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Time needed to complete: 47m

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Treating the Complex Patient: TD Management in Older Adults and Medically Fragile Populations

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Dr. Hicks:
This is a CE on ReachMD, and I'm Dr. Tracy Hicks, and with me today is Dr. Melissa Moody.

Let's start with the case highlighting the complexity of managing TD in older, medically fragile patients. So let's go over the case.

Mr. B is a 72-year-old man with a longstanding history of bipolar disorder, hypertension, type 2 diabetes, and chronic kidney disease, stage 3. He has been treated with various antipsychotics over the past 15 years, most recently quetiapine. His wife brings him to the clinic after noticing persistent lip smacking, jaw movements, and frequent blinking, which have gradually worsened over the past 6 months. Mr. B is largely unaware of these abnormal movements but has become more withdrawn and reluctant to attend social events.

Examination reveals moderate orofacial dyskinesia and mild choreiform movements of the upper limbs. His Abnormal Involuntary Movement Scale, or AIMS score, is a 9. Careful consideration is given to his multiple comorbidities and potential drug interactions when formulating a management plan for his tardive dyskinesia.

Melissa, what do you think about this case?

Dr. Moody:
Gosh, Tracy, there's so many things to take into consideration for this individual. He's not unlike many of our patients we see who have tardive dyskinesia. His age alone is a risk factor for developing tardive dyskinesia. So in our older patient population, it's really important that we be aware when we're prescribing dopamine receptor blocking agents and when we're evaluating those patients for things like abnormal movement.

So he's 72 years old. He has longstanding bipolar disorder. What his longstanding history tells me is that he's had a long-term exposure to medications that could lead to tardive dyskinesia. He has a lot of comorbidities, right? He has hypertension, type 2 diabetes, chronic kidney disease, stage 3. When we're choosing medications for treatment, we need to take all of those things into consideration. Are medications going to increase his hypertension? Are they going to cause elevations in his blood sugar? Do we need to make dosing adjustments for his chronic kidney disease? Which certain types of treatment, which we'll talk about, do not require that we make adjustments for chronic kidney disease, and that's going to be an important factor when we make choices for treating his tardive dyskinesia.

We want to talk a little bit about the degree of his tardive dyskinesia. So he has an AIMS score of 9. He has moderate orofacial dyskinesias and mild choreiform upper limb movements that are causing a lot of social withdrawnness and behavioral changes noticed by his family. He doesn't want to be around anybody. How difficult that's got to be for him to have to deal with all of those things.

So there's lots of possible things to interfere with treatment when we're making those decisions. Polypharmacy is one of them. He's an older gentleman with lots of comorbidities, he's going to be on a lot of different medications, so we're going to want to think about those CYP3A4 and CYP2D6 inhibitors or inducers. They may change the way a medication is handled in his body. We want to look for things that might again worsen his metabolic issues that he's already dealing with.

The fact that he has that limited awareness of his abnormal movements may actually make adherence to medication kind of difficult. He may not want to be on additional medication, so adding 1 pill once a day may be more beneficial. So there's a lot of things to consider.

Valbenazine would be a great option for this patient, as we can use it safely in patients who have chronic kidney disease and there's no dosing adjustment required. We do need to look at other medications that he might be on in terms of interactions with the CYP3A4 and CYP2D6 system, but we won't see any interference with his blood sugar or his blood pressure or any of those things if we choose valbenazine as the appropriate option for treating his tardive dyskinesia.

Dr. Hicks:
Thank you for that excellent feedback. Education is key. And you're right, just to summarize, I think the best choice in this case would be valbenazine, to have a simpler regimen, once daily. It's critical in older adults, as you mentioned, that polypharmacy.

And then the lower cognitive and psychiatric burden, we have to think about that, right, because he already has some issues going on cognitively and mentally. So we have to also consider depression and suicidality warnings with patients with relevant bipolar or mental health history.

And then, as you mentioned, the chronic kidney disease stage 3. So neither is heavily renally cleared, as we talked about, but valbenazine has less titration complexity and fewer interactions.

And of course, just a reminder, in our geriatric population, we have to consider polypharmacy, so we want to choose the agent with the simplest dosing and the lowest CNS burden.

Dr. Moody:
Tracy, those are wonderful points. And I think we have a lot of patients who are in maybe long-term care facilities that really look a little bit like our patient. They have that older age and all of those different medications. Valbenazine was studied in patients over the age of 65 specifically for that reason, because we know those patients are going to be at higher risk for tardive dyskinesia. Where deutetrabenazine doesn't have data necessarily to support using it safely in our patients who are older than the age of 65, so just something to take into consideration when you're making those choices.

Dr. Hicks: Absolutely, absolutely. So this has been a great discussion and such an important conversation for a challenging patient population. Thank you everyone for listening.

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