

Physical illness complicating the presentation of bipolar disorder in an elderly patient

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Abstract

It is well known that psychiatric symptoms may be caused by a wide variety of medical as well as psychiatric illnesses and it can be difficult to determine the real underlying aetiology without longitudinal observation. It is a case report of a patient with no previous psychiatric history who presented with altered mental status. The diagnosis was revised from acute psychosis to acute delirium and subsequently to bipolar affective disorder. A 62 year old Malay gentleman presented with a brief two day history of disorientation, disruptive behaviors and persecutory delusions that people were spying on him. There was no significant past psychiatric history or family history of mental illness; he had never taken any psychiatric medications before and did not abuse alcohol or illicit drugs. He had an organic workup done which was unremarkable. He was initially diagnosed with acute psychosis and treated with haloperidol 15 mg at night. Over the next 5 days, his agitation worsened and he was found to have inflammation of his left knee which was due to a flare up of gout. He was treated with colchicine and paracetamol and the inflammation subsided and the psychiatric symptoms also resolved spontaneously. As a result, the diagnosis was revised to acute delirium and haloperidol was stopped. He represented again two weeks later with full-blown symptoms of mania which included elated mood, increased energy and goal-directed thinking and activity, pressured speech and grandiose delusions. Repeated investigations were normal. The diagnosis was revised to bipolar affective disorder according to DSM-V criteria. The medication haloperidol was restarted and the dose was increased to 5 mg twice a day. The manic symptoms remitted after two weeks of treatment. This report adds to the body of evidence suggesting that physical conditions and psychiatric illness can complicate each other. Close longitudinal observation and follow-up is recommended for the proper diagnosis and management.

Introduction:

It is well known that psychiatric symptoms may be caused by a wide variety of medical as well as psychiatric illnesses and it can be difficult to determine the real underlying aetiology without longitudinal observation. It is a case report of a patient with no previous psychiatric history who presented with altered mental status. The diagnosis was revised from acute psychosis to acute delirium and subsequently to bipolar affective disorder. A 62 year old Malay gentleman presented with a brief two day history of disorientation, disruptive behaviors and persecutory delusions that people were spying on him. There was no significant past psychiatric history or family history of mental illness; he had never taken any psychiatric medications before and did not abuse alcohol or illicit drugs. He had an organic workup done which was unremarkable. He was initially diagnosed with acute psychosis and treated with haloperidol 15 mg at night. Over the next 5 days, his agitation worsened and he was found to have inflammation of his left knee which was due to a flare up of gout. He was treated with colchicine and paracetamol and the inflammation subsided and the psychiatric symptoms also resolved spontaneously. As a result, the diagnosis was revised to acute delirium and haloperidol was stopped. He represented again two weeks later with full-blown symptoms of mania which included elated mood, increased energy and goal-directed thinking

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Community surveys indicate that bipolar disorder is approximately 1/3 less common in older people than in younger people, with lifetime prevalence rates estimated to be 0.5%-1%. Individuals with bipolar disorder are at increased risk for early mortality, which likely accounts for its lower prevalence rate among older adults. Older adults with bipolar disorder include individuals with early onset illness and those who develop the first episode of mania after age 50. While relatively rare in the community, high rates of geriatric bipolar disorder are seen in both inpatient and outpatient psychiatric treatment settings. Relapse and

readmission is common among older patients with bipolar disorder, even among those individuals who have had the illness for many years.

While there has not been consensus about how to define late-life bipolar disorder most studies have used age cutoffs between 50 and 65. Reports on symptom presentation in older and younger patients with bipolar disorder have produced some conflicting results. Studies comparing the phenomenology of bipolar disorder in younger and older patients have reported that older bipolar patients tend to have less severe manias are less likely to have psychotic symptoms and are more likely to relapse into depression after a manic episode A large 2-year prospective observational study found that elderly patients with bipolar disorder, especially early-onset bipolar disorder, were more likely to report a rapid cycling course However, a recent study of outpatients with bipolar disorder found no association between age and acute bipolar depression or mood-elevation symptom presentation

Methods:

This task force report addresses the unique aspects of OABD including epidemiology and clinical features, neuropathology and biomarkers, physical health, cognition, and care approaches.

Results:

The report describes an expert consensus summary on OABD that is intended to advance the care of patients, and shed light on issues of relevance to BD research across the lifespan. Although there is still a dearth of research and health efforts focused on older adults with BD, emerging data has brought some answers, innovative questions, and novel perspectives related to the notion of late onset, medical comorbidity, and the vexing issue of cognitive impairment and decline.

Conclusion:

Improving our understanding of the biological, clinical, and social underpinnings relevant to OABD is an indispensable step in building a complete map of BD across the lifespan. Although topics related to older-age bipolar disorder OABD have been relegated to a minor place in research and professional training, the growing elderly population means we can no longer conceptualize OABD as a 'special population' for whom understanding of the disorder and recommended management can simply be extrapolated from experience in mixed age groups. The study of OABD is a research opportunity where answers to important questions that have widespread implications for all people with bipolar disorder BD may be found e.g., the long-term effects of medications on general health, cognitive function, and brain integrity. This is the first report of the International Society for Bipolar Disorders ISBD Task Force on Older-Age Bipolar Disorder OABD. Improving understanding of the biological, clinical and

social underpinnings in OABD is an indispensable step in building a complete map of BD across the life-span.

In recent years, musical stimulation, in particular the "Mozart effect" of the K448 sonata for two pianos, has been reported to decrease both interictal electroencephalographic discharges and recurrence of clinical seizures More recently, a set of Mozart's compositions was reported to be particularly beneficial in reducing seizure recurrence in children and adolescents with drug-resistant structural or genetic epileptic encephalopathies. Improved nocturnal sleep quality together with positive behavioral and mood changes were also reported. Furthermore, children appeared more compliant to a set of different music proposals than a single composition like Mozart's K448 Nevertheless, in so far available studies, there is a significant diversity with respect to protocols of music therapy as well as for kind of musical compositions, length of daily music listening, and duration of follow-up. Therefore, we conducted a prospective, randomized, open label study comparing two different protocols. Following Tomatis' method Mozart's K448 sonata or Mozart's set of compositions were compared on their effect on seizure recurrence and quality-of-life parameters, including nocturnal sleep and mood/behavioral changes, in children and adolescents with refractory epileptic encephalopathies.

Methods:

During the first study 11 outpatients, aged between 1.5 and 21 years, all suffering from drug-resistant epileptic encephalopathy associated with a severe/profound intellectual disability and cerebral palsy had to listen to a set of Mozart's compositions 2 h/day for 15 days for a total of 30 h. In the second trial, 19 patients with epileptic encephalopathies, aged between 1 and 24 years, were randomized to listen to Mozart's K448 for 2 h/day for 2 weeks or to a set of Mozart's compositions

Findings:

In the first study, 2/11 patients had a reduction of 50-75% in seizure recurrence, and 3/11 a decrease of 75-89%. Overall, 5/11 patients had a $\geq 50\%$ reduction in the total number of seizures. In the second trial, 22% of the K448 group had $\geq 75\%$ seizure decrease, compared with 70% of patients in the Mozart set group.

Conclusion:

The present study seems to confirm that music therapy may be an additional, non-pharmacological, effective treatment for patients with refractory epileptic seizures in childhood. The Mozart' set of different compositions can be better accepted and effective than the K448.