

Introduction

Awakening Psychiatry to Geriatrics: Finagle, Osler, and Ginger Rogers

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© **W**hy an entire journal supplement on psychosis in the elderly? Why is it that general and even child psychiatrists can profit from reviewing this material? The title of the introduction explains. Puzzled? Don't be.

The elderly comprise the most rapidly expanding segment of the population and consume a disproportionately large percentage of the prescription medications. Surprisingly, as many as 23% of older people will experience a psychotic disorder at some point in their lives. The etiologies of these include virtually every medical and neurologic disorder—from delirium to the extrapyramidal disorders and dementias—as well as virtually every psychiatric condition—from substance abuse to schizophrenia. The phenomenology is as complex and varied as anything encountered in psychiatry—hallucinations, delusions, and misperceptions interacting with agitation, cognitive failure, and motor signs.

Both pharmacologic and nonpharmacologic treatments can be useful in controlling the variety of symptoms. With regard to pharmacologic approaches to treatment, Finagle's Principle applies: "The most important leg of the three-legged stool is the one that is missing." In using medications, we are guided by pharmacologic principles, clinical trials data, and clinical experience. Misquoting Osler, "... relying on clinical experience alone is like going to sea without maps or compass; relying on theory and data alone is like not going to sea at all."

Several important pharmacologic principles emerge in considering medication therapy because of unique physiologic changes in the aged. These include drug-drug interactions, altered pharmacokinetics, altered metabolism, the critical role of polypharmacy and comorbid conditions, and the exquisite sensitivity of older people to motor, cardiac, cognitive, and sexual effects of available therapies. New drug developments based on limbic selectivity and novel receptor profiling have led to the introduction of kinder, gentler medications such as the atypical antipsychotics, which are clearly more suited to this and other fragile populations. The clinical trials data, ranging from preliminary open-label experiences to multicenter placebo-controlled studies, show us the strengths and weaknesses of older therapies and promise that the newer agents will not only be effective, but safer and better tolerated. In particular, the atypical antipsychotics are rapidly finding a place in the treatment of psychotic (and other) symptoms in the elderly because of their low propensity to cause extrapyramidal side effects as well as their demonstrated efficacy.

The compelling complexities of geriatrics magnify and illuminate the principles that govern sophisticated clinical practice in all of psychiatry. Like the beloved dancer, Ginger Rogers, the geriatric specialist not only has to know all the moves, but be able to dance backwards. Misquoting Osler once again, "... to know geriatrics is to know all of medicine."

Read on, and learn from watching the dance.

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