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. As many as 38% of patients are treated exclusively in primary care. The GP’s role is therefore vital in improving and maintaining patients’ quality of life. 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.

This article updates our previous review in light of the most recent NICE clinical guidance, published in 2014, which reflects advances in the treatment approaches for patients with bipolar disorder.

Presentation

Any history of depression increases the risk of bipolar disorder. A diagnosis of bipolar disorder would have implications 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. 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. 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 for a diagnosis of bipolar II disorder, they may support the diagnosis of cyclothymic disorder.

How should patients be assessed?

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

What are the treatment options?

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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 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 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

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.2 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

‘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
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

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, quetiapine, 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 disorder15-16 and more recently as a maintenance treatment on a par with lithium.6

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...
Physical health checks

- 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 (HbA1c) and blood lipid profile
- Liver function
- Renal, thyroid function, calcium and lithium levels, for patients on lithium

physical health monitoring.

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 dietitian 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 guideline 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 updated and it can be 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.

REFERENCES

3 Connolly KR, Thase ME. The clinical management of bipolar disorder: a review of evidence-based guidelines. Prim Care Companion CNS Disord 2011;13(4)
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.

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.

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Useful information

Bipolar Scotland www.bipolarscotland.org.uk
Bipolar UK www.bipolaruk.org.uk
Depression Alliance www.depressionalliance.org.uk
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
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