Bipolar disorder in the elderly

Daniel Smith
Professor of Psychiatry
Is bipolar disorder in the elderly different from bipolar disorder in younger age groups?
What works for bipolar disorder:

1. Early and accurate diagnosis
2. Expert pharmacotherapy
3. Psychoeducation and self-management
Trimodal age-at-onset of mania:

Largest group: early-mid 20’s
Intermediate group: early 40’s
Smallest group: mid-late 50’s
Trimodal age-at-onset of mania:

- Largest group: early-mid 20’s
- Intermediate group: early 40’s
- Smallest group: mid-late 50’s

Older people with bipolar disorder are heterogeneous:

- Most will have an onset of illness in early adulthood
- Some have developed bipolar disorder later in life (10%)
- A minority develop mania secondary to medical disorder, eg, steroids, endocrine disease, cerebrovascular disease
What works for bipolar disorder:

1. Early and accurate diagnosis
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Why bipolar disorder requires expert prescribing:

1. Complex disorder dominated by depression, not mania
2. Full inter-episode recovery does not occur for many patients
3. Risk of suicide is at least 8%; premature mortality of 10-15 years
4. Multiple comorbidities are the norm (eg, anxiety disorders, alcohol misuse, obesity and cardiovascular disease)
5. Patients will tend to self-medicate and ‘titrate’ their medication
Why bipolar disorder requires expert prescribing:

6. Special considerations for lithium and valproate

7. Combination mood stabilisers are often required (and may be desirable) but require expert supervision

8. Antidepressants are often overused and may be unhelpful

9. As prescribers we need to address potential adverse health outcomes of psychototropic medications
Evidence-based guidelines for treating bipolar disorder: Revised third edition recommendations from the British Association for Psychopharmacology

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Topic: Bipolar Disorder
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Assessment and management of bipolar disorder: summary of updated NICE guidance

Tim Kendall director, consultant psychiatrist, Richard Morrise professor of psychiatry and community mental health, Evan Mayo-Wilson assistant scientist, Elena Marcus research assistant, on behalf of the Guideline Development Group
Key NICE recommendations:

• **Primary care:**
  – Assess all depressed patients for past manic symptoms
  – Four or more days of manic symptoms: refer
  – Monitor physical health, at least annually
Key NICE recommendations:

• Secondary care: **mania**
  – Offer **haloperidol, olanzapine, quetiapine or risperidone**
  – If already on **lithium**: optimise dose and consider adding haloperidol, olanzapine, quetiapine or risperidone
  – If on an antidepressant: stop it and offer an antipsychotic
Key NICE recommendations:

- Secondary care: **bipolar depression**
  - Offer quetiapine or ‘olanzapine+fluoxetine’ combo
  - If preferable, offer **olanzapine or lamotrigine**
  - If already on **lithium**: optimise dose and consider adding quetiapine or ‘olanzapine+fluoxetine’
  - If preferable, add olanzapine or lamotrigine to lithium
  - If no response, add lamotrigine to lithium
  - Offer a psychological intervention with a published evidence-based manual or CBT/IPT
Key NICE recommendations:

- **Secondary care:** long-term management
  - Education of patient and carers
  - Offer structured psychological intervention (individual, group or family) to prevent relapse
  - **Explain that lithium is the most effective long-term treatment for bipolar disorder**
  - If lithium is ineffective, add valproate (though not for women of child-bearing potential)
  - If lithium not suitable, consider valproate, olanzapine or quetiapine
  - Treat ‘rapid-cycling’ as above
What works for bipolar disorder:

1. Early and accurate diagnosis

2. Expert pharmacotherapy

3. Psychoeducation and self-management
Barcelona Group Psychoeducation Programme
Psychoeducation for relapse prevention in bipolar disorder: a systematic review of efficacy in randomized controlled trials

Bond K, Anderson IM. Psychoeducation for relapse prevention in

Kirsten Bonda and Ian M Andersonb
Preventing manic relapse:  
Group effective  
Individual not effective

Preventing depressive relapse:  
Group effective  
Individual not effective

Preventing any relapse:  
Group effective  
Individual not effective
# Module:

**Introduction to group psychoeducation**

- **What is bipolar disorder?**
- **What causes bipolar disorder?**
- **Lifestyle**
- **Monitoring mood and identifying triggers**
  - Early warning signature
- **Medication**
- **Psychological approaches**
- **Partners, families and carers**
- **Bringing it all together**

2 facilitators
10 sessions
Each session 2 hours:

- **Information**
- **Exercises**
- **Discussion**
Is bipolar disorder in the elderly different from bipolar disorder in younger age groups?
Review Article

A report on older-age bipolar disorder from the International Society for Bipolar Disorders Task Force
‘Late-onset’ bipolar disorder*:

- Females > males
- Less likely to have a family history of bipolar disorder
- More cardiovascular disease and risk factors
- Depressive symptom load > manic symptom load
- Less psychosis than younger-onset
- More cognitive impairment

*First manic or hypomanic episode after age 50
Bipolar disorder in older populations - special considerations:

1. Cognitive dysfunction

2. More extensive medical comorbidity (multimorbidity)

3. Prescribing issues, eg, lithium therapy
Cognitive dysfunction

- **Neuroimaging studies**
  - Very limited prospective work on older bipolar subjects
  - Structural MRI studies: grey matter reduction (esp. frontal)
  - DTI studies: reduced white matter diffusivity in the orbitomedial prefrontal cortex
  - No clear evidence of ‘neuroprogression’ (progressive functional and cognitive decline)

- **Neuropsychological assessment**
  - Quality of data is poor: cognitive impairment in multiple domains does not appear to be progressive
  - Some evidence of increased risk of developing dementia, possibly reduced by lithium therapy
Physical health in older people with bipolar disorder:

- Majority have at least three medical comorbidities:
  - Hypertension (45-69%)
  - Diabetes (18-31%)
  - Cardiovascular disease (9-49%)
  - Respiratory illness (4-15%)
  - Arthritis (16-21%)
  - Endocrine abnormalities (17-22%)

- ‘Healthy survivor’ cohort issue

- Modifiable risk factors can and should be addressed
Physical health in older people with bipolar disorder:

- Annual physical health screen:
  - Weight and height for BMI
  - Blood pressure
  - Lipids
  - Fasting glucose
  - Renal function
  - Thyroid function
  - Hepatic function
  - Calcium concentration (if taking lithium)
Prescribing issues:

• Only one large-scale, prospective, controlled pharmacological studies have yet been conducted in ‘old age bipolar disorder’ (GERI-BD Study, 2017)

• Guidance on prescribing is extrapolated from studies of younger cohorts

• More susceptible to adverse reactions:
  – Increased end-organ sensitivity, impaired circulation, reduced hepatic and renal clearance

• Treatment doses are lower (in general)

• Lithium is effective and safe, as long as it is monitored correctly
GERI-BD Trial: Lithium versus divalproex for mania in older patients with bipolar disorder

- Patients with mania aged 60 or over
- N=224 randomised to lithium or divalproex for 9 weeks
- If inadequate response after 3 weeks, risperidone added
- Attrition rates were similar for lithium and divalproex
- Rates of sedation similar, low use of risperidone both groups
- More tremor in lithium group
- Both lithium and divalproex were efficacious but lithium associated with a greater reduction in mania scores

What we don’t know:

• Is late-onset bipolar disorder a unique sub-type?
• Is bipolar disorder an independent risk factor for dementia?
• Does bipolar disorder ‘burn out’ in older age?
• To what extent does vascular disease impact on outcomes?
• Is the therapeutic range for lithium different than for younger patients?
• Does lithium protect against cognitive decline?
• How effective are psychosocial interventions for older patients?
Thank you

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