Aging with Bipolar Disorder

Neha Jain, MD, FAPA
Assistant Professor of Psychiatry, UConn Health
Objectives

- Define bipolar disorder in the elderly
- Review comorbidities
- How does it differ from bipolar in the young?
- Course and prognosis
- Treatment
“Over the hill, but still above the ground!”

- Age: 66
- Medical Comorbidities
- Chronic mental illness
- Occupational disability
- Cognitive impairment
- Side effects
Bipolar Disorder: Definition

- Mood disorder with alternating depression and mania
- Depression- MDE
- Mania: 4-7 days
- Mixed episodes
Bipolar Depression

- Depression, fatigue, guilt
- Increased sleep and appetite
- More frequent than mania
- Earlier onset than unipolar depression
- Psychosis/Catatonia
Bipolar mania

- Mood - euphoric, irritable
- Distractibility, increased activity
- Decreased need for sleep
- Grandiosity
- Pressured speech, racing thoughts
- Impulsive, risky behaviors
Life cycle of bipolar disorder

- Euthymia
- Mania
- Subsyndromal depression
- Depression
- Hypomania
- Depression
Subtypes

- Bipolar I disorder
- Bipolar II disorder
- Cyclothymia
- Other unspecified Bipolar disorders
Four Presentations

• Early-onset bipolar d/o, now in old age
• Previously only had depression but now manic
• Never had mood disorder but now manic due to medical event
• Those who misdiagnosed
Case- early onset bipolar

- Mr. J, retired and disabled
- Multiple episodes of depression and mania
- Partially compliant
- Alcohol use disorder
- Long term care
- Frequent hospital visits
Case- late onset bipolar

- Mrs. M, part time librarian
- H/o depression and anxiety
- Sudden mania, with increased spending, risky behaviors
- Hospitalized, released
- Flight!
- Arrested and recommitted in Florida
Medical causes of mania

- Right sided CNS lesion
- Seizures
- Hyperthyroidism
- Phaeochromocytoma
- Lupus
- Multiple Sclerosis
Medications that may cause mania

- Steroids
- Bronchodilators
- Amphetamines, cocaine
- Dopamine agonists
- Antidepressants
Epidemiology

• Lifetime prevalence 4%
• Equal prevalence in men and women
• Less common in the elderly
• Community prevalence ~0.08-0.5%
• Hospitals, long term care 4.7-18.5%
• Outpatient clinics 2-25%
Comorbidities - psychiatric

- 9.4% anxiety d/o
- 5.4% PTSD
- 9%-29% Substance abuse; lower than younger samples
- 70% personality d/o(?)
Comorbidities - medical

- Neurological illness 36% among manic patients (vs. 8% in depressed patients)
- Hypertension 45%-68%
- Type 2 DM 18%-31%
- COPD 4%-12%
Mortality

- 50% if manic and 20% if unipolar at 10-15 year follow up after discharge
- Mortality ratios 2.5 for men and 2.7 for women compared with the general population
- Cardiovascular disorder, suicide and cancer
Bipolar Disorder and dementia

- 3-25% inpatient
- Deficits in executive function, verbal memory, information processing
- Lithium may be neuroprotective
- Persistent
Course of late life Bipolar disorder

- May be long latency period between index depressive episode and mania
- 10-20 years
- Aging brain leads to conversion to mania
Symptoms in late life Bipolar

- More mixed than classic mania
- Rapid cycling patterns
- Lower risk of suicide
- Longer hospitalizations
- Slower resolution of symptoms
- Lower global functioning
Age of Onset

- Early Onset
  - Family history
  - Less likely to have remission
  - More substance abuse, childhood behavior d/o, paranoid ideation

- Late Onset
  - In women, may be correlated with menopause
  - In men, increased incidence of mania in old age
  - Neurological abnormalities
  - Family history less common, but 4-22% affective illness
Neurocognitive Deficits

- Substantial neurocognitive impairment
- Deficits related to quality of life
- No difference in global measurements in unipolar and bipolar depression
- Impaired processing speed and episodic memory
- Stable over 2 years
Imaging

- Increased subcortical/limbic activity
- Decreased activity in regulatory regions
- Brain atrophy?
- Larger hippocampus volumes
MRI brain

- Increased white matter hyperintensities
- Longer hospital stays
- Rehospitalizations
- Less reduction in manic symptoms
- Cognitive changes
Treatment of Late Life Bipolar Disorder

- Mood Stabilizers
- Antidepressants
- Antipsychotics
- Electroconvulsive Therapy (ECT)
Lithium

- ~66% improve
- May respond at lower levels
- Reduced clearance in the elderly
- Dehydration common is dangerous
- Drug interactions
- Cognitive impairment
- Ataxia, edema, tremor
- Urinary frequency
Valproate

- Most prescribed
- Helpful to have multiple formulations
- Reported level may underrepresent actual dose available!
- Nausea, somnolence, weight gain
- Hair thinning
- Hepatotoxicity, pancreatitis (less likely!)
Carbamazepine

- Little known about use in elderly
- Clearance decreases with age
- Sedation
- Ataxia
- Nystagmus/blurred vision
- Hyponatremia
- Agranulocytosis
Lamotrigine

- Delays time to intervention
- Well-tolerated
- No increased risk of rash in elderly
- Fewer negative effects on cognition
Neurocognitive affects of psychotropic treatment

<table>
<thead>
<tr>
<th>Neurocognitive findings</th>
<th>Psychotropic treatment effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive findings</td>
<td>Executive dysfunction, impaired verbal memory, slowed information processing speed</td>
</tr>
<tr>
<td>Brain (neuroimaging) findings</td>
<td>Increased occurrence of white matter hyperintensities, enlarged lateral ventricles, decreased regional white matter</td>
</tr>
<tr>
<td>Effects of psychotropic treatment on cognition and brain integrity</td>
<td>Short term: GABA-ergic medications (e.g., divalproex sodium or benzodiazepines) are associated with acute cognitive blunting; glutamatergic medications (e.g., lamotrigine) are associated with acute cognitive sparing; medications with higher serum anticholinergicity more negatively impact cognitive function.</td>
</tr>
<tr>
<td></td>
<td>Long term: lithium is related to an increase in total gray matter and hippocampal volume as well as decreased white matter microstructural abnormalities. Antipsychotic medications have mixed effects on brain integrity</td>
</tr>
</tbody>
</table>

- Sajatovic et al., Neuropsychiatry (2014)
Antidepressants

- No specific studies in the elderly
- Tricyclic antidepressants more likely than other medications to induce mania
- SSRIs may be preferable
- Primary treatment should be mood stabilizer
Antipsychotics

- Limited data
- Approved for maintenance:
  - Olanzapine, Aripiprazole, Risperidone (Consta)
- Approved for acute depression:
  - Olanzapine-fluoxetine, Quetiapine, Lurasidone
- Approved for acute mania:
  - Olanzapine, Risperidone, Quetiapine, Ziprasidone, Aripiprazole
ECT

- Limited data in elderly
- Case series of patients who resisted pharmacotherapy but responded to ECT for mania
- May also be helpful for bipolar depression
  - Cognitive side effects
Psychotherapy

- Cognitive behavioral therapy (CBT)
- Family-focused therapy
- Interpersonal and social rhythm therapy
- Psychoeducation
Considerations for best practices

- Self management for behavior change
- Life charting, regular schedule, compliance
- Peer support, family support
- Care setting- collaborative model
Key Points

- Bipolar disorder remains a frequent cause of late life morbidity
- Higher mortality rate compared to general population and those with unipolar depression
- Later onset associated with fewer genetic associations and more neurological illnesses
- Cognitive impairment is common.
- Comorbidities must be treated as early as possible.
- Preventing mood relapses is key.
- “Start low, go slow.”
Resources

• bphope.com

• ibpf.org

• dbsalliance.org

• http://www.nimh.nih.gov

• www.nami.org

• An Unquiet Mind- Kay Jamison, PhD