Geriatric bipolar disorder: Maintenance treatment

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INTRODUCTION

The clinical features and treatment of older bipolar patients differ from those of younger patients [1]. Geriatric patients constitute up to 25 percent of all bipolar patients [2], and the absolute number of geriatric bipolar patients is expected to increase as the world's population ages over the next several decades [3,4].

This topic reviews the maintenance treatment of geriatric bipolar disorder. The epidemiology, pathogenesis, clinical features, assessment, diagnosis, and acute treatment of geriatric bipolar disorder are discussed separately, as are the clinical features, diagnosis, acute treatment, and maintenance treatment of bipolar disorder in mixed-age patients.

- (See "Geriatric bipolar disorder: Epidemiology, clinical features, assessment, and diagnosis".)
- (See "Geriatric bipolar disorder: Treatment of mania and major depression".)
- (See "Bipolar disorder in adults: Epidemiology and pathogenesis".)
- (See "Bipolar mania and hypomania in adults: Choosing pharmacotherapy".)
- (See "Bipolar major depression in adults: Choosing treatment".)
- (See "Bipolar disorder in adults: Choosing maintenance treatment".)

DEFINITIONS

Geriatric bipolar disorder — The minimum age used to define geriatric bipolar disorder is generally 60 years [5]. However, some authorities use an age cut-off of 50, 55, or 65 years [6]. Geriatric bipolar disorder includes both aging patients whose mood disorder presented earlier in life, and patients whose mood disorder presents for the first time in later life [1,7]. A summary statement from the International Society for Bipolar Disorders taskforce focused upon geriatric bipolar disorder used the term "older age bipolar disorder" to describe this group of patients [8].

Bipolar disorder is characterized by episodes of major depression (table 1), mania (table 2), and hypomania (table 3) [9]. However, the clinical features of bipolar disorder are different for older and younger patients in that [1,10-13]:

- Cognitive impairment is more common and severe in geriatric patients
- Comorbid general medical illnesses are more common in older patients
- Excessive sexual interest and behavior during manic or hypomanic episodes appear to be less common in older patients
- Comorbid anxiety and substance use disorders may be less common in geriatric patients

The clinical features and diagnosis of geriatric bipolar disorder are discussed separately. (See "Geriatric bipolar disorder: Epidemiology, clinical features, assessment, and diagnosis".)

Remission — Remission is defined as the resolution of mood symptoms, or improvement to the point that only one or two symptoms of mild intensity persist. If psychotic features (delusions or hallucinations) are also present, resolution of the psychosis is required for remission. The rate of remission from geriatric bipolar mood episodes is discussed separately. (See "Geriatric bipolar disorder: Treatment of mania and major depression", section on 'Recovery from mood episodes (prognosis)'.)

INDICATION

Maintenance treatment is indicated for nearly all patients with geriatric bipolar disorder, based upon observational studies that have found patients who remit from a mood episode are at high risk for suffering another episode:

- Multiple studies of geriatric bipolar patients suggest that within a 12-month period, approximately 20 percent will sustain four or more recurrences [14,15].

- A prospective study of 220 bipolar patients assessed course of illness for approximately 40 years and found that the median number of lifetime episodes was 10 and that the risk of

recurrence remained constant up to the age of 70 years or more [16].

- A retrospective study of 26 geriatric bipolar patients found that 38 percent had a lifetime history of at least three mood episodes [17].

Maintenance treatment for geriatric bipolar patients is consistent with practice guidelines from the National Institute for Health and Clinical Excellence [18], Canadian Network for Mood and Anxiety Treatments [19], International Society for Bipolar Disorders [20], British Association for Psychopharmacology [21], and Royal Australian and New Zealand College of Psychiatrists [22].

CHOOSING TREATMENT

Choosing pharmacotherapy following recovery from mood episodes — Following recovery from geriatric bipolar mood episodes, maintenance treatment usually includes pharmacotherapy [19,22]. Acutely ill patients who remit with a medication regimen should generally be maintained on the same drugs and doses. However, for patients who recover from an episode of major depression with fluoxetine plus olanzapine (the antidepressant/second generation antipsychotic combination that we generally use for refractory patients), fluoxetine is generally tapered and discontinued within a few months of remission. (See 'Following recovery from bipolar major depression' below.)

For patients who recover from geriatric bipolar mood episodes, but do not tolerate maintenance treatment with the drug regimen that achieved recovery, we suggest switching to maintenance treatment with lithium monotherapy. This approach is consistent with practice guidelines from the International Society for Bipolar Disorders for older-age bipolar disorder [20]. Target serum concentrations depend upon the patient's age:

- 60 to 79 years – 0.4 to 0.8 mEq/L (0.4 to 0.8 mmol/L)
- 80 years and over – 0.4 to 0.7 mEq/L (0.4 to 0.7 mmol/L)

The guidelines also state that reasonable alternatives to lithium include monotherapy with lamotrigine, olanzapine, quetiapine, or valproate [20]. In addition, if patients receiving lithium monotherapy require add-on pharmacotherapy, the preferred choices include lamotrigine, quetiapine, or valproate.

Comorbid diseases, concomitant medications, and age-related physiologic changes often alter a drug's pharmacodynamics and pharmacokinetics, which can affect therapeutic and adverse responses. Pharmacologic issues in older bipolar patients are discussed separately. (See "Geriatric bipolar disorder: General principles of treatment", section on 'Pharmacologic issues'.)

Evidence of efficacy — In the adult population (eg, age 18 to 65 years), multiple randomized trials have demonstrated the efficacy of different medications for preventing recurrent episodes of mania/hypomania and major depression. These studies are discussed separately in the context of choosing medications for maintenance treatment of adults with bipolar disorder. (See "Bipolar disorder in adults: Choosing maintenance treatment".)

Studies of maintenance treatment for geriatric bipolar disorder are limited. Evidence for the efficacy of maintenance pharmacotherapy for geriatric bipolar disorder includes subgroup analyses of older patients in randomized trials conducted with mixed-age patients (18 to 65 years):

- A pooled analysis of two 18-month randomized trials compared lithium, lamotrigine, and placebo in mixed-age bipolar patients who were stable for at least four weeks [23]. In the subgroup of 98 older patients, time to intervention for an emerging episode of mania, hypomania, or mixed (concurrent manic and depressive symptoms) mania was longer with lithium (modal dose 750 mg per day) than placebo [24]. Time to intervention for an emerging episode of major depression was significantly longer with lamotrigine (modal dose 240 mg per day) than placebo. These results were consistent with those from the mixed-age patients. Among older patients, withdrawal from treatment due to side effects occurred most often with lithium, followed by lamotrigine and placebo (29 versus 18 and 13 percent of patients).

- An open-label, two-year randomized maintenance trial (Bipolar Affective disorder: Lithium/Anticonvulsant Evaluation; BALANCE) compared lithium monotherapy, valproate monotherapy, and lithium plus valproate in 330 bipolar mixed-age patients [25]. Lithium monotherapy and combination treatment were superior to valproate alone, and subgroup analyses found the results did not differ significantly between older and younger patients.

Observational studies also suggest that maintenance treatment may be effective. As an example:

- Mixed-age patients with acute bipolar major depression, who completed six weeks of treatment with lurasidone monotherapy or lurasidone plus lithium or valproate as part of a randomized trial, were prospectively followed for up to six months [26]. During the six-month open-label follow-up, patients received lurasidone (20 to 120 mg/day) once daily in the evening, either as monotherapy or combined with lithium or valproate. In the subgroup of older patients (n = 141), efficacy of lurasidone was maintained [27]. In addition, pharmacotherapy was generally well tolerated, such that discontinuation of

treatment due to adverse effects occurred in 8 percent. These results were consistent with those from the mixed-age patients.

- In a retrospective study of 281 patients aged 55 years or more, with bipolar disorder or unipolar major depression, 44 (16 percent) took lithium for a mean duration of 13 years, as part of their pharmacotherapy regimen [28]. Among the 44 patients treated with lithium, the diagnosis was bipolar disorder in 33 (75 percent), and unipolar major depression in 11 (25 percent). After controlling for potential confounding factors (eg, demographics, diagnosis, and other psychotropic drugs), the analyses found that use of lithium was associated with less severe illness, including less intense symptoms of depression. In addition, there was a trend for fewer psychiatric hospitalizations in the past year among patients who received lithium.

Following recovery from bipolar major depression — Acutely ill patients who remit with a medication regimen should generally be maintained on the same drugs and doses. However, for geriatric bipolar patients with major depression who remit with the combination of fluoxetine and olanzapine (the antidepressant/second generation antipsychotic combination that we generally use for refractory patients), and then remain stable for two to six months, we suggest tapering fluoxetine by 10 mg per week until it is discontinued, and continuing olanzapine. The reason is that maintenance antidepressants may possibly induce mania or hypomania [29,30]. If symptoms of depression recur during the taper, the dose should be titrated back up to the full dose used to initially achieve remission. If a full-blown depressive episode develops despite increasing the dose and does not improve within four to eight weeks, the relapse is treated as a new acute episode; acute treatment is discussed separately. (See "Geriatric bipolar disorder: Treatment of mania and major depression", section on 'Bipolar major depression'.)

For geriatric bipolar patients with major depression who remit with the combination of fluoxetine and olanzapine and then develop manic or hypomanic symptoms during maintenance treatment, fluoxetine should be abruptly discontinued and olanzapine continued. If a full-blown manic or hypomanic episode develops despite discontinuing fluoxetine and does not improve within four to eight weeks, the relapse is treated as a new acute episode; acute treatment is discussed separately. (See "Geriatric bipolar disorder: Treatment of mania and major depression", section on 'Mania and hypomania'.)

Treatment following remission with electroconvulsive therapy — For geriatric bipolar patients who remit with electroconvulsive therapy (ECT), we suggest maintenance treatment with lithium, based upon its efficacy in the subgroup of older patients who participated in randomized trials with mixed-age adult bipolar patients (18 to 65 years) [24,25]. However,

lamotrigine is a reasonable alternative. The maintenance drug is started the day after ECT is completed, unless the patient is suffering cognitive impairment secondary to ECT, in which case maintenance pharmacotherapy is delayed until the impairment has dissipated. The dose and side effects of lithium and lamotrigine are discussed separately. (See "Geriatric bipolar disorder: Treatment of mania and major depression", section on 'First-line medications' and "Geriatric bipolar disorder: Treatment of mania and major depression", section on 'Treatment resistance'.)

For geriatric bipolar patients who remit with ECT and cannot tolerate maintenance treatment with lithium or lamotrigine, reasonable alternatives include aripiprazole, carbamazepine, olanzapine, quetiapine, risperidone, valproate, or ziprasidone, based upon their efficacy in mixed age patients. There is no evidence of superior efficacy among these alternatives; the choice is thus guided by side effect profiles, potential drug-drug interactions, comorbid general medical conditions, patient preference, and cost. The dose and side effects of these alternatives are discussed separately. (See "Geriatric bipolar disorder: Treatment of mania and major depression", section on 'First-line medications' and "Geriatric bipolar disorder: Treatment of mania and major depression", section on 'Second-line medications' and "Geriatric bipolar disorder: Treatment of mania and major depression", section on 'Refractory patients'.)

Maintenance ECT should be offered to geriatric bipolar patients who repeatedly remit with ECT and then relapse during maintenance pharmacotherapy [31]. Maintenance ECT is discussed separately. (See "Overview of electroconvulsive therapy (ECT) for adults", section on 'Continuation and maintenance ECT'.)

Managing intolerable side effects — Geriatric bipolar patients who cannot tolerate maintenance treatment with the minimum target dose of a medication are generally switched to another medication. For patients not receiving lithium, we and others suggest switching to lithium [1], based upon its efficacy in analyses of results from older patients who participated in randomized trials with mixed-age adult bipolar patients (18 to 65 years) [24,25]. However, lamotrigine is a reasonable alternative. The failed medication is generally tapered and discontinued over one to two weeks by the same amount for each dose decrease. As an example, olanzapine 15 mg per day is decreased by 5 mg per day, every one to three days. At the same time, lithium or lamotrigine is started and titrated up. The dose and side effects of lithium and lamotrigine are discussed separately. (See "Geriatric bipolar disorder: Treatment of mania and major depression", section on 'First-line medications' and "Geriatric bipolar disorder: Treatment of mania and major depression", section on 'Treatment resistance'.)

For remitted geriatric bipolar patients who cannot tolerate maintenance treatment with the medication that induced remission and are also intolerant of lithium or lamotrigine, reasonable alternatives include aripiprazole, carbamazepine, olanzapine, quetiapine, risperidone,

valproate, or ziprasidone. There is no evidence of superior efficacy among these alternatives; the choice is thus guided by side effect profiles, potential drug-drug interactions, comorbid general medical conditions, patient preference, and cost. The dose and side effects of these alternatives are discussed separately. (See "Geriatric bipolar disorder: Treatment of mania and major depression", section on 'First-line medications' and "Geriatric bipolar disorder: Treatment of mania and major depression", section on 'Second-line medications' and "Geriatric bipolar disorder: Treatment of mania and major depression", section on 'Refractory patients'.)

For geriatric bipolar patients who remit with a medication combination and cannot tolerate minimum target doses, we suggest tapering and discontinuing the drug that is most troublesome and continuing with the remaining drug. The failed drug is generally tapered and discontinued over one to two weeks by the same amount for each dose decrease. At the same time, the dose of the remaining drug should be increased within the target dose range as tolerated. The dose and side effects of medications are discussed separately. (See "Geriatric bipolar disorder: Treatment of mania and major depression", section on 'Mania and hypomania' and "Geriatric bipolar disorder: Treatment of mania and major depression", section on 'Bipolar major depression'.)

Cognitive impairment — Cognition is commonly impaired in euthymic, geriatric bipolar patients [32,33]. Although no high quality trials have demonstrated that maintenance treatment can improve or preserve cognition in geriatric bipolar patients, observational studies suggest that long-term treatment with lithium may have neuroprotective effects and reduce the risk of developing neurocognitive disorders. As an example, a meta-analysis of five observational studies found that dementia was half as likely to occur in patients treated with lithium (n >6000), compared with patients not treated with lithium (n >43,000; odds ratio 0.5, 95% CI 0.4-0.7) [33]. In the largest of the five studies (n >41,000 patients, age ≥50 years), which controlled for potential confounding factors (eg, age, comorbid general medical disorders, and use of other psychotropic drugs), the incidence of dementia was 23 percent less in patients who received lithium for approximately one year, compared with patients who did not (hazard ratio 0.77, 95% CI 0.60-0.99) [34].

Other observational studies have found that lithium reduced the risk of neurocognitive disorder in patients with bipolar disorder to the level of the general population [35]. In addition, a 12-month randomized trial compared lithium (serum concentration of 0.25 to 0.50 mEq/L [0.25 to 0.50 mmol/L]) with placebo in patients with mild neurocognitive disorder but without bipolar disorder (n = 45), and found that cognitive function was superior with lithium [36].

The specific cognitive deficits observed in geriatric bipolar disorder are discussed separately. (See "Geriatric bipolar disorder: Epidemiology, clinical features, assessment, and diagnosis",

section on 'Cognitive impairment'.)

Adjunctive psychotherapy — We suggest that older bipolar patients receiving maintenance pharmacotherapy also receive psychotherapy that focuses upon [31,37]:

- Managing bipolar disorder
  - Accepting the illness and the limitations it imposes
  - Adhering to treatment
  - Detecting and reporting prodromal symptoms
  - Limiting or eliminating use of alcohol
  - Eliminating drugs of abuse (eg, cannabis)
  - Regulating sleep
- Managing interpersonal difficulties
- Improving self-esteem
- Age-related issues (eg, changing occupational and social roles, loss of family members and friends, reduced financial resources, or decreased functioning)

Although pharmacotherapy is the cornerstone of maintenance treatment for bipolar disorder, adjunctive psychotherapy improves outcomes compared with pharmacotherapy alone in randomized trials with mixed-age adults (18 to 65 years). Thus, several practice guidelines recommend adjunctive psychotherapy. Choosing an adjunctive maintenance psychotherapy (eg, psychoeducation) is discussed further. (See "Bipolar disorder in adults: Choosing maintenance treatment", section on 'Choosing adjunctive psychotherapy'.)

Adherence — Many geriatric bipolar patients do not adhere to treatment (although their adherence generally exceeds that of younger patients) [38]. A study of 6461 older bipolar patients found that 19 percent partially adhered to treatment and 20 percent were nonadherent, and that comorbid substance abuse was associated with nonadherence. Poor adherence probably increases the risk of recurrence.

Strategies for improving adherence are discussed separately. (See "Bipolar disorder in adults: Managing poor adherence to maintenance pharmacotherapy", section on 'Management'.)

Monitoring the patient — Remitted geriatric bipolar patients should be evaluated regularly and monitored for recurrence of manic and depressive symptoms as well as medication side effects and cognitive decline. Particular attention is given to suicidal ideation and to psychotic symptoms. Older patients often require more vigilant monitoring than do younger patients [39].

For geriatric bipolar patients who remit and remain stable, monitoring can be tapered, with progressively longer intervals between assessments. As an example, a patient who is seen every two weeks at the time of remission can be seen every two weeks for one to three more visits, then every month for one to three visits, and then every two months for one to three visits. Continuously stable patients can ultimately be seen every three to six months. More frequent visits should be scheduled for patients who develop symptoms or side effects; monitoring acutely ill patients is discussed separately. (See "Geriatric bipolar disorder: Treatment of mania and major depression", section on 'General principles'.)

For patients who receive maintenance treatment with lithium, we suggest that monitoring include the following laboratory tests and clinical assessments [20]:

- Every three to six months
  - Lithium level
  - Serum creatinine
  - Estimated glomerular filtration rate
  - Blood urea nitrogen
  - Tremor
  - Gait
- Annually
  - Thyroid function
  - Fasting glucose
  - Fasting cholesterol
  - Triglycerides
  - Calcium
  - Complete blood count
  - Weight and waist circumference
  - Cognitive screen (see "Mental status scales to evaluate cognition")

This approach is consistent with practice guidelines from the International Society for Bipolar Disorders for older-age bipolar disorder [20].

Management of patients treated with lithium who develop renal toxicity (eg, arginine vasopressin resistance [previously called nephrogenic diabetes insipidus] or lithium nephropathy) or thyroid toxicity is discussed separately. (See "Renal toxicity of lithium" and "Lithium and the thyroid".)

Duration and discontinuation — Based upon clinical experience, most geriatric bipolar patients require maintenance treatment for many years, and some patients require it for their entire lives. However, the duration is not established and is generally longer in patients with:

- Residual symptoms, particularly suicidal ideation
- Ongoing comorbid psychopathology
- Psychosocial stressors
- A history of suicide attempts
- A greater number of prior mood episodes
- A history of longer or more severe (eg, psychotic) mood episodes
- Onset of bipolar disorder at an early age (eg, ≤30 years)

If the decision is made to discontinue maintenance treatment, we suggest slowly tapering the regimen to increase the probability of detecting incipient mood symptoms before a full-blown episode recurs. For geriatric bipolar patients who remit with monotherapy, we taper the medication over one month. Based upon clinical experience, we decrease the dose each week by approximately 25 percent of the dose used during maintenance treatment. As an example, lithium 1200 mg per day is reduced by 300 mg per day each week until it is discontinued. If symptoms recur during the taper, the dose should be titrated back up to the full dose used initially to achieve remission. If full-blown mania develops despite increasing the dose and does not improve within four weeks, or if a full-blown depressive episode develops and does not improve within four to eight weeks, the recurrence is treated as a new acute episode. Acute treatment is discussed separately. (See "Geriatric bipolar disorder: Treatment of mania and major depression", section on 'Mania and hypomania' and "Geriatric bipolar disorder: Treatment of mania and major depression", section on 'Bipolar major depression'.)

Discontinuing a maintenance medication combination begins by tapering the medication that is more difficult to use because of side effects or drug-drug interactions. We generally taper the medication over one month, decreasing the dose each week by approximately 25 percent of the dose used during maintenance treatment. If mood symptoms recur during the taper, the dose should be titrated back up to the full dose used initially to achieve remission. If a full-blown manic episode develops despite increasing the dose and does not improve within four weeks, or if a full-blown depressive episode develops and does not improve within four to eight weeks, the recurrence is treated as a new acute episode. Acute treatment is discussed separately. (See

"Geriatric bipolar disorder: Treatment of mania and major depression", section on 'Mania and hypomania' and "Geriatric bipolar disorder: Treatment of mania and major depression", section on 'Bipolar major depression'.)

Geriatric bipolar patients who successfully discontinue one medication from their pharmacotherapy combination should be monitored for one to six months prior to discontinuing the remaining medication. If mood symptoms recur, we suggest restarting and titrating up the discontinued drug to the full dose used initially to achieve remission. If a full-blown mania develops despite increasing the dose and does not improve within four weeks, or if a full-blown depressive episode develops and does not improve within four to eight weeks, the recurrence is treated as a new acute episode. Acute treatment is discussed separately. (See "Geriatric bipolar disorder: Treatment of mania and major depression", section on 'Mania and hypomania' and "Geriatric bipolar disorder: Treatment of mania and major depression", section on 'Bipolar major depression'.)

Geriatric bipolar patients who successfully taper and discontinue one medication from their pharmacotherapy combination and remain stable for one to six months can then be tapered off their remaining medication. We suggest tapering the medication over one month, decreasing the dose each week by approximately 25 percent of the dose used during maintenance treatment. If mood symptoms recur during the taper, the dose should be titrated back up to the full dose used initially to achieve remission. If a full-blown manic episode develops despite increasing the dose and does not improve within four weeks, or if a full-blown depressive episode develops and does not improve within four to eight weeks, the recurrence is treated as a new acute episode. Acute treatment is discussed separately. (See "Geriatric bipolar disorder: Treatment of mania and major depression", section on 'Mania and hypomania' and "Geriatric bipolar disorder: Treatment of mania and major depression", section on 'Bipolar major depression'.)

TREATING RECURRENCES

Recurrent symptoms or mood episodes during maintenance pharmacotherapy for geriatric bipolar disorder are initially treated by optimizing medication doses [31,40]. This includes ensuring serum concentrations are in the therapeutic range for medications such as lithium or valproate, as well as increasing the dose to achieve a higher serum level within the therapeutic range, provided that side effects do not intervene. For medications that do not have an established therapeutic serum concentration, such as lamotrigine or second-generation antipsychotics, the dose can be increased within the target dose range.

If a geriatric bipolar manic episode recurs during maintenance pharmacotherapy and optimizing the dose does not control symptoms within two to four weeks, the recurrence is treated as a new acute episode. If a geriatric bipolar depressive episode recurs during maintenance pharmacotherapy and optimizing the dose does not control symptoms within two to eight weeks, the recurrence is treated as a new acute episode. Acute treatment is discussed separately. (See "Geriatric bipolar disorder: Treatment of mania and major depression", section on 'Mania and hypomania' and "Geriatric bipolar disorder: Treatment of mania and major depression", section on 'Bipolar major depression'.)

For patients with geriatric bipolar disorder who decide to stop maintenance treatment and successfully taper and discontinue their medication regimen, but subsequently relapse, we suggest restarting the same regimen that was discontinued. The relapse is treated as a new acute episode; acute treatment is discussed separately. (See "Geriatric bipolar disorder: Treatment of mania and major depression", section on 'Treatment'.)

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Bipolar disorder".)

INFORMATION FOR PATIENTS

Information for patients (patient education) is discussed separately. (See "Geriatric bipolar disorder: General principles of treatment", section on 'Information for patients'.)

SUMMARY AND RECOMMENDATIONS

- The minimum age used to define geriatric bipolar disorder is generally 50 to 60 years. The clinical features of geriatric bipolar disorder differ from those of younger patients in that cognitive impairment and comorbid general medical illnesses are more common in geriatric patients, whereas comorbid anxiety and substance use disorders may be less common in geriatric patients. (See 'Geriatric bipolar disorder' above and "Geriatric bipolar disorder: Epidemiology, clinical features, assessment, and diagnosis", section on 'Clinical features'.)

- Bipolar disorder is a highly recurrent illness. For geriatric bipolar patients, we recommend maintenance treatment rather than no treatment (**Grade 1B**). Maintenance treatment

usually consists of the same medication regimen that induced remission. (See 'Choosing treatment' above and 'Choosing pharmacotherapy following recovery from mood episodes' above.)

- For geriatric bipolar patients who remitted with a medication other than lithium or lamotrigine, and cannot tolerate maintenance treatment with the medication that induced remission, we suggest switching to lithium rather than other medications (**Grade 2C**). However, lamotrigine is a reasonable alternative. For patients intolerant of lithium or lamotrigine, reasonable options include aripiprazole, carbamazepine, olanzapine, quetiapine, risperidone, valproate, or ziprasidone (See 'Choosing pharmacotherapy following recovery from mood episodes' above.)

- For patients receiving maintenance pharmacotherapy, we suggest adding psychotherapy rather than using pharmacotherapy alone (**Grade 2C**). (See 'Adjunctive psychotherapy' above.)

- Clinicians should regularly monitor remitted geriatric bipolar patients for recurrence of manic and depressive symptoms as well as medication side effects and cognitive decline. Particular attention is given to suicidal ideation and psychotic symptoms. For stable patients, we progressively lengthen the interval between assessments. (See 'Monitoring the patient' above.)

- Most geriatric bipolar patients require maintenance treatment for years, and some patients require it for their entire lives. The duration is generally longer in patients with residual symptoms (particularly suicidal ideation), ongoing comorbid psychopathology, psychosocial stressors, a history of suicide attempts, a greater number of prior mood episodes, a history of longer or more severe (eg, psychotic) mood episodes, and onset of bipolar disorder at an early age. (See 'Duration and discontinuation' above.)

- Recurrent symptoms or mood episodes during maintenance pharmacotherapy for geriatric bipolar disorder are initially treated by optimizing medication doses. If this does not control symptoms within two to eight weeks, the recurrence is treated as a new acute mood episode. (See 'Treating recurrences' above and "Geriatric bipolar disorder: Treatment of mania and major depression", section on 'Mania and hypomania' and "Geriatric bipolar disorder: Treatment of mania and major depression", section on 'Bipolar major depression'.)

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