Diagnosis and Treatment of Bipolar Disorder in the Primary Care Setting

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Objectives

1. Understand the basics of Bipolar Disorder
2. Understand the diagnosis of Bipolar Disorder
3. Understand the treatment of Bipolar Disorder

Historical Context

- Areataeus of Cappadocica (1st Century A.D.)

  "laugh, play, dance night and day, and sometimes go openly to the market crowned, as if victors in some contest of skill' only to be torpid, dull, and sorrowful at other other times"

Historical Context

- Baillarger and Falret (1854)
  - Circular insanity
  - Dual form insanity

Famous Patients

Famous Patients

Famous Patients

Prevalence

- Bipolar I
  - Lifetime Prevalence 1%
- Bipolar II
  - Lifetime Prevalence 1.1%

Onset

- Mean age=18
- Most have a depressive episode first
- Males slightly more than females (1.1:1)

Disability

- Variable function between episodes
- Up to 30% have severe impairment
- 42% of patients working

Diagnosis

- Bipolar Disorder DOES NOT equal “mood swings”

Diagnosis

- Bipolar Disorder is an *Episodic* Illness:
- Mania
- Euthymic
- Depression

Mania

A. Distinct period of abnormally and persistently elevated, expansive, or irritable mood AND abnormally and persistently increased goal-directed activity or energy

B. Plus 3 of 7 symptoms

Mania

- Symptoms:
  - D
  - I
  - G
  - F
  - A
  - S
  - T

Mania

- D istractibility
- I ncreased activity or psychomotor agitation
- G randiosity or inflated self-esteem
- F light of ideas or racing thoughts
- A ctivities that are risky
- S leep need decreased
- T alkative or pressured speech

Mania-Timing

- Must last for at least a week
- Can be shorter if hospitalized

Mania Diagnostic Strategies

- Must have the symptoms together
- Discuss with family members
- Obtain previous records

Hypomania

- Same criteria
- Level of impairment is not severe

Diagnostic Conundrums

- Substance use
- Other mood disorders
- Psychotic disorders
- Personality disorders
- Medications

Substance Use

- Cannot diagnosis while actively engaged in stimulating substances
- Cannot historically diagnosis without questioning about substance use
- If there is a question of diagnosis, best to monitor for some time without substances

Other Mood Disorders

- Major Depressive Disorder
- Cyclothymia

Psychotic Disorders

- Schizophrenia
- Delusional Disorder
- An acutely psychotic and an acutely manic individual can look very similar

Personality Disorders

- Often “mood swings” is Borderline Personality Disorder
- “Does your mood change minute to minute? Do you get angry easily?”
- Some individuals are just more animated than others

Robin Williams

Medications

- Steroids
- Stimulants
- Antidepressants

Diagnosis Conclusion

- Establish the criteria needed for a manic episode
- Establish the criteria needed for a depressive episode
- State which episode the patient is currently in

Bipolar vs. Depression

- Major Depressive Disorder
  - There is no way to know if they have had a manic episode in the past unless you ask/inquire
  - Without asking you run the risk of inducing mania with antidepressant therapy
  - Important to ask at the time of first diagnosis before treatment is started

Bipolar vs. Depression

- Bipolar II
  - If they have or have had Major Depressive Disorder and have hypomania

Bipolar vs. Depression

- Bipolar I
  - They have a history of mania

Treatment

- Depends on current phase:
  - Mania
  - Depression
  - Euthymic (maintenance)

Treatment of Mania

- 3 tiered simultaneous approach:
  - Mood Stabilizer
  - Atypical Antipsychotic
  - Benzodiazepine

Mood Stabilizers

- Lithium
- Lamictal
- Depakote
- Carbamazepine
- Oxcarbazepine

Lithium

- Dose around 900mg daily
  - Different formulations
- Level checked after approximately five days
  - Range 0.5-0.8

Alevizos et al. Low dosage Lithium augmentation in venalafaxine resistant depression: an open label study. Psychiatriki, 2012, 23:143-8.

Lithium

- Potentially toxic
- Narrow therapeutic window
- Avoid dehydration and nephrotoxic drugs
  - Ibuprofen, Advil, Motrin, Ace-I, Aleve, diuretics

Stahl, Sephen. Stah's Essential Psychopharmacology: The Prescriber's Guide, 3rd Edition. Cambridge Press, New York, 2009.

Lithium

- Workup prior to starting:
  - BMI
  - EKG
  - TSH
  - BMP
  - Lipids

Stahl, Sephen. Stah's Essential Psychopharmacology: The Prescriber's Guide, 3rd Edition. Cambridge Press, New York, 2009.

Lamictal

- Start at 25mg and increase accordingly:
  - 50 mg at 2 weeks
  - 100mg at 1 month
  - 150 at 2 months
  - 200 at 3 months
- Restart titration if >5 missed doses
- Stevens Johnson Syndrome

Depakote

- Weight based dosing…usually around 1000mg-1250mg daily
- Excessive weight gain
- Teratongenic

Bipolar Depression

- Lamictal
- Antidepressant as long as they are on a mood stabilizer
- Be cautious in the antidepressant you choose

Bipolar Maintenance

- Can continue the mood stabilizer that relieved their mania

- Discontinue adjunctive therapy
  - Atypical antipsychotics
  - Benzodiazepines

Atypical Antipsychotics

- Have some benefit
- Different ranges of FDA indications in Bipolar Disorder
- Have been proven inferior to mood stabilizers

Conclusion

- Bipolar Disorder is long recognized as distinct among mental illness
- An accurate diagnosis can be difficult but is very important
- Treatment should be best practices and evidenced based

Questions?

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