

Bipolar disorder

Bipolar disorder - F31 (Clinical term: Bipolar affective disorder Eu31)

Presenting complaints

Patients may have a period of depression, mania, mixed manic and depressive symptoms, or unusual or abnormal behaviour, with the pattern described below.

Referral may be made by others due to the patient's lack of insight.

Diagnostic features

Periods of mania with:

- increased energy and activity
- elevated mood or irritability
- rapid speech
- loss of inhibitions, including financial and sexual inhibitions
- decreased need for sleep
- increased importance of self
- delusions, hallucinations, disturbed or illogical thinking.

The patient may be easily distracted.

The patient may also have periods of depression with:

- low or sad mood
- loss of interest or pleasure
- disturbed sleep
- poor concentration or irritability
- guilt or low self-worth
- disturbed appetite
- fatigue or loss of energy
- suicidal thoughts or acts
- delusions, hallucinations, disturbed or illogical thinking.

Either type of episode may predominate. Episodes may alternate frequently or may be separated by periods of normal mood. Psychotic phases include strange or illogical beliefs, or disturbed or illogical thinking.

Mixed states are very common; even if criteria for mixed states are not met, depressive symptoms are very common in manic episodes and associated manic symptoms can occur in bipolar depression.

Lesser degrees of mania and hypomania can be missed on a brief interview and collateral information from relatives is vital.

Differential diagnosis

- Alcohol misuse - F10 or Drug use disorder - F11# can cause similar symptoms.
- Chronic psychotic disorders - F20# (psychotic subtype, schizoaffective disorder or schizophrenia) or major Depression - F32#, especially where psychotic symptoms are present.

Essential information for patient and family

- Unexplained changes in mood and behaviour can be symptoms of an illness.
- Effective treatments are available. Long-term treatment can help prevent future episodes.
- If left untreated, manic episodes may become disruptive or dangerous. Manic episodes often lead to loss of job, legal problems, financial problems or high-risk sexual behaviour. When the first, milder symptoms of mania or hypomania occur, referral is often indicated and the patient should be encouraged to see their GP straight away.
- Inform patients who are on lithium of the signs of lithium toxicity (see Medication) (see Lithium toxicity)
- Manic symptoms can be followed by depressive symptoms; the patient's GP should be informed of major changes in the patient's mood and the occurrence of suicidal ideas.

General management and advice to patient and family

(See What is bipolar disorder?)

- Remain optimistic and emphasize the patient's strengths and abilities rather than deficits.
- In acute manic or depressive episodes, refer urgently to secondary care.
- During depression, assess risk of suicide. (Has the patient frequently thought of death or dying? Does the patient have a specific suicide plan? Have they made serious suicide attempts in the past? Can the patient be sure not to act on suicidal ideas?) Ask about risk of harm to others. (see Depression - F32# and Self-harm).
- During manic periods:
 - avoid confrontation unless necessary to prevent harmful or dangerous acts
 - advise caution about impulsive or dangerous behaviour
 - close observation by family members is often needed
 - if agitation or disruptive behaviour are severe, hospitalization may be required
 - suicide is not unknown, especially in mixed states. Identify early warning signs with the patient and family
- During depressed periods, consult management guidelines for depression (see Depression - F32#).
- Describe illness and possible future treatments.
- Encourage the family to consult, even if the patient is reluctant.
- Women with bipolar disorder who are planning pregnancy or to become pregnant should seek early advice about control and prevention of the illness and use of medication ante- and postnatally. The risk of relapse is high postnatally. Specialist advice is indicated.
- Work with patient and family to identify early warning symptoms of mood swings, in order to avoid major relapse.
- The treatment plan should include recognition of early warning signs and the agreed management of crises should be clearly recorded in the medical records; a copy of the plan should be given to the patient, and with the patient's permission, to the family/carers.

- For patients able to identify early symptoms of a forthcoming 'high' (sleep disturbance is the most important warning sign for mania), advise:
 - planning for a good night's sleep
 - avoid taking major decisions
 - taking steps to limit capacity to spend money (eg give credit cards to a friend)
 - avoiding stimulating or stressful situations (eg parties) (ref 32)
- Therapeutic alliances build on respect and feeling valued; encourage the patient to build relationships with key members of the practice team, eg by seeing the same doctor or nurse at each appointment. Use the relationship to discuss the treatment plan, including medication.
- DVLA must be notified in all cases. Advise patient to inform DVLA: driving should cease during the acute illness (cars and motorbikes) and until patient has been stable and well for at least 3 years with insight into their condition (LGV/PSV driver) (ref 3)
- Cognitive behavioural therapy may be of benefit in relapse prevention of mania and the treatment of depressive episodes.

References

3 Driver and Vehicle Licensing Agency. At a Glance Guide to Medical Aspects of Fitness to Drive. URL <http://www.dvla.gov.uk>. Further information is available from The Senior Medical Adviser, DVLA, Driver Medical Unit, Longview Road, Murrington, Swansea SA99 1TU, Wales.

32 Manic Depression Fellowship. Inside Out: A Guide to Self-Management of Manic Depression. London, 1995. Available from the Manic Depression Fellowship, 8-10 High Street, Kingston-upon-Thames, London KT1 1EY, UK. This advice is based on self-management training, 7-12 sessions of which have been shown to increase time between manic episodes. See Perry A, Tarrier N, Morris R et al. Randomised control trial of efficacy of teaching patients with bipolar disorder to identify early symptoms of relapse and obtain treatment. Br Med J 1999, 318: 149-152. (BII) Teaching patients to recognise early symptoms of manic relapse and seek early treatment is associated with important clinical improvements in time to first manic relapse, social functioning, and employment.

Medication

- If the patient displays psychotic symptoms, increasing agitation, excitement or disruptive behaviour, antipsychotic medication may be needed initially (ref 33) (BNF section 4.2.) Antipsychotic medication has a specific antimanic action. The doses should be the lowest possible for the relief of symptoms (ref 34). If antipsychotic medication causes acute dystonic reactions (eg muscle spasms) or marked extrapyramidal symptoms (eg stiffness or tremors), antiparkinsonian medication (BNF section 4.9), eg procyclidine, 5 mg orally up to three times a day, may be helpful. Routine use is not necessary. Atypical antipsychotics, eg olanzapine, are now widely used and usually obviate the need for antiparkinsonian medication.
- Benzodiazepines may also be used in the short term with or without antipsychotic medication and mood stabilizers to control acute agitation (ref 35) (BNF section 4.1.2) and re-establish a normal sleep pattern. Examples include diazepam (5-10 mg up to four times a day) or lorazepam (1-2 mg up to four times a day). If required, diazepam can be given rectally, or lorazepam IM (although it must be kept refrigerated).
- Lithium can help relieve mania (ref 36) and depression (ref 37) and can prevent episodes from recurring (ref .38,39). One usually commences or stops taking lithium only with specialist advice. Some GPs are confident about restarting lithium treatment after a relapse. Alternative mood-stabilizing medications include carbamazepine and sodium valproate (ref 40).

If lithium is prescribed:

- it takes several days to show effects and is probably slower to act than the antipsychotics - there should be a clear agreement between the referring GP and the specialist as to who is monitoring lithium treatment. Lithium monitoring is ideally carried out using an agreed protocol. If carried out in primary care, monitoring should be done by a suitably trained person.
- levels of lithium in the blood should be measured frequently, when adjusting the dose, and every three months in stable patients, 10-14 hours post-dose (desired blood level is 0.4-1.0 mmol/L [BNF section 4.2.3]; locally recommended levels may vary slightly. **If blood levels are >1.5 mmol/L or there is diarrhoea and vomiting, stop the lithium immediately.** If there are other signs of lithium toxicity (eg tremors, diarrhoea, vomiting, nausea or confusion) stop lithium and check blood level. Renal and thyroid function should be checked every 2-3 months when adjusting the dose, and every 12 months in stable patients (ref 41).
- Never stop lithium abruptly (except in the presence of toxicity) - relapse rates are twice as high under these conditions (ref.39,42). Lithium should be continued for at least six months after symptoms resolve (longer-term use is usually necessary to prevent recurrences). Lithium should be tapered off over at least four weeks, and rebound mania is substantially reduced if the patient is co-prescribed an atypical antipsychotic.

- Antidepressant medication is often needed during phases of depression but can precipitate mania when used alone (see Depression - F32#). If the patient becomes hypomanic, stop the antidepressant.

References

33 Chou JC-Y. Recent advances in treatment of acute mania. J Clin Psychopharm 1991, 11: 3-21. (BII) Antipsychotics are effective in mania, and they appear to have a more rapid effect than lithium.

34 Rifkin A, Doddi S, Karajgi B et al. Dosage of haloperidol for mania. Br J Psychiatry 1994, 165: 113-116. (BII) Doses of haloperidol over 10 mg a day in management of mania confer no benefit.

35 American Psychiatric Association. Practice Guidelines: Bipolar Disorder. Washington, DC, 1996. (All) Four randomized control trials show that benzodiazepines are effective, in place of, or in conjunction with, a neuroleptic in sedating acutely agitated, manic patients.

36a Cookson J. Lithium: balancing risks and benefits. Br J Psychiatry 1997, 171: 113-119. (BIII)

36b Dali I. Mania. Lancet 1997, 349: 1157-1160.

36c Bowden C, Brugger A, Swann A et al. Efficacy of divalproex versus lithium and placebo in the treatment of mania. The Depakote Mania Study Group. JAMA 1994, 271: 918-924. (CII) This is a randomized controlled trial. Lithium is as effective as valproate and more effective than placebo.

36d A Cochrane Review will soon be available: Bhagwagar Z, Goodwin G, Geddes J. Lithium for acute mania (Protocol for a Cochrane Review). In: The Cochrane Library, Issue 2, 2003. Oxford: Update Software.

37a Zornberg G, Pope H Jr. Treatment of depression in bipolar disorder: new directions for research. *J Clin Psychopharmacol* 1993, 13: 397-408. (BIII) A review of nine controlled studies shows a high response rate to lithium for acute bipolar depression. Response may take six to eight weeks to become evident, however.

37b A Cochrane Review will soon be available. Gijsman HJ, Rendell J, Geddes J, Nolen WA, Goodwin GM. Antidepressants for bipolar depression (Protocol for a Cochrane Review). In: *The Cochrane Library*, Issue 2, 2003. Oxford: Update Software.

37c A Cochrane Review will soon be available. Bhagwagar Z, Goodwin G and Geddes J. Lithium for bipolar depression (Protocol for a Cochrane Review). In: *The Cochrane Library*, Issue 2, 2003. Oxford: Update Software.

38a Goodwin G. Lithium revisited: a re-examination of the placebo-controlled trials of lithium prophylaxis in manic-depressive disorder. *Br J Psychiatry* 1995, 167: 573-574. (BIII) Trials show prophylactic use of lithium to be effective, although most trials have had methodological flaws.

38b Berghofer A, Kossmann B, Muller-Oerlinghausen B. Course of illness and pattern of recurrence in patients with affective disorders during long-term lithium prophylaxis: a retrospective analysis over 15 years. *Acta Psychiatr Scand* 1996, 93: 349-354. The prophylactic effect of lithium can be maintained over at least 10 years.

39 Burgess S, Geddes J, Hawton K, Townsend E, Jamieson K, Goodwin G. Lithium or maintenance treatment of mood disorders (Cochrane Review). In: *The Cochrane Library*, Issue 1, 2003. Oxford: Update Software. (A1) Nine studies were analysed. Lithium was more effective than placebo in preventing relapse in bipolar disorder. Caution should be exercised in abruptly stopping lithium therapy in patients who have been taking it successfully for some time, because of the high risk of relapse.

40 Macritchie K, Geddes J, Scott J et al. Valproate for acute mood episodes in bipolar disorder (Cochrane Review). In: *The Cochrane Library*, Issue 1. Oxford: Update Software, 2003. (A1) Ten studies were analysed. No significant difference in efficacy was seen between valproate and lithium or between valproate and carbamazepine. Valproate might be less effective in reducing manic symptoms than olanzapine but it could cause less sedation and weight gain.

41 Schou M. Effects of long-term lithium treatment on kidney function: an overview. *J Psychiatry Res* 1988, 22: 287-296. This is a qualitative literature review.

42 Goodwin GM. Recurrence of mania after lithium withdrawal. Implications for the use of lithium in the treatment of bipolar affective disorder. *Br J Psychiatry* 1994, 164(2): 149-152. (BIII) Fourteen studies were analysed. More than 50% of new episodes of illness occurred within three months of treatment cessation. Lithium should not be introduced for the prophylactic treatment of bipolar illness unless or until the doctor and patient understand that it must be used for a minimum of two years. If after two years there is no worthwhile benefit, it is more likely that harm, in the form of premature recurrence of mania, will be done.

Liaison and referral

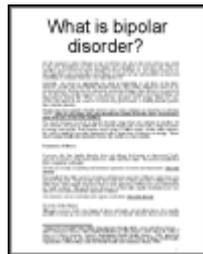
Referral to secondary mental health services is advised:

- as an emergency if very vulnerable, eg if there is significant risk of suicide or disruptive behaviour
- urgently if significant symptoms continue or escalate despite treatment.

Non-urgent referral or advice from specialist worker is recommended:

- for assessment, care planning and allocation of key worker under the Care Programme Approach
- before starting lithium
- for medication review and for other treatment strategies, eg cognitive behavioural therapy
- because of lithium's teratogenicity, for preconceptual counselling or contraception advice; for all women with a history of bipolar disorder to plan prevention and management of high risk (up to 50%) of puerperal psychosis.

Resources for patients and families



[What is bipolar disorder?](#)



[Lithium toxicity](#)

The Manic Depression Fellowship (MDF)

England: 020 7793 2600

Email: mdf@mdf.org.uk; website: <http://www.mdf.org.uk>

Scotland: 0141 560 2050; Email: manic@globalnet.co.uk

Wales: 01633 244 244; Email: mdf.wales@btclick.com; website:

<http://www.manicdepressionwales.org.uk>

Advice, support, local self-help groups and publications list for people with a manic depressive illness.

A leaflet is available from the Royal College of Psychiatrists (<http://www.rcpsych.ac.uk>): Manic depressive illness

Overcoming Mood Swings by Jan Scott. Constable & Robinson, 2001
Self-help manual.

Inside Out: A Guide to Self-Management of Manic Depression. Available from the Manic Depression Fellowship, Castle Works, 21 St George's Road, London SE1 6ES. Tel: 020 7793 2600

Living Without Depression and Manic Depression: a Workbook for Maintaining Mood Stability by Mary Ellen Copeland. New Harbinger Press, USA

New Hope for People with Bipolar Disorder by Jan Fawcett. Crown Publications 2000, Victoria, Canada