Pharmacological Management of the Geriatric Psychiatric Patient

Presented to the 26th Annual Conference of Texas Nurse Practitioners
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Objectives

• Describe the common medications used in geriatric psychiatry including clinical use and adverse side effects.
• State black box warnings for drugs used in geriatric psychiatry.
• Identify special considerations for common medications used in geriatric psychiatry.

Main Diagnosis

• Depression
• Mania
• Anxiety
• Psychosis
• Dementia and BPSD
Depression is not normal aging

• 1% - 5% of those living in the community

• 11.5% in hospitalized older adults

• 13.5% in older adults requiring home healthcare

Depression

• This is very common in seniors
  – Depressed mood OR lack of emotions
  – Change in appetite and sleep patterns
  – Loss of energy
  – Prolonged sadness/unexplained crying spells OR irritability and fearfulness
  – Increased feeling of worry and anxiety
  – Feelings of guilt and hopelessness
  – Inability to concentrate and make decisions
  – Social withdrawal
  – Unexplained aches and pains
  – Use of ETOH
  – Either a diurnal pattern or multiple fluctuations in a single day

Depression Assessment

Clinical interview – family history? Successful treatment?

Objective testing:
  • Geriatric Depression Scale

Always ask if a person is suicidal and take it seriously. They may need to be hospitalized.

Try to eliminate contributing medical cause if possible.
Treatment of Depression

• Non medication interventions:
  – Psychotherapy: important even with medication!!
  – Exercise and diet
  – Increased socialization
  – Education about depression

Treatment for Depression

Excellent resource:
Texas Implementation of Medication Algorithms
Guidelines for Treating Major Depressive Disorder

Treatments for Depression

• First line:
  SSRI (Selective Serotonin Reuptake Inhibitor)
    Examples are Prozac, Zoloft, Celexa, Lexapro, Viibryd
  SNRI (Serotonin-norepinephrine reuptake inhibitors)
    Examples are Cymbalta and Effexor
  Remeron
  Wellbutrin (increases norepinephrine)
Treatments for Depression

A few pearls

- Partial response to antidepressant Augment with another antidepressant. For example if started with Zoloft, can add Wellbutrin for energy. Add Mirtazapine if the patient is not eating.

  For pain: Cymbalta is worth a try. It can be very helpful to reduce neurogenic pain with a reduction in depressive symptoms. Also works well if Mirtazapine is added to assist with sleep, appetite, anxiety.

  Effexor can reduce depression and with dosages above 150mg increase energy.

  Folks who do well on Prozac may have problems switching to something else if they have been on the Prozac for the long-term. Augmentation with another medication may be helpful.

Treatment for Depression

4-6 week for treatment response

If not effective at all by week 4 it may be time to taper down the medication and start another antidepressant. There is no reason to augment if it is not effective.

Cross taper by adding the new medication and tapering the old medication at the same time.

With seniors, start low and go slow. If there are no adverse reactions or side effects, dosage increases can be more rapid.

Black Box Warning

- Frequent follow-up is crucial. There is an increased risk of suicide when starting these medications. A very depressed person may not have the energy to commit suicide. A less depressed person may have more energy to do it.

Increased risk of suicidality in children, adolescents, and young adults but risk goes down for > 65 yrs of age.
Side Effects of Antidepressants

- Sedation
- **Low sodium**
- Insomnia
- Dizziness
- Stomach difficulties
- Sexual dysfunction
- Orthostatic hypotension
- Cardiac conduction problems (Trazodone)
- Increased falls

Treatment for Depression
When is an antipsychotic appropriate?

- Low dose antipsychotics may augment antidepressants when the patient continues to be depressed in spite of alternative medications.
- Use carefully due to side effects.
- There is an increased risk of CVA/Cardiac events in persons with dementia.

Transcranial Magnetic Stimulation

- Repetitive pulses of magnetic energy that stimulate the nerves to fire.
- Deep Brain TMS
- No long term side effects or systemic effects
- Is covered by Medicare
This is the Perfect Time to Talk about Polypharmacy

- There is an increased risk of adverse drug interactions and adverse drug reactions with multiple medication.
  - 40% of seniors take 5 or more drugs in one week
  - 12% of seniors take 10 or more drugs per week
  - 27% of adverse drug events in primary care and 42% in long-term care were preventable
  - $7.2 billion cost of inappropriate medications

### Potentially Inappropriate Medication Use

<table>
<thead>
<tr>
<th>Medication</th>
<th>Rationale</th>
<th>Recommendation</th>
<th>Quality of Evidence</th>
<th>Strength of Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticholinergics: Diphenhydramine</td>
<td>Clearance reduced; risk for confusion</td>
<td>Avoid</td>
<td>Moderate</td>
<td>Strong</td>
</tr>
<tr>
<td>TCAs; amitriptyline; Doxepin</td>
<td>Highly anticholinergic, orthostatic hypotension</td>
<td>Avoid</td>
<td>High</td>
<td>Strong</td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>Increased risk of cerebrovascular accident and mortality in persons with dementia</td>
<td>Avoid use for behavioral problems unless nonpharmacological options have failed - threat</td>
<td>Moderate</td>
<td>Strong</td>
</tr>
<tr>
<td>Thioridazine</td>
<td>Highly anticholinergic, risk of QT interval prolongation</td>
<td>Avoid</td>
<td>Moderate</td>
<td>Strong</td>
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</table>

### PIM’s Continued

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<tr>
<th>Medication</th>
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<td>Benzodiazepines</td>
<td>Increased sensitivity, slower metabolism, increased risk for cognitive impairment, delirium, falls, fractures</td>
<td>May be appropriate for REM sleep disorder, Severe generalized anxiety</td>
<td>High</td>
<td>Strong</td>
</tr>
<tr>
<td>Nonbenzodiazepine hypnotics</td>
<td>AL’s similar to Benz; minimal improvement in sleep latency and duration</td>
<td>Avoid chronic use &gt; 90 days</td>
<td>Moderate</td>
<td>Strong</td>
</tr>
</tbody>
</table>

### PIM’s = Exacerbation

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<thead>
<tr>
<th>Disease/Syndrome</th>
<th>Drug(s)</th>
<th>Rationale</th>
<th>Recommendation</th>
<th>Evidence/Strength</th>
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<tr>
<td>Syncope</td>
<td>AChEI’s; TCA’s; clonazepam</td>
<td>Orthostatic hypotension or bradycardia</td>
<td>Avoid</td>
<td>Moderate/strong for AChEI and TCA, weak for antipsychotics</td>
</tr>
<tr>
<td>Chronic Seizures</td>
<td>Bupropion, clonazepam, thioridazine, Tramadol</td>
<td>Lowers seizure threshold, may be OK in well-controlled patients</td>
<td>Avoid</td>
<td>Moderate/Strong</td>
</tr>
<tr>
<td>Delirium</td>
<td>TCA’s, anticholinergics, sedative hypnotics, thioridazine</td>
<td>Worsening of delirium</td>
<td>Avoid</td>
<td>Moderate/Strong</td>
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<td>Dementia</td>
<td>anticholinergics, benzodiazepines, zolpidem, antipsychotics</td>
<td>Adverse CNS effects, CVA risk</td>
<td>Avoid</td>
<td>High/Strong</td>
</tr>
<tr>
<td>Hx of falls and fractures</td>
<td>anticonvulsants, antipsychotics, benzodiazepines, nonbenzodiazepine hypnotics, TCA's and SSRI</td>
<td>Ataxia, impaired psychomotor function, syncope, additional falls</td>
<td>Avoid unless safer alternatives are not available</td>
<td>High/Strong</td>
</tr>
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### Mania

**Causes of Mania**
- Illness
- Delirium
- Medications

**Bipolar 1 or Bipolar 2**

- Usually diagnosed in the teens or early 20’s
- Occasionally never diagnosed or treated
- History is critical in initial evaluation
- Look for highs and lows
- Bipolar 1 extreme highs and lows with disruptions in life
- Bipolar 2 less intense mood swings

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Mania

• Symptoms of Mania
  – Excessive happiness, hopefulness, excitement
  – Sudden changes from being joyful to irritable
  – Restlessness, increased energy, less sleep
  – Rapid, pressured speech, talkative
  – Racing thoughts
  – Easily distracted
  – High sex drive (even in seniors)
  – Tendency to make grand plans
  – Poor judgment
  – Inflated self esteem
  – Increased reckless behavior

Mania-treatment

Texas Medication Algorithm Project
Bipolar Disorder Algorithms

Medication management is a must!!

Due to risk of adverse reactions with atypical antipsychotics in seniors, start with Depakote or Lamictal. Add an antipsychotic if necessary. Must always look at risk vs benefit.

Treatment for Mania

• Medications that are FDA approved for Bipolar treatment:
  Valproate
  Carbamazepine ER
  Lamictal
  Lithium
  Abilify
  Geodon
  Risperdal
  Seroquel: only med approved for bipolar depression
  Thorazine
  Zyprexa
  Symbyax (Prozac and Zyprexa)
Treatment for Mania

- May take 4-6 weeks for treatment to be effective
- There is an increased risk of suicide with mood swings. A person can crash into a depressive episode quickly.
- Frequent monitoring is a must; patients need to come to the office.
- Depakote, Lithium, and Carbamazepine require lab monitoring.
- Antidepressants may increase the risk of mania in bipolar patients.

Anxiety

- Common symptoms
  - Fearfulness
  - Difficulty thinking, speaking, forming thoughts
  - Persistent, excessive, and unrealistic worry
  - May have physical problems such as dizziness, weakness, poor appetite, excessive appetite, restlessness
  - May have panic attacks

Treatment for Anxiety

Talk therapy:

Cognitive-behavior therapy: helps to identify and challenge the negative thinking patterns

Exposure therapy: Confront fears in a safe, controlled environment
Treatment for Anxiety

- Medications
  - Antidepressants: SSRI, Remeron, SNRI
  - Benzodiazepines:
    - Ativan, Xanax are short acting
    - Clonazepam and Valium are longer acting
    - In seniors watch for gait disturbance, delirium, psychosis, increased depressive symptoms.
    - Cannot be stopped. Must be tapered to prevent discontinuation syndrome
  - Buspar:
    - Sometimes it works, sometimes it doesn’t. May take a few weeks to be effective.

Psychosis

Symptoms of psychosis

- Delusions: false beliefs
- Hallucinations: visual, auditory, olfactory (less common)
- Paranoia
- Catatonia
  - Diagnostic criteria for delusional disorder, brief psychotic disorder, schizophrenia and common in dementia patients
  - Can also occur in response to illness, medications, infections, lack of sleep, anesthesia, change of location

Treatment of psychosis

- If possible, remove stimulus that is causing psychosis
- Sometimes psychotherapy can be useful, but often it is not effective until symptoms are under better control
- It may take 4-6 weeks for medications to be effective

- Medication management
  - Atypical antipsychotics
    - Risperidone: helpful for agitation
    - Ability helpful for depression, works with small doses
    - Seroquel: causes weight gain
    - Abilify: can be helpful for anxiety and sleep
    - Zyprexa: causes weight gain
    - Geodon
    - Latuda
    - Fanapt
    - Haldol
Major side effects of Antipsychotics

• Again, start low and go slow. Small doses can go a long way with seniors.
  – Watch for gait disturbance!!
  – Watch for sedation!!!
  – Dry mouth
  – Tremors
  – Confusion
  – Weight gain
  – Urinary retention
  – EPS
  – Tardive dyskinesia
  – Increased risk of Diabetes does not occur as often in seniors
  – Hyperlipidemia,
  – Prolongation of QTc interval especially with Geodon
  – Sexual side effects (yes it matters with seniors)

Antipsychotics with Dementia Patients

Black Box Warning

Mortality Risk in elderly dementia patients on conventional or atypical antipsychotics; most deaths due to cardiovascular or infections events

Antipsychotics in Seniors

• Be sure to inform patients and/or significant others of the increased risk of adverse events with antipsychotics and possible adverse side effects.
• Give medication enough time to be effective
• Again look at risk vs benefits
Dementia and BPSD

- Group of diseases that cause permanent decline in cognitive function
- Biological processes within the brain damage brain cells
- Behavioral and psychological symptoms are common sequelae

Major Neurocognitive Disorders

- Evidence of significant cognitive decline from a previous level of performance in one or more cognitive domains (complex attention, executive function, learning and memory, language, perceptual – motor, or social cognition)
  - Concern by individual or knowledgeable informant,
  - A substantial impairment in cognitive performance preferably documented
- The cognitive deficits interfere with independence of everyday activities
- The deficits do not occur exclusively in the context of delirium
- The deficits are not better explained by another mental disorder
  
  DSM-5, 2013

Probable Alzheimer's Disease

- DSM-5

  A. Meets criteria for major or mild neurocognitive disorder
  B. There is insidious onset and gradual progression of impairment in one or more domains
  C. Memory and learning + at least one other domain; steadily progresses; no evidence of mix
Treatments for AD

• Best to start treatment early!!!
• For some patients, they get somewhat better. For some there is a slowing of their decline. For some there is no change.
• Acetylcholinesterase inhibitors (AChE's) including Donepezil (Aricept), Galantamine(Razadyne), and Exelon (Rivastigmine)
• Namenda for moderate and severe dementia
• Cerefolin –B12, formulation increases the absorption

Lewy Body Dementia

• DSM-5
C. Disorder meets core diagnostic features:
  • Core diagnostic features:
    1. Fluctuating cognition with pronounced variations in attention and alertness
    2. Recurrent visual hallucinations that are well formed and detailed.
    3. Spontaneous features of parkinsonism, with onset subsequent to the development of cognitive decline
  • Suggestive diagnostic features
    1. Meets criteria for REM sleep disorder
    2. Sever neuroleptic sensitivity

Treatment for Lewy Body Dementia

• Acetylcholinesterase inhibitors and Namenda are used to treat symptoms of cognitive decline and are also helpful with behavioral problems.
• Non-medication interventions are best to try for behavioral symptoms before psychiatric medications are used.
• Consult a geriatric psychiatrist or neurologist for further care.
Frontotemporal Lobe Dementia

- Group of related conditions resulting from the progressive degeneration of the temporal and frontal lobes of the brain.
- Usually first appears in mid-40's-early 60's
- Behavior variant and language variant
- There is no specific treatment for FTD. Caretaking techniques, medications to reduce symptoms, lifestyle changes can improve quality of life.

Vascular Dementia

DSM-5

A. The criteria are met for major or mild neurocognitive disorder
B. The clinical features are consistent with vascular etiology: onset is temporally related to one or more cerebrovascular events and decline is prominent in complex attention (including processing speed) and frontal executive function
C. Hx of cerebrovascular disease
D. Not better explained by another brain disease

Vascular dementia

- Treat the risk factors for stroke such as hypertension, hyperlipidemia, diabetes
- Make lifestyle changes including a healthy diet, exercise, stop smoking
- Acetylcholinesterase inhibitors and Namenda are sometimes used for vascular dementia. Often patients have a mixed dementia.
Treating the Behavioral and Psychological Symptoms

- Depression/Dysphoria
- Apathy/Indifference
- Agitation/Aggression
- Anxiety
- Elation/Euphoria
- Irritability/Lability
- Psychosis: Delusions, Hallucinations
- Disrupted sleep
- Appetite and Eating disorders
- Aberrant Motor Behavior
- Disinhibition

Impulse Control Disorder

- Impulse control problems are common in seniors with dementia.
- First line treatment is usually Depakote or a low dose atypical antipsychotic if the senior is very disruptive. Again, look at benefit vs risk. Monitor closely
- Sexual disinhibition is not uncommon in men or women with dementia.
  - high dose of SSRI
  - Provera for men
  - Depo-provera injections for men
  - Proscar for men.

  There is an increased risk of CVA with Provera.

  It is very difficult to treat woman with sexual disinhibition. Caretakers must look at the environment and make changes.

Questions?????

Thank You!

Reference List Available