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Importance of complete assessment in the work-up of late onset mania

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CASE

- 78-year-old female
- Chief complaint" "Super anxious" for 4 months
- Past medical history: generalized anxiety disorder, episode of major depression, and hypothyroidism
- Medications: levothyroxine 150 mcg started 3 weeks ago
- Physical exam: talkative, overinclusive, pressured speech, labile mood, and lid lag
- Labs: Neuropsychology testing, CBC, and CMP are normal. TSH is 0.173.

DIFFERENTIAL DIAGNOSES

-Vascular etiology
-Dementia
-Medications
-Renal failure/electrolyte derangement
-Thyroid derangement

DISCUSSION

- Late-onset mania is a (hypo)manic syndrome in a person 50 or older without a previous history of mania[1].
- 5-10% of patients are 50+ years when they experience their first manic episode of bipolar disorder[2].
- Organic factors should also be considered.
- **We recommend** neurocognitive testing, medication review, and lab testing to evaluate late-onset mania.
- Brain MRI should be considered in patients with vascular risk factors.

New onset mania is **twice as likely to be due to organic cause in older adults** compared to patients <65.

Late-onset mania warrants **complete evaluation** to better treat patients.

Bipolar and Related Disorder Due to Another Medical Condition

Diagnostic Criteria

A. A prominent and persistent period of abnormally elevated, expansive, or irritable mood and abnormally increased activity or energy that predominates in the clinical picture.
B. There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct pathophysiological consequence of another medical condition.
C. The disturbance is not better explained by another mental disorder.
D. The disturbance does not occur exclusively during the course of a delirium.
E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning, or necessitates hospitalization to prevent harm to self or others, or there are psychotic features.

Medication-induced depressive or manic symptoms. An important differential diagnostic observation is that the other medical condition may be treated with medications (e.g., steroids or alpha-interferon) that can induce depressive or manic symptoms. In these cases, clinical judgment using all of the evidence in hand is the best way to try to separate the most likely and/or the most important of two etiological factors (i.e., association with the medical condition vs. a substance/medication-induced syndrome). The differential diagnosis of the associated medical conditions is relevant but largely beyond the scope of the present manual.

Figure 1. DSM V Diagnostic Criteria for Bipolar and Related Disorder Due to Another Medical Condition and description of differential diagnosis considering medication-induced manic symptoms[5].

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- Limited research has been conducted, preventing conclusions about whether organic causes of mania in older adults are a separate disease or unveiling factor in manic episodes.
- One study reports a 2.8% prevalence of organic cause of mania in those >65 compared to 1.2% prevalence in those <65[3].

- In one review[4], 82% of patients with late onset mania had a postulated organic cause. Patients were given mood stabilizing medications but also treated for organic causes. Treatment of the organic cause was thought to contribute to improvement in 28% of cases.
- Late onset mania was more likely to improve or resolve compared to bipolar disorder related mania[4].

- Only about half of patients had prior psychiatric history, most often depression (34%), which was mostly also late onset[4].
- Imaging studies revealed focal changes in over half of patients[4].
- Studies of organic mania show inconsistent association with family history of psychiatric disorders[6].

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I have no financial interests or relationships to disclose.