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Psychiatry and Addictions Case Conference

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ANTIPSYCHOTIC USE IN GERIATRIC PATIENTS: SHOULD I USE THEM IN PATIENTS WITHOUT PSYCHOSIS?

WHITNEY CARLSON, MD

HARBORVIEW MENTAL HEALTH AND ADDICTION SERVICES

UW Medicine
UW SCHOOL OF MEDICINE

Integrated Care Training Program
UW Psychiatry & Behavioral Sciences

project ECHO

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Mark Duncan MD
Barb McCann PhD
Rick Ries MD
Kari Stephens PhD
Cameron Casey
Betsy Payn
Diana Roll
Cara Towle MSN RN

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OBJECTIVES

1. Discuss major indications for using antipsychotics for non-psychotic symptoms in older adults

2. Discuss common side effects in older adults and FDA black box warning

3. Discuss relative choice of antipsychotic based on patient profile

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ABBREVIATIONS

- BPAD = bipolar affective disorder
- MDD = major depressive disorder
- SGA = second generation antipsychotic
- SNF = skilled nursing facility
- CKD = chronic kidney disease
- EPS = extrapyramidal symptoms
- TD = tardive dyskinesia

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CASE

- 70 year old woman long history of BPAD
- Recent episode of lithium toxicity, CKD
- Started on valproic acid as mood stabilizer
- Diabetes and CAD among medical issues
- 12 chronic medications
- Ongoing mixed symptoms
- Mild cognitive impairment prior to episode

BURDEN OF ANTIPSYCHOTICS

- In the U.S.
  - 26% of antipsychotic prescriptions for schizophrenia and BPAD were for age>65
  - >2% patients aged 80 to 84 receiving antipsychotics
  - 54% patients aged 70 to 74 prescribed for >120 days
  - 88% of Medicare claims for SGAs in SNFs associated with dementia diagnosis

- Satovic M et al, Prescribing Antipsychotics in Geriatric Patients, Current Psychiatry Oct-Dec 2017

2005 FDA BLACK BOX WARNING ANTIPSYCHOTICS

- increased risk of death in elderly patients **with dementia**

- applies to both SGAs and first generation antipsychotics

- "spillover effect"—decreased use of SGAs for FDA approved indications even for younger

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WHAT ARE FDA APPROVED INDICATIONS FOR SGAS?

- BPAD: mania/mixed
- BPAD: depression
- BPAD: maintenance
- MDD: monotherapy
- MDD: antidepressant augmentation
- MDD: with psychosis
- Schizophrenia
- Schizoaffective disorder

ADDITIONAL POSSIBLE USES—OFF LABEL

- Augmentation in OCD
  - Response in 1/3 SSRI resistant cases
  - 1st line augmenting agents OCD
  - risperidone and aripiprazole favored

- PTSD
  - May help with sleep/comorbid depression symptoms
  - Not first line—would be augmentation

- Dementia with significant behavioral disturbance
  - Non pharmacologic options best
  - aggression, placement-threatening, quick response needed
  - Lowest effective dose
  - Time limited
  - Document discussion of risks

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SGAS IN BIPOLAR DISORDER

	Mania/mixed	Depression
aripiprazole (Abilify)	x	
asenapine (Sycrest)	x	
cariprazine (Vraylar)	x	x
lurasidone (Latuda)	x	x
olanzapine (Zyprexa) (with fluoxetine for depr.)	x	x
quetiapine (Seroquel)	x	x
risperidone (Risperdal)	x	
ziprasidone (Geodon)	x	

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DATA IS LIMITED

- No prospective controlled studies in BPAD
- Does clinical effectiveness=long term safety
- Studies lack “real world” older adult patients
- Impact of long term use of SGAs vs. alternative agents on brain health

ANTIDEPRESSANT AUGMENTATION

- olanzapine (Zyprexa)
- quetiapine (Seroquel)---IR or XR
- aripiprazole (Abilify)
- brexpiprazole (Rexulti)

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CLINICAL CONSIDERATIONS

- Medical comorbidities
  - Dementia
  - Diabetes
  - Parkinson's disease/parkinsonism
- Fall risk
- Other QTc prolonging medications
- Orthostatic hypotension
- Cost

ADVERSE EFFECTS MORE COMMON IN OLDER ADULTS

- EPS/TD
- Postural hypotension→falls/fractures
- Anticholinergic→constipation, urinary retention, cognitive
- Antihistaminic→sedation, dry mouth
- Cardiovascular→QTc prolongation, stroke, arrhythmia
- Metabolic
- Hematologic→reduced WBC/platelets, bleeding

GENERAL PRESCRIBING SUGGESTIONS

- Match choice given comorbidities/symptom profile
- Start low
- Titrate slowly
- Use lowest effective dose
- Evaluate often for EPS and TD—dose reduction
- Metabolic monitoring
- Long term: monitor cognition, dose reduction?

WHAT WOULD YOU RECOMMEND FOR OUR EARLIER CASE?

- Consider
  - Diabetes/CAD
  - Mixed symptoms (depression, ongoing hypomania/mania)
  - Sleep disturbance vs. sedation
  - Orthostasis
  - Short term or maintenance use likely

THINGS I CONSIDER AS A GERIATRICIAN

- One medication to cover as many symptoms as possible
- Non-antipsychotic options I haven't considered
- Medical issues that are most likely to limit other choices
- Patient side effect concerns/cost limitations
- Relapse history/hospitalizations/suicide risk

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