

key points

SELECTED BY

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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

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. After stabilisation at the desired serum level, serum lithium levels should be normally 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 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 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.