Skip Meds First in Treating Agitation

B Y  R O B E R T  F I N N
San Francisco Bureau

S AN  F R A N C I S C O — At least 80% of patients with dementia will experience agitation, Dr. Joseph A. Cheong said at the annual meeting of the American Academy of Clinical Psychiatry, 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 she 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 Haldo?” Dr. Cheong asked. “It would be nice, but that’s not what we do. Once, it’s not socially acceptable. And two, it’s not appropriate.”

“I really feel much the same way,” Dr. Cheong said. In treating agitation, she asks, “What’s the 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 of the most common medical restrictive has failed.”

Many patients don’t have a regular occupational environment or routine. Manna might present with less of the granularity of the younger patients and more irritability. “There’s more of a dysphoric quality to geriatric mania,” Dr. Cheong said. Additionally, disorientation and the act of keeping track of symptoms for symptoms of dementia instead of mana. Elderly patients with bipolar disorder also have some special issues with common symptoms. 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 too high for most geriatric patients. With geriatrics, I would definitely recommend keeping the range between 0.3 or 0.6 (mEq/L),” Dr. Cheong said. “I’m higher than that in geriatric patients (and you can run into) about a lot of trouble with things like tremor, agitation 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, amphetamine, 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, iron, isoniazid, potassium, valproate, verapamil, and macrodantin. Carbamazepine can decrease serum levels of alprazolam (Xanax), bupropion, clonazepam (Klonopin), clozapine (Clozaril), haloperidol (Haldol), and olanzapine (Zyprexa).

Age May Confound Bipolar Dx

Elderly from page 1
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