



Managing bipolar disorder in primary care

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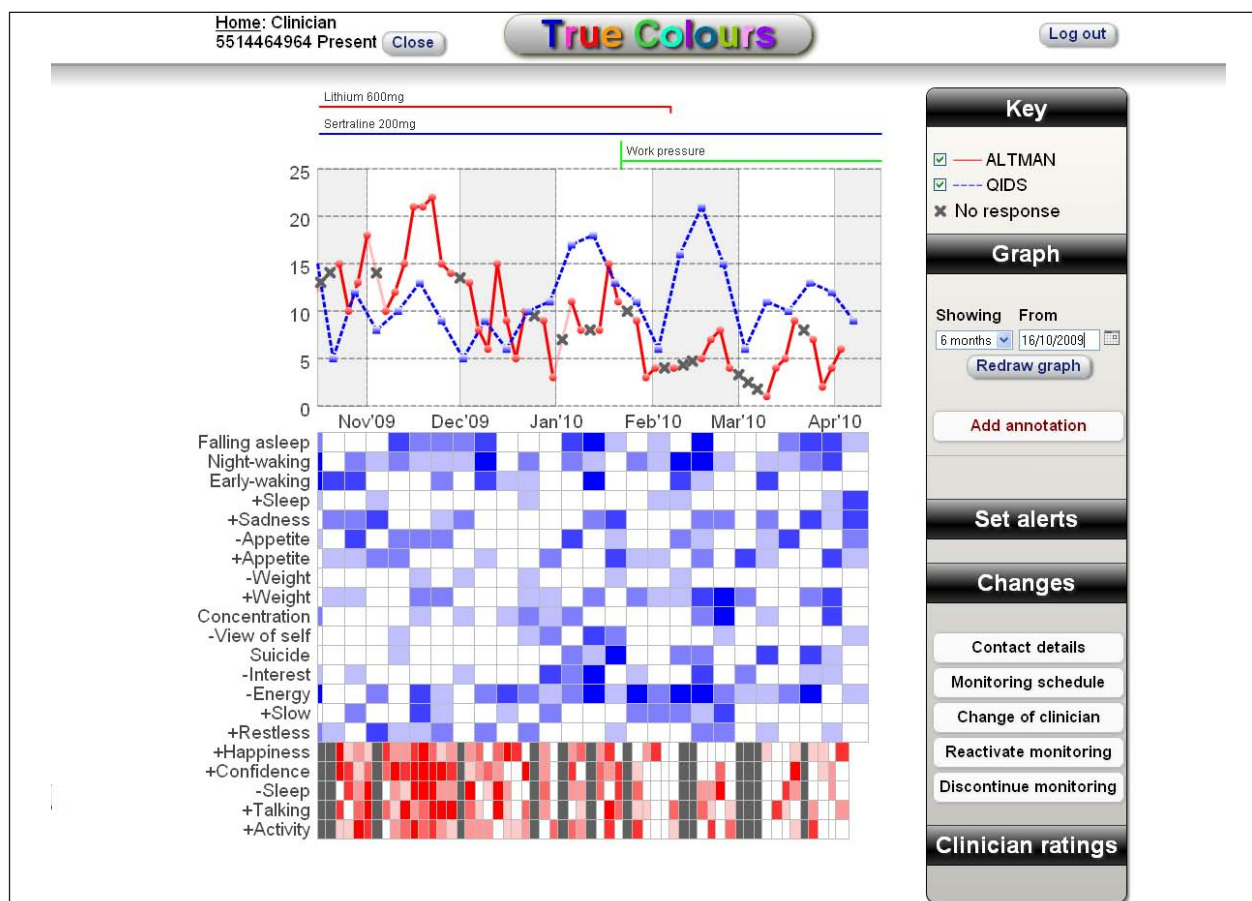
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FIGURE 1
True Colours Version 2: the doctor's interface allows for the simultaneous display of depressive (blue, QIDS) and manic (red, Altman) symptoms texted to the server directly by the patient, as well as clinical items, such as medication (lithium blood levels) and stressors. True Colours is being developed by Oxford University's Department of Psychiatry and Computing Laboratory, and funded by the Oxfordshire and Buckinghamshire Mental Health Foundation Trust



How should bipolar disorder be diagnosed?

What are the treatment options?

How should patients be monitored?

BIPOLAR DISORDER IS RELATIVELY COMMON, AT LEAST TWICE AS COMMON AS SCHIZOPHRENIA, and eminently treatable. It is also perfectly suited to the well established outpatient model practised in general practice and psychiatry,¹ although perhaps less well suited to the 'new ways of working' widely promoted within mental health trusts.² However, bipolar disorder has a lower profile within research, clinical psychiatry, and also sometimes in general practice.¹ Serious and enduring mental illness

tends to be equated with schizophrenia or even dementia, and the new community-based mental health services are designed to deal with these two chronic illnesses which require continuous, but relatively low-intensity support.

The NICE guideline on bipolar disorder³ recommends that all GP practices should include people with a diagnosis of bipolar disorder on their case register of people with severe mental illness. Bipolar disorder is also included in the QOF (see box 1, p20).

DIAGNOSIS

One reason for misdiagnosis of bipolar disorder is that it is not possible to exclude a bipolar diagnosis categorically if there are only symptoms of depression.⁴ This means that all depressed patients may turn out to be bipolar; about 10% ultimately present with symptoms of mania.⁴ Most patients will have had a (hypo)manic episode by their 30s.

While 15-17% of people in the community suffer from depression,⁵ the lifetime prevalence of bipolar affective disorder proper is 1%, with »

Table 1

Summary of diagnostic criteria for mania and hypomania⁷

Diagnosis	Criteria
Mania (+ depression = bipolar I)	● One week of elevated, expansive, or irritable mood (or less if hospitalised) ● 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 3 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
Hypomania (i.e. below threshold of mania) + depression = bipolar II)	● Four days of elevated, expansive or irritable mood ● 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

Box 1

Quality and Outcomes Framework: Mental health indicators (2009/2010)

Records

MH 8. The practice can produce a register of people with schizophrenia, bipolar disorder and other psychoses. **4 points**

Ongoing management

MH 9. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses with a review recorded in the preceding 15 months. In the review there should be evidence that the patient has been offered routine health promotion and prevention advice appropriate to their age, gender and health status. **23 points**

MH 4. The percentage of patients on lithium therapy with a record of serum creatinine and TSH in the preceding 15 months. **1 point**

MH 5. The percentage of patients on lithium therapy with a record of lithium levels in the therapeutic range within the previous 6 months. **2 points**

MH 6. The percentage of patients on the register who have a comprehensive care plan documented in the records agreed between individuals, their family and/or carers as appropriate. **6 points**

MH 7. The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who do not attend the practice for their annual review who are identified and followed up by the practice team within 14 days of non-attendance. **3 points**

a further 1.2% presenting with milder hypomanic symptoms (so-called bipolar II disorder), and an additional 2–3% with bipolar disorder not otherwise specified.⁶ Relaxing diagnostic symptom criteria increases the frequency of depressed patients who develop symptoms of mania for any length of time to 50%.⁴

While such 'bipolar spectrum disorder' is of great theoretical and clinical relevance, evidence for treatment efficacy is mainly available for bipolar I disorder. This evidence can only be transferred for use in bipolar II disorder with some caution. The clinical demarcation between the two is somewhat fuzzy: for example,

varying thresholds for inpatient admission or for defining functional impairment may shift the boundary between the two.

The diagnostic symptoms of bipolar I and bipolar II disorder are listed in table 1, above. If a manic episode has been present during the history, the diagnosis is bipolar disorder in the narrow sense of the term (bipolar I).

If there has been a hypomanic episode, the diagnosis is bipolar II disorder. The presence of depressive episodes in the history of the illness is common, but not obligatory to arrive at the diagnosis. Nevertheless, the lifetime course of the illness tends to be dominated by depressive episodes: half the time is estimated to be spent in the euthymic (well) state, 12% in a manic state and 38% in a depressed state.⁴ As the presence of manic or hypomanic symptoms in the past has important implications for appropriate treatment, any depressed patient should be asked about periods in the past when (s)he has been elated in mood, found it unnecessary to sleep, talked a lot, spent excessive amounts of money etc. (see table 1, above).

TREATMENT OPTIONS

Treatment for bipolar disorder has to be divided into:

- treatment of mania
- treatment of bipolar depression (i.e. depressive syndrome with

Table 2**Evidence-based treatment options for bipolar disorder**

Treatment aim	Source	Treatment
Treatment of mania or mixed state (manic and depressive symptoms at the same time)	BAP guidelines 2009 ⁹	● Antipsychotics or valproate for severe mania (avoid valproate in women of childbearing age)³ ● Lithium or carbamazepine for milder mania ● Adjunctive benzodiazepines for insomnia ● No psychotherapy currently provides an alternative strategy for management ● Consider atypical antipsychotics, because of fewer motor side effects ● Taper and discontinue antidepressants
Treatment of bipolar depression	ECNP consensus meeting 2007 ⁴	● Antidepressants: early studies show efficacy comparable with unipolar depression, newer studies do not, but this may be a confounding effect of additional treatment with antimanic agents. Switch to mania may be more frequent with tricyclic antidepressants and venlafaxine, less common with SSRIs and bupropion. Induction of rapid cycling not well documented ● Antidepressants usually in combination with antimanic prophylaxis with lithium, valproate or atypical antipsychotic ● Antidepressants should probably be withdrawn gradually after full remission (>3 months) ● Anticonvulsants: some indirect evidence for semisodium valproate; small effect of lamotrigine ● Antipsychotics: small effects of olanzapine and quetiapine
	BAP guidelines 2009 ⁹	● Quetiapine if early response is desirable ● Lamotrigine (but this requires gradual up-titration to avoid skin rash) ● In mild depression consider lithium, or valproate alone ● Consider interpersonal therapy, cognitive behaviour therapy (CBT) or family-focused therapy (FFT) when available since these may shorten the acute episode
Prevention of relapse	BAP guidelines 2009 ⁹	● Consider lithium as initial monotherapy, as it appears to be superior to other presumptive mood stabilisers in preventing manic and depressive relapses¹⁰ ● If lithium does not work, consider monotherapy prophylaxis, or if necessary combination with: - Mainly antimanic: aripiprazole, olanzapine - Mainly antidepressive: lamotrigine - Probably both: carbamazepine, valproate, quetiapine ● Psychoeducation at any stage of the treatment should be considered standard clinical practice. Withdrawal of long-term medication always carries the risk of symptoms recurring
	NICE guideline 2006 ³	● Valproate should not be prescribed routinely for women of childbearing age

a history of previous mania)
● prophylaxis of mood swings in either direction

Specifically, antidepressant treatments are unlikely to help manic symptoms, at worst they can precipitate or aggravate them. Antimanic treatments are unlikely to help symptoms of depression. An exception to this rule would be a genuine mood stabiliser such as lithium⁸ which treats and prevents mood swings in either direction. Table 2, above, lists the evidence-based treatment options available.

MONITORING

Patients with bipolar disorder usually require long-term medication together with regular monitoring of symptoms, medication effects and side effects. Supportive educational interventions (to explain the medication plan, sleep

hygiene, self-monitoring of mental state, identification and monitoring of 'relapse signatures' etc.) will also be required.

The most intense, but by no means most expensive, form of outpatient monitoring involves the patient recording their mood over the week and transmitting the results to their doctor by SMS. The doctor will be able to display the current mood profiles together with previous symptom profiles on request (see figure 1, True Colours Version 2, p19). The project has been rolled out within the Oxfordshire and Buckinghamshire MHT (for further details see Useful information box on p22).

The NICE guideline gives detailed advice about initiating and monitoring drugs used in bipolar disorder.³ The most important procedures unique to bipolar disorder

relate to lithium monitoring: lithium has a plasma half-life of about 12 hours with a narrow therapeutic window. Serum levels should be checked one week after any dose change or interventions that may affect lithium levels (e.g. starting ACE inhibitors, NSAIDs or diuretics), and as soon as possible after any evidence of toxicity, such as gastrointestinal symptoms, increased tremor and other neurological symptoms, or conditions that affect electrolyte and lithium kinetics (change in sodium balance, or symptoms suggesting abnormal renal or thyroid function). Otherwise, and after stabilisation at the desired serum level, serum lithium levels should normally be monitored every 3 months, possibly more often in older patients and those with renal problems. Thyroid and renal function tests should be done every 6 months»

key points

SELECTED BY

Dr Peter Saul

GP, Wrexham and associate GP Dean for North Wales

Bipolar disorder is relatively common, at least twice

as common as schizophrenia, and eminently treatable. It is also perfectly suited to the well established outpatient model practised in general practice and psychiatry. All GP practices should include people with a diagnosis of bipolar disorder on their case register of people with severe mental illness.

It is not possible to exclude a bipolar diagnosis

categorically if there are only symptoms of depression, this means that all depressed patients may turn out to be bipolar. Most patients will have had a (hypo)manic episode by their 30s. The lifetime prevalence of bipolar affective disorder proper is 1%, with a further 1.2% presenting with milder hypomanic symptoms (so-called bipolar II disorder). Relaxing diagnostic symptom criteria increases the frequency of depressed patients who develop symptoms of mania for any length of time to 50%.

The lifetime course of the illness tends to be dominated

by depressive episodes: half the time is estimated to be spent in the euthymic (well) state, 12% in a manic state and 38% in a depressed state. Any depressed patient should be asked about periods in the past when (s)he has been elated in mood, found it unnecessary to sleep, talked a lot, spent excessive amounts of money etc.

Treatment for bipolar disorder has to be divided into:

treatment of mania, treatment of bipolar depression and prophylaxis of mood swings in either direction. Antidepressant treatments are unlikely to help manic symptoms, at worst they can precipitate or aggravate them. Antimanic treatments are unlikely to help symptoms of depression but an exception to this rule would be a genuine mood stabiliser, such as lithium.

The most important procedures unique to bipolar disorder

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Patients with bipolar disorder should have an annual

physical health review. This will include monitoring for weight gain, lipid levels, including cholesterol in all patients over 40 even if there is no other indication of risk, plasma glucose levels, smoking status and alcohol use, as well as blood pressure. Manic and hypomanic patients must cease driving during the acute illness.

or more often if there is evidence of impaired renal function.

Patients with bipolar disorder should have an annual physical health review. This will include monitoring:

- weight gain caused by lithium, atypical antipsychotics, antidepressants, oedema, hypothyroidism or overeating
- lipid levels, including cholesterol in all patients over 40 even if there is no other indication of risk
- plasma glucose levels
- smoking status
- alcohol use
- blood pressure.³

In special situations, such as treatment resistance, deteriorating renal function, or unexpected pregnancy, advice from relevant specialists may be necessary.³

The clinician should also be aware of, and be able to advise the patient on, the restrictions imposed on driving by the DVLA.¹¹ In particular, manic and hypomanic patients must cease driving during the acute illness. Re-licensing can be reconsidered, if the patient:

- remains well and stable for at least 3 months
- is compliant with treatment
- has regained insight
- is free from adverse effects of medication which would impair driving
- can provide a favourable specialist report.¹¹

CONCLUSION

Bipolar disorder has been described as the heartland of psychiatry.¹ It is a disorder during which patients are intermittently severely ill and unable to function in their normal environment, but they usually return to their normally functioning self. While the extremes of symptoms and experiences require intensive specialist care, the overall success of management will depend on an informed and complementary interaction between primary and secondary care.

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Useful information

For doctors

Further information about True Colours is available from the True Colours Office, University of Oxford, Department of Psychiatry, Warneford Hospital, Oxford OX3 7JX, tel: 01865 613167 (answer phone out of hours), email: truecolours@psych.ox.ac.uk

For patients

MDF The Bipolar Organisation
www.mdf.org.uk

Bipolar Scotland

www.bipolarscotland.org.uk

NIMH

www.nimh.nih.gov/health/publications/bipolar-disorder/complete-index.shtml

Rethink

www.rethink.org/about_mental_illness/index.html

Royal College of Psychiatrists

www.rcpsych.ac.uk/mentalhealthinfo/forall/problems/bipolarmanicdepression/bipolardisorder.aspx

SANE

www.sane.org.uk/AboutMentalIllness/ManicDepression

We welcome your feedback

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