Bipolar Disorder Demystified

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Underdiagnoses of Depression In Primary Care

• 2005 Study of 650 primary care patients on antidepressants done at University of Texas

• 21.3% screened positive for Bipolar Disorder

• 67% had never been diagnosed with Bipolar before

# Overdiagnosis of Bipolar Disorder in Psychiatric Settings

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Overdiagnosis of Bipolar Disorder in Psychiatric Settings

Findings

Clinician-based diagnosis of Bipolar: PPV of 34% and NPV of 95%

Only 42.9% of patients diagnosed with Bipolar actually met diagnostic criteria

Only 33% of patients diagnosed with bipolar disorder actually met criteria for that condition. Misdiagnosis associated with cocaine and polysubstance abuse

Clinician-based diagnosis of Bipolar Disorder: PPV of 37% and NPV of 95%

40% of patients with borderline personality disorder mistakenly diagnosed with BD

Patients over diagnosed with BD were significantly more likely to receive disability payments

Goals and Objectives

• Define bipolar disorder and review DSM-5 criteria

• Discuss screening tools that may aid in diagnosing Bipolar Disorder
Goals and Objectives

• Compare and contrast medications used in the treatment of Bipolar Disorder

• Discuss appropriate laboratory monitoring and adverse effects for medications commonly used in the treatment of Bipolar Disorder

• Provide a simple framework for initiating treatment in primary care settings
But isn’t this what psychiatrists are for?
Part 1: What is bipolar disorder and how can I be confident in the diagnosis?
3 Types of Mood Episodes

- Hypomania
- Mania
- Depression
DSM- 5 Criteria for a Manic Episode

A. **Distinct period** of abnormally and persistently elevated, expansive, or irritable **mood** AND abnormally and persistently increased goal-directed **activity or energy** lasting at least 1 **week** and present most of the day, nearly every day
DSM-5 Criteria for a Manic Episode

B. During the period of mood disturbance and increased energy you must have 3 or more of the following (4 if the mood is only irritable)

1. Inflated self-esteem or grandiosity
2. Decreased need for sleep
3. More talkative than usual or pressure to keep talking
4. Distractibility
5. Flight of ideas or subjecting experience that thoughts are racing
6. Increase in goal-directed activity or psychomotor agitation
7. Excessive involvement in activities that have a high potential for painful consequences
C. Symptoms are severe enough to cause marked impairment in functioning

D. Episode is not attributable to effects of a substances or a medical condition*
DSM-5 Criteria for Hypomanic Episode

Same criteria for a manic episode except:

- **Duration**: Changes only have to last 4 days
- **Intensity**: Less impairment
Depression

- Lasts ≥ 2 weeks
- Impaired Functioning
- Sleep change, low interest, guilt, low energy, concentration, appetite changes, psychomotor changes, suicidality

Hypomania

- Lasts ≥ 4 days
- Change in functioning but not major impairment

Mania

- Lasts ≥ 7 days
- Impaired Functioning
- Distractibility, Indiscretion, Grandiosity, Flight of ideas, Activities increased, Sleep deficit, Talkativeness

Bipolar II

Bipolar I*

*Depressive episode is not needed to diagnosis Bipolar I but most people have them

Bipolar I*

*Depressive episode is not needed to diagnosis Bipolar I but most people have them.
Differential Diagnosis for Mania

- Substance intoxication/withdrawal
- ADHD
- Psychosis
- Delirium
- Insomnia
- Traumatic Brain Injury
- Remission of depressive symptoms
- Borderline personality disorder
Clues To the Diagnosis
Clues to the Diagnosis: Highs followed by Lows

- 60% of manic episodes occur immediately before a depressive episode
Clues to the Diagnosis: Age of Onset

• Mean age at onset for first depressive or hypomanic/manic episode is 18 for bipolar I and mid 20s for bipolar II

• Onset of mania can happen in late adulthood but is rarer

Diagnostic and Statistical Manual of Mental Disorders 5th edition. American Psychiatric Association
Clues to the Diagnosis: It’s in the Genes

• Risk increases 10 fold among adult relatives of individuals with bipolar I or II disorders

• Risk increases with degree of kinship
Clues to the Diagnosis: Treatment Failures

Traditional antidepressants are not uniformly considered efficacious for treatment monotherapy for Bipolar Disorder

Diagnosistic and Statistical Manual of Mental Disorders 5th edition. American Psychiatric Association
Clues to the Diagnosis: Screening Questionnaires

- Modified HCL-32 (Hypomania Checklist)
- Mood Disorder Questionnaire (MDQ)
- Bipolar Spectrum Diagnostic Scale (BSDS)
Mood Disorders Questionnaire (MDQ)

• Sensitivity .58 (primary care setting)
• Specificity .93 (primary care setting)

• Negative screen does not exclude Bipolar

Asking Patients about Manic Symptoms

• Have you ever felt the complete opposite of **depressed**, to the point that others were worried that you were too happy?

• Have you ever had so much **energy** that you could go for days with very little sleep or no sleep?
Part 2: Now what do I do about treatment?
Refer to Psychiatry and **Consider** Initiating a Treatment
Why Treat?

- About half of individuals will have a repeat episode in 1 year without treatment

- 90% will have a repeat manic episode in their lifetime
Medication Complications

• At the very least primary care providers need to be aware of medical complications of treatment
But what if I’m still unsure?
Refer to Psychiatry before initiating treatment
But what if I miss the diagnosis and I start them on an SSRI?
Rates of switching

• Rates of switching into mania are controversial but generally reported as low

• Highest risk: TCAs or Venlafaxine (Effexor)

• Lowest risk: Bupropion (Wellbutrin)

If You Decide to Initiate Treatment

Step 1: Refer to Psychiatry
If You Decide to Initiate Treatment

Step 2: Dive In to Treatment
Step 2: Dip Your Toes in the Water
### Antipsychotics
- Seroquel (Quetiapine)
- Zyprexa (Olanzapine)
- Abilify (Aripiprazole)
- Geodon (Ziprasadone)
- Risperdal (Risperidone)
- Thorazine (Chlorpromazine)
- Saphris (Asenapine)

### Mood Stabilizers
- Lithium
- Depakote (Valproic Acid)
- Tegretol (Carbamazepine)

### Depression
- Seroquel (Quetiapine)
- Latuda (Lurasidone)
- Symbyax (fluoxetine/zyprexa)

### Mania
- Lithium and Lamictal (lamotrigine) often used though not FDA approved
Mood Stabilizers
Traditional “Mood Stabilizers”

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<th>Potential Drawbacks</th>
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<td>• Most are anti-seizure agents</td>
<td>• Can be hard to tolerate</td>
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<td>• Well studied in Bipolar</td>
<td>• Most require periodic labs</td>
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<td>• Can monitor blood levels</td>
<td>• Switching and titration can be tricky</td>
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Lithium

• Narrow therapeutic range (0.6-1.2 mEq/ml)*
• Dosed 1-3 times/day depending on formulation
• Renally Cleared
• Teratogenic (Pregnancy category D)

*Anything that decreases GFR will increase Lithium Levels (NSAIDS, thiazide diuretics, dehydration)
Lithium Side Effects

- GI upset
- Hypothyroidism
- Diabetes Insipidus
- Tremor
- Skin problems
- Cognitive slowing
- Fatigue
- Weight gain
- Overdose can be lethal
- Leukocytosis

Lab monitoring: UPT, BMP, TSH at baseline; Li level and repeat labs q6 months once stable
Depakote (Valproic Acid)

- Wide Therapeutic range (50-100 ug/ml)
- Hepatically metabolized
- Pregnancy category D
Depakote Side Effects

- Weight gain
- Sedation
- GI upset
- Alopecia
- Tremor

- Thrombocytopenia
- PCOS
- Increased LFTs
- Increased Ammonia
- Rarely pancreatitis

Lab monitoring: CBC, LFTs at baseline and then q6 months
Lamotrigine (Lamictal)

- No need to check labs
- Pregnancy category C
- Takes 6 weeks to reach therapeutic dose
Lamictal (Lamotrigine) Side Effects

- Rash, Rash, Rash
- Steven’s-Johnson*
- Hepatitis
- Anemia
- Thrombocytopenia
- Balance problems

*If patient’s miss more than 2-3 days in a row, need to start titration over again
Lamictal (Lamotrigine) Titration

- 25mg for 2 weeks
- 50mg for 2 weeks
- 100mg for 1 week
- 200mg
Other “Traditional” Mood Stabilizers

- Carbamazapine
- Oxcarbamazapine
- Topiramate
Antipsychotics
2nd Gen Antipsychotics

Potential Benefits

• Nearly all are approved for mania
• Fairly well tolerated at low doses
• No drug level monitoring
• All can be dosed once daily
Antipsychotics Side Effects

- Hyperglycemia
- Hyperlipidemia
- Weight Gain
- Sedation
- QTc prolongation

- Orthostatic hypotension
- Tardive Dyskinesia
- Dystonia
- Akathesia
- Parkinsonism
Seroquel (Quetiapine)

- Approved for bipolar depression, mania, and maintenance
- Very sedating and Notorious for weight gain
- Target dose is 300mg for bipolar depression
Latuda (Lurasidone)

• Approved for Bipolar Depression
• Has to be taken with food
• Typically not very sedating
• Pregnancy Category B
• Expensive
How do I pick a med?

P- Phase of illness
H- History of prior med trials
A- Associated illnesses
S- Side effects
E- Ease of use/Provider comfort
Assess for severity, suicide and level of functioning

• Refer to Psych and consider starting a treatment with close follow up

Easy Primary Care Treatment Options
1) Do what worked last time
2) Consider VPA OR 2nd Generation Antipsychotic

Mania/Hypomania

Manic → Refer to ED

Hypomania
Assess for severity, suicide and level of functioning
• Refer to Psych and consider starting a treatment with close follow up

Easy Primary Care Treatment Options
1) Do what worked last time
2) Consider VPA OR 2nd Generation Antipsychotic

Maintenance

Treatment Options
• Continue what worked during their last mood episode
• Refer to Psychiatry

Depression
Assess for severity, suicide, and level of Functioning
• Danger to self → ED
• No SI but severity warrants treatment → Consider starting a treatment and make a Psych referral

Easy Primary Care Treatment Options
1) Do what worked last time
2) Consider Lamictal, Latuda, or Seroquel
Additional Resources

• Stahl’s prescriber’s guide
• Mood Disorder Questionnaire (MDQ) is free online
• NAMI.org for patient medication guides
Questions?