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

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

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.

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.

Non-pharmacological therapy

NICE emphasises the importance of non-pharmacological therapy, including structured psychological interventions, such as cognitive behaviour, interpersonal, psychodynamic, 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.

Antipsychotics should not be prescribed for longer than 12 weeks without review. 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.

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 4, above.

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.

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, 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.

‘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. 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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