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# Geriatric Affective Symptoms in a Case Report: Bipolarity or Dementia?

## Bir Olgu Sunumu Eşliğinde Geriatrik Afektif Belirtiler: Bipolarite mi, Demans mı?

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## Geriatric Affective Symptoms in a Case Report: Bipolarity or Dementia?


### ABSTRACT

Bipolar disorder and dementia are two independent and unrelated diagnostic groups. Recently, some commonalities in the pathophysiological processes of bipolar disorder and dementia have been described in the literature. However, this association has not been adequately evaluated at the clinical level, as affective dysregulation in the elderly has typically been attributed to an emotional and behavioral complication secondary to dementia. Here, we present and discuss an 89-year-old male patient who presented to our outpatient clinic with manic symptoms, was not previously diagnosed with bipolar disorder, and was diagnosed with bipolar type VI after clinical evaluation. The manic symptoms began with the addition of antidepressants, while his follow-up and treatment continued with the diagnosis of dementia.


**Keywords:** Bipolar disorder, dementia, first manic episode.


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### ÖZET

Bipolar bozukluk ve demans birbirinden bağımsız, ilişkisiz iki tanısal gruptur. Literatürde son zamanlarda bipolar bozuklukların ve demansın patofizyolojik süreçlerinde bazı ortak noktalar tanımlanmıştır. Bununla birlikte, bu ilişki klinik düzeyde yeterince değerlendirilmemiştir, çünkü yaşlılardaki afektif düzensizlik tipik olarak demansa sekonder duygusal ve davranışsal komplikasyona atfedilme eğiliminde olmuştur. Burada; manik semptomatoloji ile polikliniğimize başvuran daha önce bipolar bozukluk tanısı olmayan, demans tanısı ile takip ve tedavisi devam ederken antidepresan eklenmesi ile manik belirtiler başlayan, klinik değerlendirme sonucu bipolar tip VI tanısı ile uyumlu olduğu düşünülen seksen dokuz yaşında erkek hasta ile ilgili klinik bilgiler sunulmuş ve literatür eşliğinde tartışılmıştır.


**Anahtar Sözcükler:** Bipolar bozukluk, demans, ilk manik epizot.

## Introduction

Bipolar disorder is a chronic illness characterized by manic, depressive and mixed episodes and the age of onset is before the age of 50 in a significant proportion of patients. Affective symptoms that appear for the first time in old age are different from the episodes of older bipolar patients and show a different course. These symptoms may occur in the course of dementia or may be precursor symptoms for dementia. In this presentation, we aimed to evaluate a case of manic episode that started after antidepressant treatment in an 89-year-old male patient with dementia. He had no previous diagnosis of bipolar disorder. We discussed the case in the light of the current literature.

## Case Report

An eighty-nine-year-old male patient was brought to the outpatient clinic by his relatives because of irritability, insomnia, increased sexual desire, and inappropriate sexual behavior. According to information from his children and medical records, he had been treated for Alzheimer's dementia for about a year and a half. For about four months, he had been experiencing irritability, decreased sleep, increased speech, and preoccupation with marriage and sexuality. For the past week, he had not slept at all at night and had been exhibiting inappropriate sexual speech and behavior. The patient thought his granddaughter was his fiancée and said that they were getting ready to marry soon, that he wanted to buy her an engagement ring, and that she wanted to buy him a gold watch. He had inappropriate sexual conversations with his granddaughter and other women in the family. It was planned to admit the patient to the ward for further investigation and treatment, with the consent of his relatives.

At the time of admission, the patient was taking rivastigmine transdermal patch 9.5 mg/24 hours, memantine 20 mg/day, quetiapine 50 mg/day, and escitalopram 10 mg/day. He had no known systemic disease other than Alzheimer's dementia. A review of his medical records revealed that escitalopram had been added 5 months earlier because of depressive symptoms that had developed during his antidementia treatment, which had been ongoing for 1.5 years. The neurologist, to whom he had been referred with complaints of insomnia and aggressive behaviour, had started him on quetiapine 50 mg/day 1 month earlier.

The patient was born in a village, started working as a carpenter after finishing primary school, and moved to the city with his family before military service. He completed his military service, continued to work as a carpenter, married at the age of 24, had 4 children, had a functional level to support his household, retired voluntarily at the age of 64, started gardening after retirement, and had no psychiatric admissions except for depressive symptoms that appeared at the age of 73.

The history did not describe any prior episodes of mania or hypomania. However, it was noted that he had a lively, active, talkative, and outgoing personality. He had experienced a depressive episode triggered by a stressor at age 74, after his son got into debt. There was a period of insomnia, unhappiness, fear of leaving home, thoughts that he and his family would be harmed, and complaints of auditory hallucinations. He was treated for a short period of time without hospitalization. The patient's relatives did not recall the medications used at that time. The medical records did not contain any information from that time. There was no history of alcohol or drug use. There was no family history of bipolar disorder, major depression or suicide.

On mental status examination, the patient was conscious with partially inadequate orientation to place, time and person. His affect was elevated, with increased speech volume, rapid thought flow, excessive preoccupation with marriage in thought content, disinhibited behavior, decreased sleep and appetite, and impaired judgment and reality testing. The uneducated version of the Mini-Mental State Examination revealed inadequate orientation, attention, and recall, with a score of 15/30.

Vital signs, including temperature, pulse and blood pressure were within normal ranges. Initial laboratory tests, including complete blood count, biochemistry, thyroid function tests, erythrocyte sedimentation rate, C-reactive protein, and urinalysis, were within normal limits. Atrial fibrillation (AF) was detected on electrocardiographic examination, and treatment with enoxaparin 6000 ANTI-XA IU/0.6 mL/day and metoprolol succinate 50 mg/day was started in

consultation with the cardiologist. In diffusion MR examination, acute pathology was not considered because no diffusion restriction was observed but diffuse atrophy and ischemia findings were present.

Because the patient's clinical symptoms were compatible with a manic episode, escitalopram 10 mg was discontinued, and risperidone 0.5 mg was started. Because of persistent sleep disturbances, quetiapine was increased to 100 mg. During clinical follow-up, the patient's mood elevation, sexually inappropriate talk and behavior toward female staff persisted, and risperidone was increased to 1 mg on day 3 of hospitalization and to 2 mg on day 5. No sedation or extrapyramidal symptoms were observed during follow-up. From the third day of follow-up, the patient's sleep duration was found to be adequate and there was no daytime sedation. Beginning on the tenth day, the patient's speech decreased, disinhibited behaviors regressed, sleep duration increased, and the preoccupation with marriage decreased. Toward the end of the second week, when the patient appeared overly subdued, the risperidone dose was reduced to 1 mg and he was discharged for outpatient follow-up and treatment at the family's request. At an outpatient follow-up visit 1 week later, the quetiapine dose was increased to 150 mg because of prolonged sleep latency. No significant side effects were observed with treatment, and the patient's mood was assessed as euthymic. Written informed consent was obtained from the patient's legal guardian before the case was prepared and written.

**Discussion**

Bipolar disorder is a chronic mood disorder with a prevalence of 1-5% in the population. It has a significant impact on individuals and society due to problems such as impaired occupational and social functioning, increased medical costs, decreased productivity, and increased risk of suicide (1). It typically begins in late adolescence or early adulthood (2).

A diagnosis of mania occurring after the age of 50 in a patient with no history of manic episodes is rare, but clinically significant. Late-onset mania differs from late-onset bipolar disorder and mania in patients diagnosed with bipolar disorder at an older age in several ways, primarily suggesting a more organic etiology. First manic episodes occurring at an older age are often referred to as secondary mania, with cerebrovascular events, medication treatments, metabolic problems, and other neurological disorders often identified as causes in the etiology (3-5). In addition, treatment of the underlying organic cause has been found to contribute to the successful management of the manic episode (5). Although no neurological deficit was found to explain the manic symptomatology in the patient, the presence of previously undiagnosed atrial fibrillation and ischemic lesions on brain imaging suggest vascular dementia. There are studies associating inappropriate sexual behaviors with vascular dementia rather than other dementias (6)

Although the first episode of classic mania is quite rare in the elderly, mood instability, mixed periods of irritability, agitation, and atypical depression may occur in previously healthy individuals beginning in the sixth decade of life, along with cognitive decline. In a review by Akiskal et al, it was suggested that the intersection of dementia and bipolarity could be temporarily defined as "bipolar type VI" (7). In support of this proposal, a case series was published in which 10 elderly patients without a clear history of bipolar disorder but with late-onset affective symptoms, associated behavioral symptoms, and cognitive decline were selected. Clinical features, temperament, cognition, family history, and pharmacological response were assessed to identify prototypical patients to demonstrate the complexity of the dementia-bipolar interface (8). Results showed that mixed and depressive mood symptoms were more common in these patients, most of whom had a premorbid hyperthymic, cyclothymic, and/or irritable temperament, with a psychiatric history and/or family history of mood disorders in most cases. Symptoms were generally resistant to antidepressants and acetylcholinesterase inhibitors, but responded well to mood stabilizers and/or atypical antipsychotics.

Due to the patient's advanced age, history could not be obtained from the patient's peers and parents, resulting in limited history information. Although we did not use a temperament scale due to the patient's age and cognitive status, we believe the premorbid condition is consistent with

characteristics of a hyperthymic temperament based on history and clinical assessment. The patient's hyperthymic temperament may have made it difficult to identify occasional hypomanic episodes, and thus a previous diagnosis of bipolar disorder may have been missed. Although there was no family history of mood disorders, it was understood that the patient had experienced a psychotic depressive episode approximately a decade before the dementia symptoms, and that the manic symptoms were triggered by antidepressant treatment initiated for recurrent depressive symptoms after the dementia diagnosis. The rapid improvement in the patient's symptoms after discontinuation of the antidepressant, initiation of protective antiplatelet therapy for atrial fibrillation, and atypical antipsychotic treatment supports the idea that sexually disinhibited behaviors were related to affective elevation rather than dementia-related behavioral problems.

In addition to neurocognitive symptoms, patients with dementia experience a group of psychological and behavioral symptoms called neuropsychiatric symptoms. These symptoms include apathy, depression, sleep disturbances, hallucinations, delusions, psychosis, agitation, aggression, and disinhibition. (9) Inappropriate sexual talk and behavior, which was prominent in this case, can be considered a symptom of disinhibition, which can be seen in various types of dementia. Symptoms of sexual disinhibition are seen in the early stages of frontotemporal dementia, whereas they occur in the intermediate and advanced stages of Alzheimer's dementia (10). In a recent retrospective study, hypersexual behaviors were found with a frequency of 9.3% in patients with dementia, and male gender, diagnosis of frontotemporal dementia, alcohol, and smoking were reported as factors associated with hypersexual behaviors (11).

Inappropriate sexual behavior in dementia has also been associated with the use of levodopa, benzodiazepines, alcohol and antidepressant treatments. Sometimes undressing and touching the genitals may occur as a result of inability to cope with physical symptoms such as hyperthermia or itching. Or, as in our case, the person with dementia may substitute others as sexual partners because they cannot recognize their relatives. Inappropriate sexual behaviors that occur in old age may lead to the development of feelings such as fear and shame in the caregiver and disruption of the care of the patient with dementia (10).

The fact that inappropriate sexual behaviors and increased sexual desire symptoms were accompanied by symptoms such as elevated mood, increased speech and energy, insomnia and loss of appetite, and met the criteria for mania, led us to move away from the diagnosis of sexual disinhibition that occurs clinically in the course of dementia.

## Conclusion

Sometimes late affective symptoms may precede or predict dementia. These symptoms can also be considered a form of pseudodementia. As in our case, affective symptoms may appear after dementia symptoms. Antidepressants may exacerbate behavioral dysregulation and affective symptoms in these patients. Assessing temperament prior to illness and/or a family history of bipolarity and related conditions can provide a broader perspective for understanding these patients. Achieving mood stabilization and avoiding antidepressants in selected patients may provide a better treatment option.

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