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Optimising the management of bipolar disorder

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How should diagnosis be confirmed?

THE PREVALENCE OF BIPOLAR DISORDER IN PRIMARY CARE PATIENTS IS ESTIMATED TO BE between 0.5 and 4.3%, with 9.3% having bipolar spectrum illness.[1] As many as 38% of patients are treated exclusively in primary care.[2]

The GP's role is therefore vital in improving and maintaining patients' quality of life.[3] In particular, accurate and timely recognition and assessment of often lifelong and disabling symptoms is essential for long-term engagement in treatment and support at primary care level. This can reduce the use of inpatient services and prevent long-term loss of function.[4]

This article updates our previous review,[5] in light of the most recent NICE clinical guidance, published in 2014, which reflects advances in the treatment

How should patients be assessed?

approaches for patients with bipolar disorder.[6]

PRESENTATION

Any history of depression increases the risk of bipolar disorder. A diagnosis of bipolar disorder would have implications

'When adults present with depression ask about previous periods of overactivity or disinhibited behaviour'

What are the treatment options?

for any planned antidepressant treatment. NICE recommends that when adults present in primary care with depression, they should be asked about previous periods of overactivity or disinhibited behaviour.[6] If this behaviour has lasted for four or more days, referral for a specialist mental health assessment should be considered.

The Diagnostic and Statistical Manual of Mental Disorders (DSM 5) defines bipolar disorder using the criteria listed in table 1, p12.[7] If a manic episode has been present during the history, the diagnosis is bipolar I disorder, while a hypomanic episode is indicative of bipolar II disorder. Cyclothymia refers to a chronic (two years and longer) mood disturbance with depression and hypomanic symptoms that does not meet criteria for a full episode. Although depressive episodes are not necessary »

Table 1

DSM-IV diagnostic criteria for bipolar disorder (simplified)

Diagnosis	Criteria
Bipolar I = manic episode, at least one (+ depression)	● One week of abnormally elevated, expansive, or irritable mood (or less if hospitalised) plus increased activity or energy ● Three (or more) of the following seven symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree: **1** Inflated self-esteem or grandiosity **2** Decreased need for sleep (e.g. feels rested after only three hours of sleep) **3** More talkative than usual or pressure to keep talking **4** Flight of ideas or subjective experience that thoughts are racing **5** Distractibility (i.e. attention too easily drawn to unimportant or irrelevant external stimuli) **6** Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation **7** Excessive involvement in pleasurable activities which have a high potential for painful consequences (e.g. engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments) ● The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalisation to prevent harm to self or others, or there are psychotic features ● Symptoms are not caused by a drug of abuse, medication or a general medical condition
Bipolar II = hypomanic episode, at least one (+ depression)	● Four days of elevated, expansive or irritable mood plus increased activity or energy ● Three (or more) of the seven symptoms (1-7) listed above have persisted (four if the mood is only irritable) and have been present to a significant degree ● Not severe enough to cause marked impairment in social or occupational functioning, or to necessitate hospitalisation, and there are no psychotic features ● Symptoms are not caused by a drug of abuse, medication or a general medical condition ● A hypomanic episode emerging during antidepressant treatment, and persisting after this has been stopped, counts as a hypomanic episode and implies a diagnosis of bipolar II disorder

for a diagnosis of bipolar disorder, they are common and dominate the lifetime pattern of the condition: 50% of the time is spent in a euthymic (well) state, 38% in a depressed and 12% in a manic state.[8]

If there have only been depressive symptoms, it is not possible to exclude bipolar disorder. Whether depressed patients will develop bipolar disorder is not clear until the first (hypo-) manic symptoms actually occur (in around 10% of depressed patients), typically by their thirties.[8]

'Patients should undergo a risk assessment at the time of diagnosis'

Over three years, one in 25 people with major depression will develop bipolar disorder.[9] Comorbid social anxiety disorder, generalised anxiety disorder, childhood abuse and problems with the patient's social support group within the past year may predict this transition.[9]

A family history of bipolar disorder also provides an index of suspicion, with diagnostic concordance highest in identical twins (40-70%) and first-degree relatives (a 5 to 10 times greater risk than in the general population).[10]

Psychosocial influences, including childhood maltreatment, may predispose an individual to develop bipolar disorder in adult life, while social class, social support, and self-esteem may modify the course of episodes.[6]

ASSESSMENT

NICE[6] recommends that patients should undergo a risk assessment at the time of diagnosis, whenever there is a significant change in personal circumstances or mental state, and at the time of discharge or leave of absence from inpatient care. This implies that the GP has an ongoing therapeutic relationship with the patient and carer to support care plans and recovery goals, follow-up on crisis plans developed in secondary care, facilitate the transition between secondary and primary care, and review treatment regularly.

NICE advises that questionnaires are not useful to identify bipolar disorder in adults, young people and children in primary care.[6] Clinical assessment should include dependency or abuse of drugs and alcohol. The possible benefits and risks of psychological and pharmacological interventions should be discussed with the patient, especially during remission of symptoms, as patients may be more susceptible to information, but also less motivated to continue treatment.

'Questionnaires are not useful to identify bipolar disorder in primary care'

If bipolar disorder is diagnosed in secondary care, the secondary care team should liaise with primary care to generate a care plan developed in collaboration with the patient, and monitor mood and activity levels. Care that is integrated and contiguous between primary and secondary agencies favours the overall success of management.

If patients do not have the capacity to make decisions, healthcare professionals should follow the code of

Table 2

NICE criteria for referral in bipolar disorder [6]

- Poor or partial response to treatment
- Patient's work or social functioning declines significantly
- Treatment adherence is poor
- Intolerable or medically important side effects from medication
- Comorbid alcohol or drug misuse
- The patient stops medication after a period of relatively stable mood
- A woman with bipolar disorder is pregnant or plans a pregnancy

practice that accompanies the Mental Capacity Act and the supplementary code of practice on deprivation of liberty safeguards, unless the respective Mental Health Act needs to be invoked.

CONFIRMING DIAGNOSIS

A diagnosis of bipolar disorder is supported by diagnostic criteria and usually confirmed by a psychiatrist. The individual should be monitored appropriately following diagnosis, especially after the first episode, when diagnostic uncertainty is common. Individuals may present a significant period after the condition first arises, which may make the diagnosis difficult, as insight into previous episodes may be poor.

Further complications arise from inconsistencies between diagnostic criteria. The two classification systems (DSM 5[7] and ICD-10[11]) are not identical, with differences in the number of required episodes and distinction between bipolar I and II disorders.

NICE recommends that for children or young people, diagnosis of bipolar disorder should be made only after a period of intensive, longitudinal monitoring by a healthcare professional or multidisciplinary team trained and experienced in the assessment, diagnosis and management of bipolar disorder for that age group, and in collaboration with parents or carers.[6] Mania and euphoria must be present for a diagnosis of bipolar disorder; irritability should be taken into account but is not a core diagnostic criterion.

Children or young people with depression and a family history of bipolar disorder should be followed up, but a diagnosis cannot be made on family history alone.

The updated guidance includes specific recommendations for diagnosis in these age groups, as the presentation of symptoms can be complicated by other conditions, such as ADHD.[6]

Table 3

QOF mental health indicators

Records
MH001 The contractor establishes and maintains a register of patients with schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy. **4 points**
Ongoing management
MH002 The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate. **6 points**
MH003 The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months. **4 points**
MH007 The percentage of patients with schizophrenia, bipolar affective disorder, and other psychoses who have a record of alcohol consumption in the preceding 12 months. **4 points**
MH008 The percentage of women aged 25 or over and who have not attained the age of 65 with schizophrenia, bipolar affective disorder, and other psychoses whose notes record that a cervical screening test has been performed in the preceding 5 years. **5 points**
MH009 The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 9 months. **1 point**
MH010 The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range within the preceding 4 months. **2 points**

REFERRAL

If the GP suspects mania or severe depression, or if patients are a danger to themselves or others an urgent referral should be made for a specialist mental health assessment. If bipolar disorder is managed solely in primary care, patients should be re-referred to secondary care under any of the circumstances listed in table 2, left.

MANAGEMENT

Pharmacological treatment

Although the evidence base is rapidly expanding, the pharmacological treatment of bipolar disorder continues largely to consist of a two-drug combination approach, which includes lithium as a mood stabiliser, and acutely anti-manic and antidepressant drugs of several different drug classes. As acute antimanic treatments, olanzapine, risperidone and haloperidol are recommended.[12]

'During remission patients may be more susceptible to information but less motivated to continue treatment'

The evidence base for the use of antidepressants has almost doubled since the 2006 NICE guideline was published.

Recent specific recommendations suggest combining fluoxetine with olanzapine to protect against both poles of the illness.[6] Quetiapine too has empirical support as an antidepressant treatment in bipolar disorder[13-15] and more recently as a maintenance treatment on a par with lithium.[16]

With its recent official FDA approval in the USA, the use of lurasidone as an effective and tolerable antidepressant in bipolar disorder is also gaining ground.[17-19]

Although its acute anti-manic efficacy remains less impressive, lithium continues to have the best evidence base for the long-term management and relapse prevention of bipolar disorder, reducing the risk of suicide by more than 50%.[20] NICE recommends other drugs, such as olanzapine, quetiapine and valproate as second-line prophylactics, if there is »

Table 4

Physical health checks [7]

- Weight and BMI, diet, nutritional status and level of physical activity
- Cardiovascular status, including pulse and blood pressure
- Metabolic status, including fasting blood glucose, glycosylated haemoglobin (HbA_{1c}) and blood lipid profile
- Liver function
- Renal, thyroid function, calcium and lithium levels, for patients on lithium

little or no response to lithium.[6] However, there is limited evidence for the efficacy of valproate in the long-term management of bipolar disorder,[21] but lamotrigine has been shown to reduce the risk of relapse by 36% over 18 months.[22]

Valproate should not be started in primary care to treat bipolar disorder, nor should lithium for people who have not taken lithium previously, except under shared-care arrangements.[5] Furthermore, women of childbearing potential should not be prescribed valproate, but if no alternative can be identified, adequate contraception should be used, and teratogenic and other risks of taking valproate explained.[6]

Non-pharmacological therapy

NICE emphasises the importance of non-pharmacological therapy, including structured psychological interventions, such as cognitive behaviour, interpersonal, psycho-education, or behavioural couple therapy, which could be used independently to develop coping strategies and crisis plans in milder bipolar disorder. Interventions should be limited to those with published evidence-based manuals describing in detail how they should be delivered.

Psychological treatments are preferred in children and young people, because of the potential of drug treatments to impact on growth and development. If the response to a psychological therapy is poor after 4-6 weeks, alternative individual or family psychological interventions should be considered.

If the young person's condition is moderate to severe, combining psychological and pharmacological interventions should be considered. If drug treatment is necessary, the same drugs used to treat adult bipolar disorder are used for children and young people, but modified with reference to the *BNF for Children*, and with the addition of aripiprazole for moderate to severe mania, based on a positive technology appraisal by NICE.[23] Antipsychotics should not be prescribed for longer than 12 weeks without review.[6]

Patients with bipolar I and bipolar II disorder should be offered the same treatment interventions in the first instance, as should those with rapid cycling bipolar disorder, as there is no strong evidence to suggest that the latter should be treated differently.[6] Supportive and empathetic relationships should be maintained to encourage full adherence to treatment regimens.

Monitoring

The quality and outcomes framework (QOF) mental health indicators state that practices should produce a register of patients with bipolar disorder and review their physical health annually, see table 3, p13.

The contract further suggests that the patient's care plan should include current health status, social situation, social support, co-ordination arrangements with secondary care, details of early warning signs, and the patient's preferred course of action in the event of a clinical relapse. This is in accordance with the NICE recommendation that registers should be developed and used to monitor the physical and mental health of people with bipolar disorder in primary care.[6]

Physical health should be monitored whenever responsibility is transferred from secondary to primary care, and then at least annually, see table 4, above. Shared care protocols should be developed between primary and secondary care physicians to clarify arrangements and responsibilities for physical health monitoring.

Checks should focus on cardiovascular disease, diabetes, obesity and respiratory disease given the heightened risk for these illnesses in bipolar disorder. The identification of any of these should lead to further assessment, treatment and management. Those with bipolar disorder and diabetes or cardiovascular disease should be offered treatment in primary care in line with the relevant guidance on diabetes and lipid modification.

Several medications used to treat bipolar disorder can result in weight increase. If a patient gains weight during treatment, the GP should provide dietary advice, recommend regular aerobic exercise, consider referral to a dietician or to mental health services for a weight management programme.

CONCLUSION

Although bipolar disorder has been described as the heartland of psychiatry,[24] with the introduction of New Ways of Working psychiatrists have relinquished the medical outpatient model of practice, and the GP plays an increasingly central role in monitoring and maintaining the long-term mental stability and general health of patients with bipolar disorder.[25]

'Adhering to guidelines uncritically may not be beneficial'

Given that clinical guidance applies to the average patient (possibly selected for evidence generating studies from a less severe, healthier and more co-operative sub-sample), adhering to guidelines uncritically may not be beneficial.[26] Guidelines are continually adjusted and will change as more is understood about the aetiology of the bipolar spectrum, the efficacy of specific and combination treatments, and the complicated presentation of symptoms, when other physical and mental conditions are present.

The implementation of guidelines is further complicated by significant social, financial, personality and other risks. Crises may arise from suicide attempts, exploitation and self-neglect, engagement problems through lack of insight and other unique individual circumstances. The pooling and co-ordination of the resources of primary and secondary care as well as other community resources are essential to maintain support for patients with bipolar disorder.

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key points

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NICE recommends that when adults present in primary care with depression, they should be asked about previous periods of overactivity or disinhibited behaviour. If this behaviour lasted for four or more days referral for a specialist mental health assessment should be considered. If a manic episode has been present during the history the diagnosis is bipolar I disorder, while a hypomanic episode is indicative of bipolar II disorder.

Although depressive episodes are not necessary for a diagnosis of bipolar disorder, they are common and dominate the lifetime pattern of the condition: 50% of the time is spent in a euthymic (well) state, 38% in a depressed and 12% in a manic state. If there have only been depressive symptoms, it is not possible to exclude bipolar disorder.

A diagnosis of bipolar disorder is supported by diagnostic criteria and usually confirmed by a psychiatrist. For children or young people, diagnosis of bipolar disorder should be made only after a period of intensive, longitudinal monitoring. If the GP suspects mania or severe depression, or if patients are a danger to themselves or others, an urgent referral should be made for a specialist mental health assessment.

The pharmacological treatment of bipolar disorder consists of a two-drug combination approach, which includes lithium as a mood stabiliser, and acutely anti-manic and antidepressant drugs of several different drug classes. NICE emphasises the importance of non-pharmacological therapy, including structured psychological interventions which could be used independently to develop coping strategies and crisis plans in milder bipolar disorder.

The patient's care plan should include current health status, social situation, social support, co-ordination arrangements with secondary care, details of early warning signs, and the patient's preferred course of action in the event of a clinical relapse. Checks should focus on cardiovascular disease, diabetes, obesity and respiratory disease given the heightened risk for these illnesses in bipolar disorder.

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www.depressionalliance.org/

Mind
www.mind.org.uk/information-support/types-of-mental-health-problems/bipolar-disorder

NHS Choices
www.nhs.uk/conditions/Bipolar-disorder/Pages/Introduction.aspx

Rethink Mental Illness
www.rethink.org/diagnosis-treatment/conditions/bipolar-disorder

Royal College of Psychiatrists
www.rcpsych.ac.uk/healthadvice/problemsdisorders/bipolardisorder.aspx

SANE
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