Age May Confound Bipolar Dx

Elderly *from page 1*

to demonstrate, because many elderly patients don't have a regular occupational environment or routine.

Mania might present with less of the grandiosity often seen in younger patients and more irritability. "There's more of a dysphoric quality to geriatric mania," Dr. Cheong said. Additionally, disorientation and distractibility might be mistaken for symptoms of dementia instead of mania.

Elderly patients with bipolar disorder also have some special issues with common drug treatments. Lithium in particular has a very narrow therapeutic index in all patients, but this problem is exacerbated in the elderly, who might be taking other medications that can increase or decrease serum lithium levels.

While therapeutic plasma concentrations of lithium are generally quoted as 0.8-1.2 mEq/L for acute mania and 0.6-1.0 mEq/L for maintenance, these ranges are much too high for most geriatric patients. "With geriatrics, I would definitely recommend keeping the range somewhere between 0.3 and 0.6 [mEq/L]," Dr. Cheong said. "Higher than that in the geriatric patient [and you can run into] a lot of trouble with things like tremor, metallic taste, gait ataxia, blurred vision…You really need to titrate according to the symptoms as well as the side effects."

But too low a serum concentration is also risky, because patients with bipolar disorder are more likely to commit suicide in the manic phase than in the depressed phase.

Serum lithium levels can be increased by a host of medications, including ACE inhibitors, cyclooxygenase-2 inhibitors, NSAIDs, furosemide, and thiazides. Similarly, a low-sodium diet, dehydration, and renal disease can increase lithium levels.

Serum lithium levels can be decreased by acetazolamide, aminophylline, caffeine, mannitol, and theophylline.

Carbamazepine is a major alternative to lithium, but it has problems of its own. Dr. Cheong refers to it as a "dirty drug," because it's subject to a lot of drug-drug interactions and many serious side effects.

Serum carbamazepine levels can be increased by cimetidine (Tagamet), fluoxetine, isoniazid, ketoconazole, valproate, verapamil, and macrolides. Carbamazepine can decrease serum levels of alprazolam (Xanax), bupropion, clonazepam (Klonopin), clozapine (Clozaril), haloperidol (Haldol), and olanzapine (Zyprexa). ■

Comparison of Symptom Characteristics

	Alzheimer's Disease	Unipolar Depression	Bipolar Disorder
Cognitive impairment	Present	Possible	Possible
Depressive symptoms	Possible	Likely	Possible
Sleep disruptions	Possible	Possible	Possible
Inappropriate sexual behavior	Possible	Less likely	Possible
Progressive functional and clinical deterioration	Present	Possible	Possible

Source: Dr. Cheong

Skip Meds First in Treating Agitation

BY ROBERT FINN
San Francisco Bureau

SAN FRANCISCO — At least 80% of patients with dementia will experience agitation, Dr. Josepha A. Cheong said at the annual meeting of the American Academy of Clinical Psychiatrists. The temptation, especially at in-patient facilities, is to go immediately to medical management for that agitation.

Before reaching for the prescription pad, however, one should rule out any medical causes for that agitation, and then try nonmedical management, which can be highly effective, said Dr. Cheong of the University of Florida, Gainesville.

In dealing with patients with dementia, Dr. Cheong asks herself how she would deal with this patient if he or she were a 3- to 5-year-old child. "Has there ever been a time when you were raising [toddlers] that you wanted to just pull out that syringe of Haldol?" Dr. Cheong asked. "It would be nice, but that's not what we do. One, it's not socially acceptable. And two, it's not appropriate.

"I really feel much the same way in treating agitation in dementia. A lot of times, there's a tendency to go straight to the meds. And there's nothing wrong with that if what's least restrictive has failed."

Urinary tract infections are one of the most common medical causes of agitation. This has inspired a joke: What's the first-line medication for agitation in an in-patient medical unit? Septra.

Dehydration is another common cause of agitation. "Even if they don't have a urinary tract infection, it's amazing how people will perk up if you just hydrate them a little," Dr. Cheong said.

Anticholinergics and over-the-counter medications can also result in agitation. Ditropan, which is used for urinary incontinence, is one of the biggest offenders, in Dr. Cheong's view. "I always tell patients and their families: 'Look, it's better to be in Depends than to be demented because of Ditropan.' This can make the difference between keeping someone at home and having them in a nursing home in restraints or in an inpatient unit," Dr. Cheong said.

Drug interactions can also cause agitation. The combination of an NSAID and lithium is a frequent culprit. A patient taking lithium might turn to a seemingly innocuous dose of ibuprofen after an especially vigorous golf game, and the next thing you know he's in the emergency room suffering from lithium toxicity.

Once medical causes have been excluded, consider whether the patient has experienced a recent change in environment, which can often result in agitation. Has a beloved pet died recently? Has the care facility's routine changed? Is there a new nurse on the ward?

Consider also whether the patient's agitation comes at a certain time of the day, or with certain activities. Shower time often precipitates agitation. One solution is simply not to insist that patients shower daily. Elderly patients often do fine showering or bathing just twice a week, and this has the extra benefit of preventing their skin from drying out.

Another tip is to enter the reality of the patient. People who work in geriatric units are used to seeing patients waiting every morning by the front door for the bus to take them to work. The patient is likely to become upset if told he or she has been retired for 20 years. Instead, it might be better to say, "Why don't you come sit down and have some breakfast while you're waiting?"

Overstimulation and understimulation should both be avoided. The change-of-shift chaos in many in-patient units can be highly disturbing to patients. This might be a good time to have patients away from the chaos in a quiet day room with soothing music. On the other hand, lack of activities and boredom can lead to restless behavior and attempts to escape. Studies show that simply adding a recreational therapist to a nursing-home setting can decrease the amount of agitation that patients experience.

Keep the patients' choices simple. Three choices of salad dressing and four choices of entrées at meals may be confusing to the patient; it's better to provide a single offering. And, just like toddlers, patients with dementia do best with finger foods.

Everyone needs attention, intimacy, and affection. The lack of that human connection can lead to agitation and impulsive sexual behavior. Soothing rituals such as massage or even hair brushing can go a long way to calming the agitated patient.

Psychiatrists may have difficulty getting paid for nonmedical treatment of agitated patients, because Medicare may regard it as psychotherapy, and psychotherapy is not indicated for patients with dementia. Dr. Cheong's tip is to code the treatment as being for behavioral and psychotic symptoms of dementia. ■

Episodic Nature Key to Dx Of Seizures in Older Adults

BY KERRI WACHTER
Senior Writer

SAN JUAN, P.R. — Seizures in older adults have a different presentation than they do in younger patients, with these events resembling many other conditions and making diagnosis difficult, but there are a few keys that can help make the right diagnosis, said one expert speaking at the annual meeting of the American Association for Geriatric Psychiatry.

Seizures in older adults often are a byproduct of stroke and/or hemorrhage, said Dr. Joseph I. Sirven, of the department of neurology at the Mayo Clinic in Phoenix, who spoke from anecdotal experience. In addition, neurodegenerative conditions, such as dementia, also cause problems that lead to seizures.

In general, partial seizures are most commonly seen in older adults because there is a specific area of injury or damage involved, said Dr. Sirven. In older adults, the foci of seizures usually occur in the frontal or parietal lobes.

"We also know that simple partial seizures, in which there is not a loss of consciousness, tend to have more focal and/or sensory symptoms [such as] tremor or a sense of numbness," said Dr. Sirven. Auras—primarily dizziness—may also be present. Complex partial seizures often present with altered mental activity, staring, blackouts, and confusion.

Diagnosing seizures in older adults is difficult because the presentation can resemble so many other conditions. "The differential mirrors almost everything else," said Dr. Sirven, including syncope, transient ischemic attack, transient global amnesia, vertigo, and delirium.

The key to seizure recognition is episodic frequency of symptoms that are stereotypic. In particular, episodes may present with loss of consciousness, dizziness, confusion, or language change. "If you see transient episodes of certain behaviors that are stereotypic, the first test really is the EEG," said Dr. Sirven. Other diagnostic tests to consider include MRI, laboratory tests, cardiovascular testing, ambulatory EKG, and tilt table testing.

Seizure medication should be considered only if the seizures are truly impacting the patient's quality of life. "Why I'm making a big deal about it is that the moment you start someone on seizure medication … you've branded that person and no one down the road is going to stop that medication," said Dr. Sirven.

Dr. Sirven listed the following three main points to consider when deciding on a seizure medication for an elderly patient:

► **Efficacy.** Try to use monotherapy whenever possible. Choose a medication that is appropriate for the seizure type. If the seizure type is unspecified, choose a broad-spectrum agent.

► **Safety and tolerability.** First minimize drug interactions. In addition, choose a drug with a favorable safety profile that minimizes the inhibition of cognitive function and has a minimal effect on gait, balance, and orthostatic blood pressure.

► **Simplification.** Once-daily dosing helps with patient compliance. Choose a drug with a quick onset of action. Reduce interacting drugs, especially psychoactive ones. ■