

FINDING & FIXING BIPOLAR DISORDER



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LEARNING OBJECTIVES

Learn

how to accurately diagnose bipolar disorder and commonly associated psychiatric comorbidities

**Focus
on**

measurement-based care and treatment adherence

Know

when and why to refer bipolar patients to a mental health specialist and criteria for hospitalization.

CASE PRESENTATION

A 45-year-old married, domiciled, employed man with no past psychiatric history presented to his primary care physician and reported one month of low mood, poor sleep, poor concentration, anhedonia and passive suicidal ideation. After citalopram 20mg once daily demonstrated no efficacy over several months, the patient was cross titrated onto sertraline 100mg once daily. Eight days after the initiation of sertraline and after the complete cessation of citalopram, the patient's family brought him to his primary care physician where he reported increased energy, decreased effective productivity at work, "talking a lot," "needing to sleep only a couple of hours per night," racing thoughts, and "being very happy" with plans to "rule the world."

QUESTIONS TO CONSIDER

- What diagnoses should be considered and how can the diagnosis be clarified?
- What are the criteria for hospitalization in this case?

BIPOLAR SPECTRUM DISORDERS

- Bipolar Disorder 1 (BD I): defined by **manic episodes** that last **1 week** or **require hospitalization**.
 - Significant **impairment** in psychosocial functioning
 - Accompanied by **psychotic features**
- Bipolar Disorder II (BD II): defined by **hypomanic episodes** which are **shorter duration** -4 days- and less functional impairment than mania
- Cyclothymia: includes periods of **hypomanic** and **depressive symptoms** that last at least 2 years in adults (1 year in children).

Note: a full manic episode that emerges during antidepressant treatment (e.g., medication, ECT) but persists at fully syndromal level beyond the physiological effect of that treatment is sufficient evidence for a manic episode and therefore bipolar I diagnosis.

BIPOLAR DISORDER

Symptoms

Mania

Inflated self-esteem or grandiosity
Distractibility
Prolixity or pressured speech
Psychomotor agitation
Goal-directed activity ↑
Need for sleep ↓
Energy and activity ↑
Risk-taking behaviour
Flight of ideas or racing thoughts
Elevated and/or expansive mood
Irritable mood

Depressed mood

Anhedonia

Feelings of guilt or worthlessness

Sleep ↑ or ↓

Weight or appetite ↑ or ↓

Fatigue or loss of energy

Psychomotor retardation

Ability to think or concentrate ↓

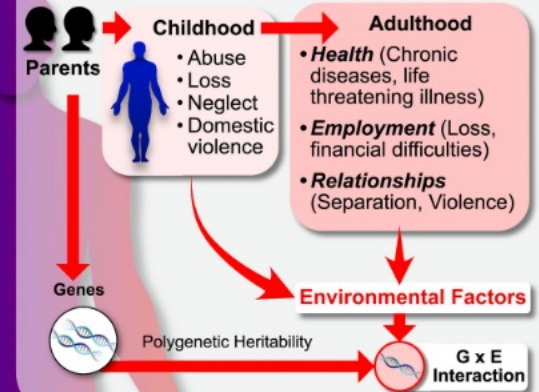
Suicidal ideation, plan or attempt

Depression

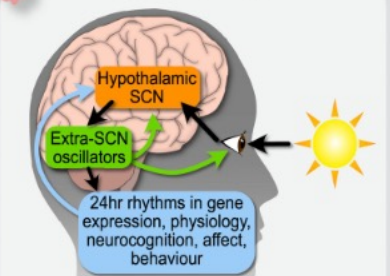
Facts

- 1 in 100 people will experience bipolar disorder in their lifetime
- Bipolar disorder affects men and women equally
- Average onset occurs in late teens, but average age of diagnosis is late 20s
- Bipolar disorder confers a risk of suicide 30 - 60 times the general population

Genetic and Environmental Causes



Chronobiology



ASSESSMENT AND FORMULATION

- Screening tools: Mood Disorder Questionnaire, the Hypomanic/Mania Symptom Checklist
- Specific questions to ask to assess for mania/hypomania:
 - Elevated Mood:**
“Have you ever had a period of sustained extreme happiness or elation”
 - Irritability:**
“have your friends or family commented on your irritability”
 - **Distractibility:**
“have you ever found it easy to jump from one idea to another?”
 - Grandiosity:**
“ever get the feeling you have super powers or you are invincible?”
 - Flight of Ideas:**
“racing thoughts in your head?”
 - Activity:**
“have you been doing a lot more at work? Sexual indiscretion when you normally wouldn’t? Having sexual relations with strangers?”
 - Sleep:**
“has your sleep decrease to the point where you don’t have to sleep for days? More specifically, you are not sleeping because you have so much energy and you don’t need to sleep?”

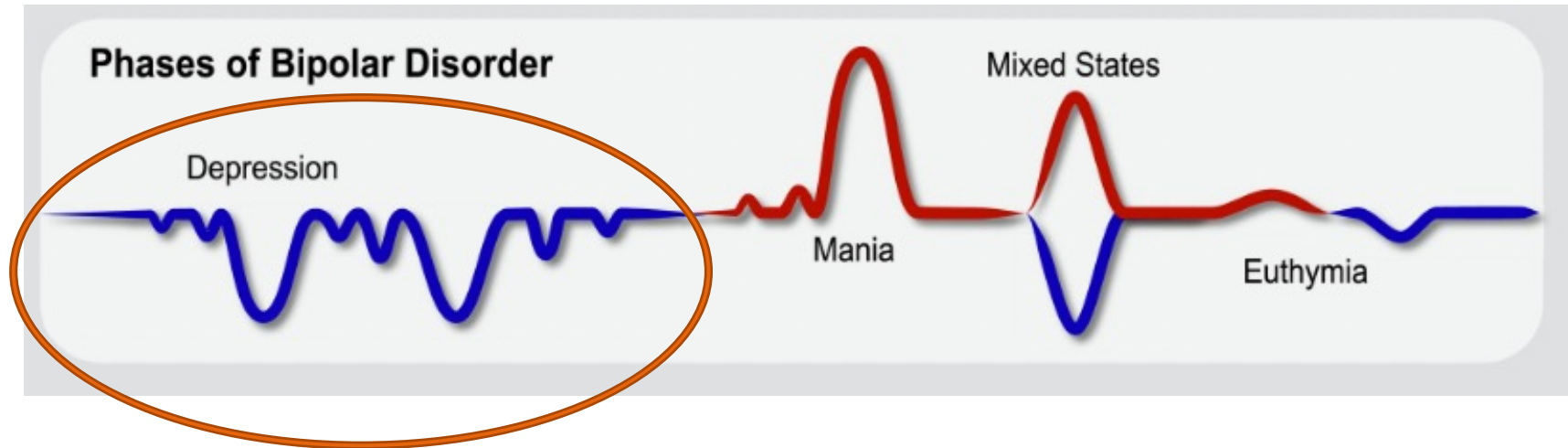
CASE CONTINUED

The patient was admitted to inpatient psychiatry. Labs including complete blood cell count, electrolytes, thyroid stimulation hormone (TSH), urine toxicology and serum alcohol level were all unremarkable. Sertraline was discontinued and Lithium 300mg BID was started and was uptitrated to a therapeutic dose of 1200mg daily, with serum concentration being 0.8 mEq/L (therapeutic range 0.6-1.2 mEq/L). Patient's manic symptoms rapidly improved and he was discharged after a 1-week stay. Patient achieved euthymia and continued follow-up with his primary care provider.

Six months later, patient presents with low mood, anhedonia, fatigue, and poor sleep. Patient reports that he is hopeless, and his life is not worth living anymore. He recently mentioned to family that he plans to buy a gun. He scored 21/27 on the Patient Health Questionnaire -9 (PHQ-9).

ASSESSMENT AND FORMULATION

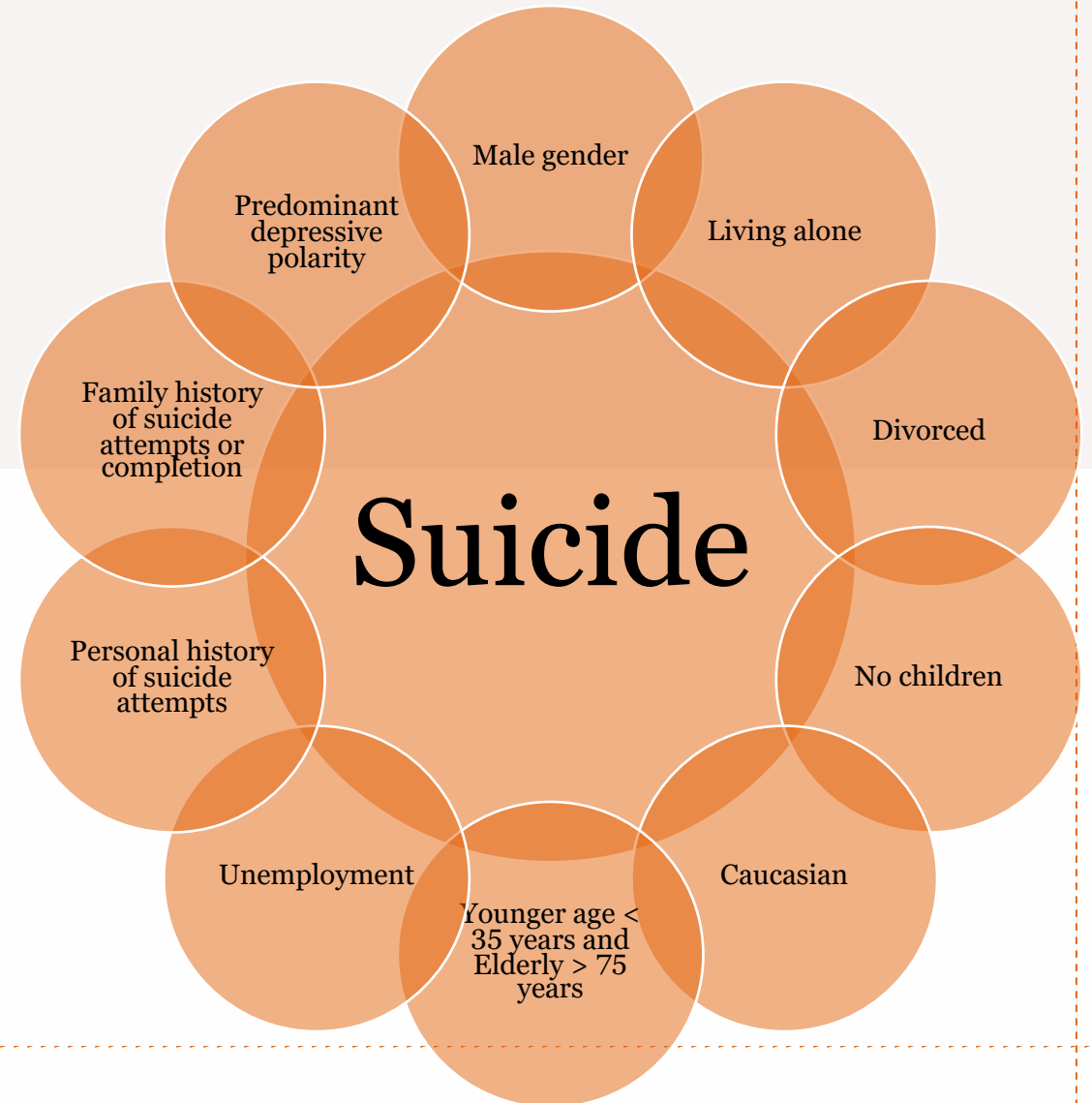
- Adherence to medications: treatment cessation trigger episodes
- Assess the severity of depressive symptoms
 - Patient Health Questionnaire -9



BIPOLAR DISORDER AND SUICIDE

- Highest rate of suicide of all psychiatric conditions
 - 20-30 times that of the general population
 - x2 of MDD
- Suicide behavior is uncommon in manic or hypomanic patients

→ Do not avoid the topic of suicide



SAFETY EVALUATION

- Complete a **safety evaluation** and assess for **suicidal ideation, method, plan** and **intent**
 - Suicidal ideation
 - Active suicidal ideation: thoughts of taking action to kill oneself
 - Passive suicidal ideation: the wish or hope that death will overtake oneself
 - Suicide plan and degree of intent to kill oneself
 - Has a specific plan been formulated or implemented, including a specific method, place and time? What is the anticipated outcome of the plan?
 - Are the means of committing suicide available or readily accessible? Does the patient know how to use these means?
 - What is the lethality of the plan? What is the likelihood of rescue?
 - Past history and Family History of suicide should also be assessed
 - Protective factors: social support and family connectedness, pregnancy, parenthood, religiosity

COLUMBIA-SUICIDE SEVERITY RATING SCALE
Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	Past month	
	YES	NO
Ask questions that are bolded and <u>underlined</u> .		
Ask Questions 1 and 2		
1) <u>Have you wished you were dead or wished you could go to sleep and not wake up?</u>		
2) <u>Have you actually had any thoughts of killing yourself?</u>		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) <u>Have you been thinking about how you might do this?</u> <i>E.g. "I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it...and I would never go through with it."</i>		
4) <u>Have you had these thoughts and had some intention of acting on them?</u> <i>As opposed to "I have the thoughts but I definitely will not do anything about them."</i>		
5) <u>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</u>		
6) <u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u> <i>Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.</i> If YES, ask: <u>Was this within the past three months?</u>		

- Low Risk
- Moderate Risk
- High Risk

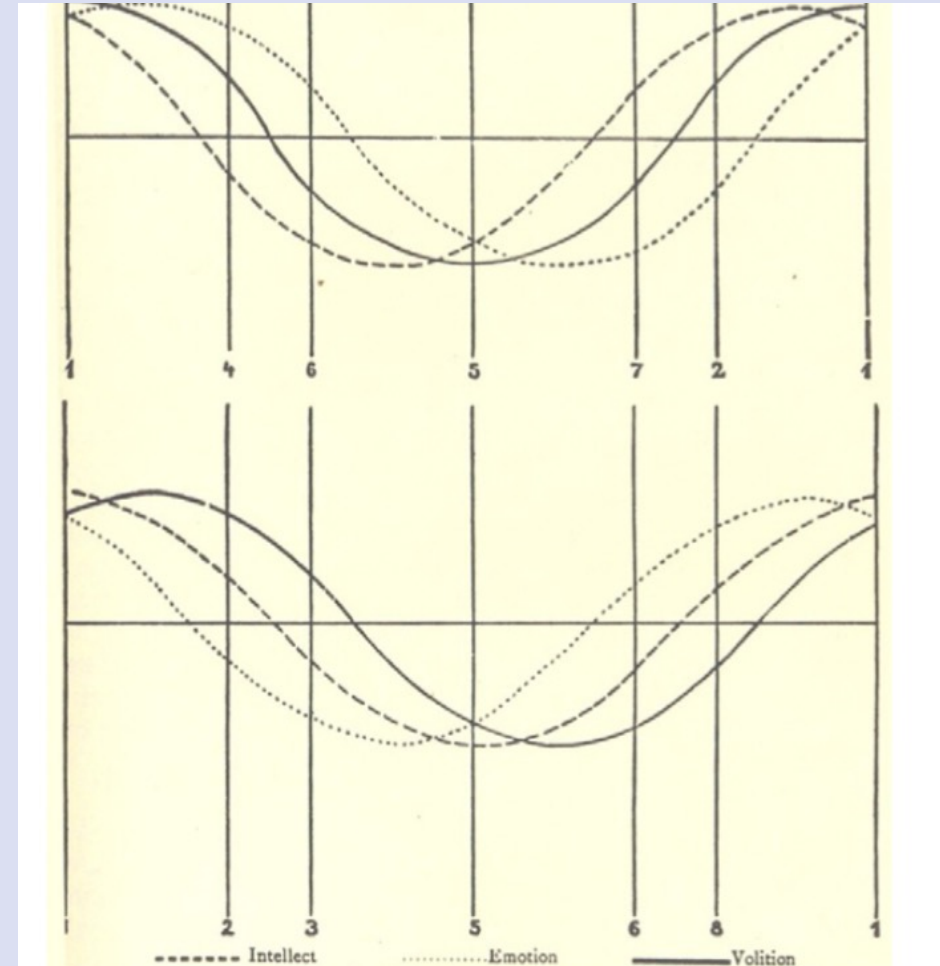
Columbia-Suicide Severity
Rating Scale (C-SSRS)
assessment

CASE PRESENTATION

A 38-year-old man with a past psychiatric history of bipolar disorder type I on long-standing lithium 900mg daily and bupropion 150mg daily who presented to the primary care clinic due to fatigue. He reports being unable to work for 6 months because “I am a failure, and I don’t have enough energy to get up in the morning.” He reports a long-standing history of sleep problems and now lays awake in bed every day from 3 am until mid-morning. He smokes 15 cigarettes throughout the day “to try to get moving.” He has gained 18 pounds over 6 months and now has a body mass index of 26 and daily low back pain. He endorses problems with concentration, decreased interest in previously pleasurable activities, low energy, racing thoughts and flight of ideas. His girlfriend ended their relationship, reportedly due to his ongoing irritability. He was hospitalized once on a psychiatry ward at the age of 19, “because I smoked a lot of pot and did not sleep for 3 weeks, and I spent all of my parents’ money on important electronics.”

MIXED STATES

- Mixed states occur during the transition from depression to mania or vice versa
- Different types of mixed states can develop if during the time, different combinations of **emotion**, **volition**, and **intellect** occur



Emil Kraepelin



SLEEP

- Sleep and circadian disruptions are prominent symptoms of bipolar disorder and are dependent on polarity
 - Decreased need for sleep is seen in mania
 - Insomnia or hypersomnia is seen in depression
 - Genetic contributions have been implicated BD
- Social Zeitgeber Theory of Bipolar Disorder:
 - Life events disturb social zeitgebers (time givers) which lead to disturbance of biological rhythms
→ affective symptomatology in vulnerable individuals
 - Regular social schedules, meal times, regular awake/sleep times, and regular exposure to light and dark are important
 - Changing the time (springing forward in the spring) can be difficult for some bipolar patients

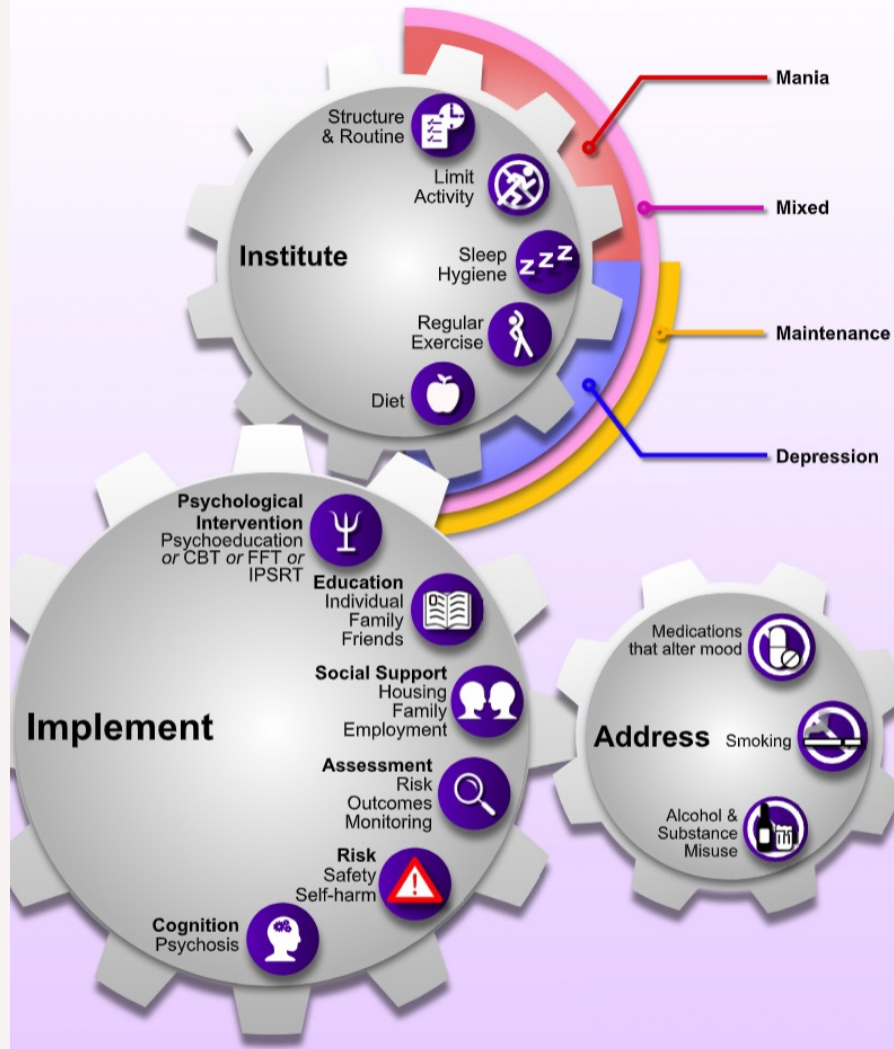
CASE CONTINUED

Patient endorses compliance with his medications. His bupropion 150mg daily was discontinued. Labs including electrolytes, blood count, thyroid function, and urine drug screen was within normal limits. ECG was normal. Lithium level was 0.4 mEq/L (therapeutic range 0.6-1.2mEq/L).

Lithium was increased to a therapeutic dose of 1200mg once daily with repeat lithium level being 0.6 mEq/L. Olanzapine 5mg was added and uptitrated to 10mg once before bedtime. Patient also implemented adequate sleep measures. He was then referred to an outpatient psychiatrist for continued medication management and longitudinal monitoring.

TREATMENT OF BIPOLAR DISORDER

ACTIONS



Options for Management of Bipolar Disorder:

- Lifestyle Measures
- Pharmacotherapy
- Psychosocial Interventions
- Neuromodulation: ECT

GENERAL CLASSES OF PHARMACOTHERAPY FOR BIPOLAR DISORDER

Treatment	Features	Indications
Lithium salts (as carbonate hydroxide monohydrate and citrate salts)	Dose adjustment to therapeutic serum levels (0.6-1.2 mEq/L); monitor for signs of lithium toxicity, maintain adequate fluid and salt intake due to potential sodium depletion with lithium therapy. Avoid diuretics, ACE inhibitors, NSAIDs, COX inhibitors	Acute episode of either polarity, maintenance
Divalproex and valproic acid	Potential to cause hepatotoxicity; liver function must be monitored; increased risk of pancreatitis	Acute mania, mixed episodes and maintenance
Antipsychotics	Potential for treatment emergent tremor and EPS; metabolic syndromes, weight gain; and monitor for tardive dyskinesia	Adjunctive treatment in mania/depression
Lamotrigine	Maintenance treatment for BD; start/stop gradually for potential SJS; slower titration when used with divalproex and potentially other inhibitors of UGT glucuronidation	Bipolar depression

Treatment Recommendations: APA Clinical Practice Guidelines

- Treatment of acute mania or mixed episode:
 - Lithium + antipsychotic or valproate + antipsychotic
 - Monotherapy with lithium, valproate, or an antipsychotic (e.g. olanzapine, Risperdal)
 - Short – term adjunctive treatment with a benzo may also be helpful
 - Alternatives include carbamazepine or oxcarbazepine in lieu of lithium or valproate
 - Taper/discontinue antidepressants
 - For severe or refractory cases: clozapine and/or ECT

- Treatment of depressive episodes:
 - Initiation of either lamotrigine or lithium
 - Antidepressant monotherapy is not recommended
 - It is possible to add lithium and an antidepressant
 - For suicidal patients, ECT can be used
 - Psychotherapy: CBT or interpersonal therapy

ANTIDEPRESSANTS IN BIPOLAR DEPRESSION: AN ENDURING CONTROVERSY

- Evidence of antidepressants in treating bipolar depression is weak
- Many experts and clinicians worry about antidepressants' capacity to cause switching or mood stabilization
 - Seen in older antidepressants e.g. tricyclics
 - Evidence with SSRIs is lacking
 - Short term studies- most patients taking both mood stabilizers and antidepressants do not switch
- Predictive of affective switching with antidepressants include:
 - Bipolar I disorder (v.s. bipolar II)
 - Mixed features
 - TCAs versus modern antidepressants
 - Rapid cycling
 - History of drug abuse especially stimulant abuse

CONCLUSION

- History, use of rating scales, and can help in Bipolar Disorder diagnosis
- Assessing for suicidality is crucial to keep patients safe
- Ensure treatment adherence and barriers to treatment adherence
- Lithium, Depakote, lamotrigine and antipsychotics can treat bipolar mania and mixed episodes
- Most bipolar patients don't respond to antidepressants in bipolar depression

PATIENT PERSPECTIVE

This is excellent.

“When I’m manic, I tend to lose control of myself and my activities. I also experience psychosis, which is when you lose touch with reality. When I’m hypomanic, I’m very energetic. I’m impulsive. I’m risk-taking. I can be irresponsible in my decisions... You can treat mania pretty quickly when you can catch it. But the depression lasts for months and for years. It’s the most debilitating part of the illness. And it’s very very discouraging. It’s very demotivating. You can’t function during the day. You can’t pursue recovery, and recovery is what we want. But we lack the motivation to pursue these goals. And I like to say it’s the mania that gets you into trouble, but it’s the depression that can kill you.”