatment," Dr. Cremens said. "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. The medications prescribed for comorbid medical illness further complicate the treatment process.

When an accurate diagnosis of bipolar disorder has been 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 of the treatments 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 frequently prescribed in the elderly, such as diuretics, NSAIDs, ACE inhibitors, and others," Dr. Cremens explained.

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.

Anticonvulsant medications are increasingly being used as a safe and effective alternative to lithium because of their more tolerable side effect profile, she said.

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. Cardiovascular effects can also occur, she said.

When initial mood stabilizing treatment is insufficient, adjunctive treatment with atypical antipsychotic medications may be indicated. "Atypical antipsychotics have been widely used for treatment of mania and, more recently, shown to improve symptoms of depression," Dr. Cremens said.

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."

Aggressive treatment of the acute depressive state in elderly bipolar patients is critical, given the increased risk of suicide in this population. "Elderly are at the highest risk for suicide, which is among the top 10 causes of death in this cohort. And suicide in bipolar illness occurs in 10%-20% of depressed patients," Dr. Cremens said.

For drug-resistant severe depression or acute mania, electroconvulsive therapy has shown therapeutic benefit in some elderly patients. Maintenance pharmacotherapy or electroconvulsive therapy should be used indefinitely unless a medical problem arises, Dr. Cremens said. ■

Home Visits and Phone Follow-Up Improve Depression in Elderly

BY DAMIAN McNAMARA
Miami Bureau

FORT MYERS, FLA. — Home visits and follow-up telephone calls improved elderly depression in a program that used existing community services for seniors in Seattle, according to a presentation at the annual meeting of the Academy of Psychosomatic Medicine.

Rates of depression are higher in older adults who are socially isolated, have comorbid conditions, or are homebound. About one-fifth to one-sixth of elderly individuals in the United States have clinically significant depression. They are more likely to have minor depression or dysthymia, compared with their younger counterparts.

A 12-month, randomized, controlled trial showed the Program to Encourage Active, Rewarding Lives for Seniors (PEARLS) effectively improved depression among older adults at higher risk, specifically those who are physically impaired, socially isolated, and/or of lower socioeconomic status.

"It is home based, so in a way it is a systematized, stylized way to do house calls, but a postmodern version done by social workers, not doctors," Paul Ciechanowski, M.D., explained.

"It's amazing how much extra information you get by observing and visiting patients in their own homes," said Dr. Ciechanowski of the University of Washington, Seattle. The university runs PEARLS in collaboration with Senior Services Seattle/King County, Aging and Disability Services, and Public Health Seattle King County. The study was funded by the Centers for Disease Control and Prevention.

There were 138 participants, 99 referred from agencies and 39 who were self-referred. About half were diagnosed with dysthymia, the other half with minor depression. The mean age was 73 years, 79% were female, and the majority had a mean annual income of less than $10,000. At baseline, 35% were taking antidepressants. People were excluded if they had major depression or another psychiatric disorder, substance abuse, or a cognitive disorder.

After randomization, there were 66 patients in a routine care group and 72 in an intervention group. Routine care included referral and communication between the patient's primary care physician, the community agency social worker, and University of Washington researchers.

The intervention included a mean of 6.6 1-hour problem-solving treatment (PST) sessions in the home over 19 weeks. PST is effective, nonpsychiatric, and consistent with other modern self-management strategies in medical disease, Dr. Ciechanowski said. "We define and break down problems, establish realistic goals, and take small, incremental steps. They begin to feel empowered."

The intervention also included one or more of the following: problem-solving counseling sessions, social activation, physical activity, and/or prescription of antidepressants.

If there was not a 50% improvement in depression scores, it was a red flag. The PEARLS staff would then consult with the patient's primary care physician about initiation or adjustment of medication. "I ended up calling 52 people, mostly providers, about drug therapy and other patient factors," Dr. Ciechanowski said. ■

Black Caregivers of Alzheimer's Patients Less Likely to Be Depressed

BY JOYCE FRIEDEN
Associate Editor, Practice Trends

WASHINGTON — Black women caring for patients with Alzheimer's disease or other dementias are less likely to be depressed than their nonblack counterparts, Betsy Sleath, Ph.D., of the University of North Carolina School of Pharmacy, Chapel Hill, said at the annual meeting of the American Public Health Association.

Dr. Sleath and her associates looked at data from the National Longitudinal Caregiver Study, a survey of informal caregivers of elderly male veterans diagnosed with probable Alzheimer's or dementia. The sample included 608 caregivers with depression, of whom 11% were African Americans. Overall, African Americans constituted 16% of the entire initial sample of more than 2,000 female caregivers.

The mean age of depressed caregivers was 67; 86% had a high school diploma or less.

The researchers found that white caregivers were almost twice as likely as African Americans to have depressive symptoms. "There are different positive reasons for that. Spirituality may play a role, as well as how you perceive something as a burden—African Americans may perceive caregiving differently than whites," Dr. Sleath said. African Americans also were less likely to be using antidepressant and antianxiety medications.

More than 80% of caregivers with depressive symptoms were not on an antidepressant medication, but the caregivers who had more physician visits in the past 6 months were more likely to be taking antidepressants, she said. "In this population, it's probably very difficult for caregivers to go get therapy."

The researchers found that caregivers who had more social support were actually more likely to be using antidepressants. "We find that interesting. Perhaps that's because the support network is telling them, 'Maybe you need to go on an antidepressant,' " she said.

Younger caregivers were more likely to be receiving antidepressants than older caregivers, and although slightly less than half of the caregivers had health insurance that covered prescription drugs, insurance did not seem to have an effect on medication use, she said.

Limitations of the study included using a self-reported mail-in questionnaire and that it did not examine other types of depression treatment. ■

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