

The information in this column is not intended as a definitive treatment strategy but as a suggested approach for clinicians treating patients with similar histories. Individual cases may vary and should be evaluated carefully before treatment is provided. The patient described in this column is a composite with characteristics of several real patients.

Prophylaxis and treatment of bipolar disorder in older adults

A 82-year-old man with bipolar disorder had been successfully treated with lithium (Li).¹ Renal failure is uncommon with long-term Li treatment (0.5%–1.2% on Li > 15 yr); however, during a 10-year period of stable mood, chronic renal disease (glomerular filtration rate [GFR] ~30 mL/min/1.73m²) developed, and the patient's physician recommended he discontinue Li.^{2,3} The dilemma was whether he should start an alternative, unproven treatment.

He first presented with a manic episode at age 23. Past treatment included antipsychotic medication during manic episodes. Multiple clusters of episodes were separated by periods of 10–15 years with relative clinical stability. The most recent relapse occurred 10 years earlier, and since then his mood had been euthymic. Given his deteriorating renal function, we discontinued Li (slowly to minimize the risk of manic relapse); however, within a month, the patient experienced a manic relapse.

In addition to Li, valproate and olanzapine can be used to treat bipolar disorder in adults,⁴ although Li as monotherapy or combined with valproate is more effective than valproate alone.⁵ After his relapse, we introduced valproate because of potential antipsychotic side-effects in this age group, particularly in those with cognitive changes (common in bipolar disorder).⁶ Next, we added olanzapine, but despite dual therapy, he did not improve. He experienced disorganized behaviour, pressure of speech and flight of ideas, and was admitted to our psychiatry intensive care unit (PICU). The PICU staff suspected organic confusion; however physical examination and assessment excluded organic con-

fusion, and his aggression and suitability for PICU care was demonstrated when he broke a staff member's arm.

During admission, his renal function remained severely impaired so we persisted with alternative treatments, including other antipsychotics with which he experienced side-effects at low doses. There is little evidence to support the use of alternative mood-stabilizing or antipsychotic agents in older adults with bipolar disorder, although valproate, carbamazepine, newer antipsychotics and lamotrigine have some evidence for efficacy.^{7,8} Carbamazepine can be used as second-line treatment for manic episodes (requires caution for hematologic toxicity and drug interactions).⁸ In older adults, quetiapine can lead a sustained reduction in manic symptoms on the fourth day of treatment.⁹ Aripiprazole may also reduce bipolar symptoms in older adults.¹⁰ Lamotrigine may be most effective in prevention of bipolar depression rather than mania.^{8,11,12}

The patient spent 1 year in the inpatient unit while medications were tried systematically, as described. His level of arousal and hyperactivity could be reduced, but his mental state remained distractible, euphoric and easily roused to anger. Electroconvulsive therapy had short-lasting effects, but we thought he would not tolerate maintenance treatment, as he never completely recovered, complained of poor memory and was too frail to tolerate multiple repeat general anesthetics. After 1 year off Li, mostly as an inpatient, his treatment plan was reviewed between his family, his renal physician and psychiatrist. His renal function had improved by 20 mL/min/1.73m², so we risked reintroducing Li, knowing that his renal function would deteriorate again. Judging from his previous annual de-

cline, this would have given him another 5 years of renal function above his previous lowest GFR level. Following the reintroduction of Li, he showed dramatic clinical improvement. Six months after discharge he had fully recovered.

This case represents the common dilemma of treating severe and enduring mental illness with medication that has side-effects affecting physical health. It illustrates the potential problems of changing medication, which can lead to relapse of serious mental illness. There is a risk that failing to review or change medication may leave patients with serious and sometimes life-threatening physical side-effects. Without a straightforward solution, changing medication is likely worth the risk when there is evidence that alternative treatments may be effective. In addition to illustrating the potential risks for individual patients and the need to discuss these openly, this case also highlights the relative lack of evidence on which to base complex decisions about psychiatric care for older adults.

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