Behavioral Emergencies

Special Considerations in the Geriatric Psychiatric Patient

Awais Aftab, MD[a,*], Asim A. Shah, MD[b,c,d,e]

KEYWORDS

• Geriatric psychiatry • Emergency psychiatry • Delirium • Dementia • Agitation • Suicide

KEY POINTS

- As a result of multiple physiological and pharmacokinetic changes, the elderly are more vulnerable to the side-effects of medications, and require lower doses of medications and slower rates of titration.
- Geriatric population is a high-risk group for suicide, with more serious intent, fewer warning signs, and more lethality. Suicide risk assessment should be part of a standard emergency psychiatric assessment.
- Prompt diagnosis and treatment of delirium in emergency settings is essential given the association with worse outcomes such as prolonged hospital stay, risk of cognitive decline, and increased mortality.
- Behavioral interventions for agitation in dementia are the first-line measure before pharmacologic interventions. Pharmacologic options with demonstrable efficacy are mostly limited to antipsychotics, the use of which is problematic, as all antipsychotics increase the risk of mortality in dementia.

INTRODUCTION

It is estimated that by the year 2030 about 72 million US citizens will be age 65 or older, making up about 20% of the US population.[1] A total of 15.4% of visits to the

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[a] Department of Psychiatry, University Hospitals Cleveland Medical Center, Case Western Reserve University, 10524 Euclid Avenue, 8th Floor, Cleveland, OH 44106, USA; [b] Psychiatric Residency Education, Menninger Department of Psychiatry, Baylor College of Medicine, 1977 Butler Boulevard, Houston, TX 77030, USA; [c] Menninger Department of Family and Community Medicine, Baylor College of Medicine, 3701 Kirby Drive Suite 600, Houston, TX 77098, USA; [d] Mood Disorder Research Program at BT, Neuropsychiatric Center, Ben Taub Hospital/HHS, Room 2.125, 1502 Taub Loop, Houston, TX 77030, USA; [e] Community Behavioral Health Program, Psychotherapy Services, Neuropsychiatric Center, Ben Taub Hospital/HHS, Room 2.125, 1502 Taub Loop, Houston, TX 77030, USA
* Corresponding author.
E-mail address: awaisaftab@gmail.com

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emergency department are by the elderly,[2] and the visit rates by older adults have had the highest increase among all age groups in the last decades.[2]

Emergency psychiatric presentations in the elderly are often challenging, given the lack of well-defined presenting complaints, multiple medical and neurologic comorbidities, and the complex nature of presentations. Psychiatric symptoms can often be the result of a medical disorder in the elderly, and particularly new-onset psychiatric symptoms should warrant a thorough medical and neurological work-up. Evaluation of cognitive status and suicide risk assessment should be essential components of any emergency psychiatric assessment of the elderly. Review of medications for polypharmacy and medication side effects are also important. Substance use is often overlooked in the geriatric population and warrants careful history taking and urine toxicology. Geriatric patients are sometimes unreliable historians, and collateral history taking in many cases is warranted. Common disorders like depression can also have atypical presentations in the elderly compared with adults.

This report provides an overview of special psychiatric considerations in the geriatric population and common psychiatric emergencies of specific relevance in the elderly that warrant prompt assessment and management.

GENERAL PSYCHOPHARMACOLOGIC CONSIDERATIONS IN THE ELDERLY

Geriatric subjects are more vulnerable to the side effects of medications. This increased susceptibility is a result of several physiologic changes associated with aging that lead to pharmacokinetic changes. For instance, decreased concentration of plasma albumin can lead to increased plasma concentration of free drugs, decreased glomerular filtration rate results in decreased renal clearance of medications and active metabolites, reduction in hepatic blood flow can cause decreased hepatic clearance, and increase in body fat can lead to increase in elimination half-life of lipid soluble drugs.[3,4] Furthermore, elderly patients are frequently subjected to polypharmacy, leading to an increased burden of side effects.[3,4]

Homeostatic mechanisms (eg, orthostatic circulation, postural control, and thermoregulation) are also less vigorous in the aged, which can lead to additional vulnerabilities, such as increased risk of falls and hip fractures with psychotropics.[4] The elderly are also more vulnerable to the development of the syndrome of inappropriate antidiuretic hormone secretion.[4] Neurotransmitter changes such as reduction in dopamine and acetylcholine function mean that elderly have increased sensitivity to extrapyramidal symptoms with antipsychotics and cognitive impairment with anticholinergic medications[4] (**Table 1**).

As a general rule, physicians should use lower doses of medications and slower rates of titration in the elderly compared with the younger adult population.

As a result of reduced renal clearance and decreased total body water, the elderly are more susceptible to lithium toxicity. This vulnerability is present even with therapeutic serum lithium levels, in particular to neurological adverse effects such as tremor and ataxia.[5] Elderly patients therefore generally are best maintained on serum levels lower than those recommended in adults—in the range of 0.4 to 0.8 mEq/L.[5]

Benzodiazepines are best avoided in the geriatric population. Even short-term use can lead to impairments in cognition and psychomotor functioning.[3,5] These drugs increase the risk of falls and hip fractures.[3,5] These negative effects are in addition to the general risk of abuse and dependence that exists with benzodiazepine use. If benzodiazepines are clinically necessitated, lorazepam may be preferred given that it does not undergo phase I hepatic metabolism, it has no active metabolites, the half-life does not vary as much with age, and it is well absorbed intramuscularly.[5]