Healthier You

Ascension Via Christi

Bipolar Disorder Care Path

Screening and Diagnosis

Diagnosis: Bipolar I Disorder, as the name suggests, is characterized by extremes on the mood spectrum, one being “depression” and other being “mania”. Bipolar Disorder can present as a depressive episode, manic episode or a mixed episode. Diagnostic criteria for depressive episodes are similar to Major Depressive Disorder, the only difference being the history of a manic episode. Mixed episodes have features of both depression and mania present concomitantly.

A manic episode is defined as a distinct episode of abnormally and persistently elevated, expansive or irritable mood, increased goal directed activity or energy, inflated self-esteem, decreased need for sleep, pressured speech, flight of ideas, distractibility, and involvement in risky activities (spree spending, sexual indiscretions) lasting at least 1 week which causes significant impairment in functioning. Patient rarely seeks help voluntarily during a manic episode and is either hospitalized or gets into legal troubles. If the patient does present in the ambulatory setting, is usually coerced by family.

Another entity in Bipolar Disorders is Bipolar II Disorder in which there is no history of full blown manic episode but a milder form of mania called Hypomania. Hypomania lasts >3 days and <7 days and the severity is less than Mania. It is common for patients with Bipolar II disorder to spend more time in depressive episodes than hypomania.

In severe cases of mania or depression, patient may have psychotic symptoms.

NOTE: ANGER OUTBURSTS AND MOOD SWINGS DO NOT CONSTITUTE MANIA/BIPOLAR DISORDER

Screening: “The Mood Disorder Questionnaire (MDQ)” is widely accepted evidence based self-administered screening tool for bipolar disorder.

IMPORTANT: If the MDQ is positive in all three areas and the patient meets the criteria for Bipolar Disorder, treatment is recommended.

Most common differential diagnoses to consider:

- Substance Abuse (alcohol, and often stimulants such as cocaine, amphetamines, hallucinogens)
- Hyperthyroidism
- Recent treatment with steroids

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- Hyper-adrenergic states

Treatment

A. Pharmacotherapy:

1. Early referral to a Psychiatrist would be recommended.
2. Any episode of Bipolar Disorder (Mania, Hypomania, Depression or Mixed) is best treated with a mood stabilizer and not with an anti-depressant medication.
3. First line mood stabilizers are:
   - Lithium: especially in a manic/mixed episode. Check Renal Function Tests and Thyroid Function Tests. Avoid in females of child bearing age (risk of cardiac defects) and in patients with electrolyte abnormalities. Avoid when also taking NSAIDs, ACE inhibitors and thiazide diuretics. Narrow therapeutic index and requires therapeutic drug monitoring with Lithium level. Avoid if high risk of suicide.
   - Divalproex: avoid in females of child bearing age (risk of open neural tube defects). Requires therapeutic drug monitoring with valproic acid levels. Monitor LFTs.
   - Carbamazepine: avoid in females of child bearing age (risk of open neural tube defects). Watch for agranulocytosis and SIADH. It is an auto-inducer, so decreases blood levels of other medications.
   - Oxcarbazepine: avoid in females of child bearing age (risk of open neural tube defects). Watch for SIADH.
   - Lamotrigine: avoid in females of child bearing age (risk of cleft lip & cleft palate). Requires very slow titration because of risk of Steven Johnson Syndrome. Titration is even slower if using Lamotrigine and Divalproex together.
   - Poor data regarding efficacy with gabapentin and topiramate as mood stabilizers.
4. Second line mood stabilizers are atypical antipsychotics:
   - Aripiprazole: Watch for akathisia. Avoid in patients with obesity, Diabetes Mellitus, Dyslipidemia, age >65 (risk of stroke).
   - Asenapine: avoid in patients with obesity, Diabetes Mellitus, Dyslipidemia, age >65 (risk of stroke). Sublingual formulation. No titration required.
   - Lurasidone: minimal metabolic side effects. Only Pregnancy Category B mood stabilizer.
   - Olanzapine: avoid in patients with obesity, Diabetes Mellitus, Dyslipidemia, age >65 (risk of stroke). Causes sedation, may be used if also targeting insomnia. Also watch for orthostasis which is usually transient.
   - Quetiapine: avoid in patients with obesity, Diabetes Mellitus, Dyslipidemia, age >65 (risk of stroke). Causes sedation, may be used if also targeting insomnia. Also watch for orthostasis which is usually transient.

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- Risperidone: avoid in patients with obesity, Diabetes Mellitus, Dyslipidemia, age >65 (risk of stroke). Watch for hyper-prolactinemia.
- Paliperidone: avoid in patients with obesity, Diabetes Mellitus, Dyslipidemia, age >65 (risk of stroke).
- Ziprasidone: avoid in patients with obesity, Diabetes Mellitus, Dyslipidemia, age >65 (risk of stroke). Watch for QTc prolongation.

5. Benzodiazepines: can be used for a short term to target insomnia and mood stability. Long acting benzodiazepines preferred.
6. Bipolar Depression can be challenging to treat and may require treatment with an anti-depressant medication for a short period of time. The anti-depressant should be considered only after the patient is therapeutic on a traditional mood stabilizer or antipsychotic. The thought being that a manic switch would be less likely in the presence of a mood stabilizer.

Other Treatment Considerations:

- Remove access to means of self-harm in severe phase of a depressive episode or a manic episode such as firearms. Avoid giving 90 day supply of medications.
- If patient needs emergent mental health services because of bizarre behavior, self-care failure or potential of danger to self or others, send patient to nearest ED. If concerned about safety of the patient and patient is not reachable, can ask law enforcement to do a “welfare check” on the patient.

Reassessment

Monitor weekly in acute phase. Maintenance reassessment can be done every 2-3 months.

Monitor using MDQ

Therapeutic drug monitoring where applicable

Patient Engagement

Psychoeducation

Encourage compliance

Sleep hygiene education

Community engagement

Specialist Consult

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When to Refer:

- Early referral will be recommended as Bipolar Disorder can be challenging to manage.

References:

1. The Diagnostic and Statistical Manual of Mental Disorders 5th ed.; DSM–5; American Psychiatric Association [APA], 2013
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3. Practice Guideline for the Treatment of Patients with Bipolar Disorder. 2nd ed. American Psychiatric Association Work Group on Bipolar Disorder. Hirschfeld RM et al. April 2002.
4. Guideline Watch: Practice Guideline for the Treatment of Patients with Bipolar Disorder. 2nd ed. Hirschfeld RM. November 2005.

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