

Dealing with bipolar disorder in general practice

Rodseth D, MBBCh MMed

Psychiatrist at WITS Donald Gordon Medical Centre, Honorary Lecturer of the University of the Witwatersrand

Correspondence to: Dr Duncan Rodseth, e-mail: drrodseth@icon.co.za

Keywords: bipolar disorder, mania, hypomania, depression, DSM-IV criteria, bipolar I disorder, bipolar II disorder

Abstract

Bipolar disorder is a complex mood disorder, both in terms of the diagnosis and management. It can have devastating consequences if inappropriately managed, but good management can allow sufferers to lead normal lives. While it is in the general realm of specialist diagnosis and care, general practitioners can play an important role in early identification of the disorder and long-term management, in shared care with the psychiatrist.

© Medpharm

S Afr Fam Pract 2011;53(6):549-553

Introduction

Bipolar disorder is a recurrent, episodic illness, that has a cyclical nature. Typically, patients have sustained episodes of marked mood changes, which last for at least a week (DSM-IV criteria for mania), and may continue for months. These episodes consist of periods of mania or hypomania, depression, or mixed mood, interspersed with periods of normal mood (euthymia).¹

Bipolar disorder is broadly classified as bipolar I disorder, which is usually characterised by at least one lifetime episode of mania, and episodes of depression, and bipolar II disorder, in which patients experience episodes of hypomania and depression, but no mania.² In most patients, depression is the predominant mood state, and this is a frequent reason for presentation.

The frequency of episodes varies tremendously between patients, and at different times, in the evolution of the illness. By definition, patients with bipolar disorder have fewer than four episodes in a year, except for those who suffer from the "rapid cycling" form of the illness.

The lifetime prevalence of bipolar disorder is about one per cent, but may be as high as four per cent,² if disorders in the subtypes of the bipolar spectrum are included. Therefore, it is highly likely that general practitioners will encounter patients with bipolar disorder in their practices.

Bipolar disorder can be a very serious illness, and places an enormous burden on the sufferer and his family and friends. The disease usually manifests in early adulthood,

and impacts on cognitive and emotional development, and this leads to educational, occupational, and interpersonal difficulties.¹ During episodes of mania, patients may act impulsively or be driven by delusional thinking, and destroy many aspects of their lives, including relationships, finances, and occupations, within a very short time.² Their lives are often placed at risk. They may commit criminal acts as a result of distorted ideas, and be imprisoned as a result. This complicates the situation considerably, particularly if, while in a manic state, they are in a foreign country.

During the depressive phase of the illness, suicide is a serious risk, and depression can also have a profound impact on occupational and social functioning.

Diagnosis: complexities and controversies

Generally, the diagnosis of bipolar disorder is not a spot diagnosis. An incorrect diagnosis can have far-reaching consequences for patients. If the diagnosis is missed, and inappropriate treatment prescribed, this might precipitate an episode of illness, together with all the dangers associated with mania or depression. On the other hand, a glib and inaccurate diagnosis might have implications with regard to patients' occupations, insurability, and other areas of their lives.

In one study, carried out among members of a support group, it was found that about two-thirds of the patients were initially incorrectly diagnosed. The misdiagnoses included depression, anxiety disorders, schizophrenia, borderline or

antisocial personality disorder, alcohol or substance misuse or dependence, and schizoaffective disorder.²

The diagnosis is frequently difficult to make, and may not be obvious, even to the most practised eye. In order to establish whether or not the condition is bipolar disorder, it is necessary to follow patients longitudinally.

In order to clarify the diagnosis, a very useful tool to use is a mood chart, with which patients rate their mood every day on a scale that encompasses manic and depressed moods. This also educates patients about the condition, and enhances their insight and ability to judge their mood, and to become aware of the trigger factors that precipitate mood changes. It may be useful to review a patient's mood chart over several weeks, or even months, before making a definitive diagnosis.

Instruments such as the Mood Disorders Questionnaire (MDQ) are accurate, and are very useful for screening patients with mood disorders, but they should not replace a thorough clinical assessment.

The diagnosis of the disorder should be made carefully, and should include a detailed history from patients, including a family history, and collateral history from family members or work colleagues.

A positive diagnosis of the condition generally implies life-long treatment, and so it is vital that patients commit to long-term management. At the best of times, medication adherence is poor.² Diligent follow-up and education improves treatment adherence. Abrupt discontinuation of lithium treatment is often followed by a manic episode, and so merely giving a prescription without adequate commitment from patients, may worsen the long-term prognosis, especially if they discontinue treatment after only a few months.

The diagnosis of bipolar disorder is often complex, for a number of reasons. At the time of assessment, patients mood states may distort the manner in which they recall their history, and they may underplay, or even exaggerate, previous episodes. Patients rarely report manic or hypomanic symptoms.²

Patients may deny experiencing the symptoms because they are unwilling to accept the diagnosis, or to take medication indefinitely. They also may not be willing to sacrifice the hypomanic or manic periods, during which they feel so good. Patients may present to general practitioners with complaints, frequently at the instigation of family members, of impulsive behaviour, such as aggressive outbursts, excessive spending, substance abuse, or volatile

mood swings. These symptoms could point to a diagnosis of bipolar disorder, but on their own, are not diagnostic of the condition. Such symptoms are also associated with a number of other psychiatric diagnoses.

Ideally, the bipolar disorder diagnosis should be confirmed by a psychiatrist, who would then develop a treatment plan,² after which treatment monitoring and surveillance could be shared between the psychiatrist and the general practitioner.³

Core signs and symptoms of the manic and depressive states are listed in Table I.¹

Table I: Core signs and symptoms of the manic and depressive states of bipolar disorder

Symptom	Mania	Depression
Appearance	Colourful, strange, garish style	Loss of interest in personal appearance and grooming
Mood	Prolonged elation and euphoria Excessive optimism Cheerfulness Heightened irritability	Feelings of sadness Low mood Pessimism Suicidal ideation
Speech	Rapid loud speech Difficult to interrupt	Slowed speech Monotonous and monosyllabic
Activity	Restlessness. Impulsivity. Risk-taking behaviour	Difficulty initiating tasks Low energy Loss of interest in activities Psychomotor slowness
Sleep	Decreased need for sleep	Insomnia: (early morning waking), or hypersomnia
Cognition	Difficulty planning and reasoning. Distractible.	Reduced ability to concentrate Poor memory
Self-perception and thinking	Exaggerated self-confidence. Grandiose thinking.	Low self-esteem Feelings of guilt and worthlessness Sense of hopelessness

Co-morbidity

The diagnosis may be obscured by co-morbid physical and psychiatric conditions, and these may complicate treatment.⁴ Co-morbidity is common in patients suffering from bipolar disorder, and many suffer from one, or more, other psychiatric conditions. These often manifest before the diagnosis of bipolar disorder is made.

Drug and alcohol abuse and dependence

Drug and alcohol abuse are common in patients suffering from bipolar disorder.³ Patients may use substances in an attempt to medicate themselves, or as a manifestation of

risk-taking and impulsive behaviour. It is difficult to make an accurate assessment of patients' moods in the presence of substance abuse, as many recreational drugs have powerful mood effects. The pre-morbid history might provide some clues as to the presence of bipolar disorder. If possible, it is best for the substances to be withdrawn, and then an evaluation of the patients' moods conducted. Ongoing substance use can interfere significantly with the management of the condition.

Management and medication

Bipolar disorder is a condition that requires management in its broadest sense. Patient education and self-management are essential components.³ The management goal is mood stability. This requires regular follow-up, education, and identification of triggers and early symptoms of relapse.

The mainstay of pharmacological treatment of bipolar disorder is mood-stabilising drugs. These are used in all phases of treatment.⁵ Recurrence of episodes or mood instability is ideally managed by optimising the mood stabiliser doses, or prescribing additional mood stabilisers.

The medications that have been studied most for their mood-stabilising properties are lithium, valproate, carbamazepine and lamotrigine.⁵ These are either used alone at optimal doses, or in combination. Evidence exists to support the use of atypical antipsychotics, olanzepine and quitapine, for long-term mood stabilisation.

Studies have suggested that there is a role for antidepressants in the depressive phase of the illness.⁵ The role of antidepressants remains controversial, with conflicting evidence from different studies.² However, their efficacy may not be as robust as it is when treating major depression, and

evidence indicates that antidepressants may increase the risk of a switch to mania, or induce rapid cycling.⁵

In managing medication for patients with bipolar disorder, general practitioners should do the following:

- Monitor the efficacy and side-effects of maintenance therapy (Table II)
- Implement treatment in the acute manic or depressive phase, in consultation with a psychiatrist
- Support medication adherence.²

General practitioners play an important role in the acute manic episode. This is regarded as a medical emergency, as within hours, patients can create havoc in their lives.² The general practitioner is in an ideal position to initiate therapy, assist with the patients' admission and provide support and information to their families. In acute manic episodes, antipsychotic drugs and benzodiazepines are prescribed.

During acute episodes, loss of insight is a frequent symptom, and denial of symptoms and resisting treatment may pose a serious danger to patients. Doctors need to balance the need to respect patients' autonomy and confidentiality, with their obligation to provide adequate care. Decisions need to be made about the legal competence of patients, and the degree to which they pose a danger to themselves and others.²

In managing bipolar disorder, education is of vital importance. Education of patients encompasses imparting knowledge about the manifestations and management of the illness in general, as well as enhancing patients' recognition and management of their particular conditions.

Patients need to identify the specific triggers to which they are vulnerable, and to learn how to avoid these, or manage them effectively. Early awareness of relapse symptoms

Table II: Monitoring of medication used for maintenance therapy in bipolar disorder

Medication ²	Test	Frequency
Lithium	Serum lithium concentration (aim for 0.6-0.8 mmol/l)	3 monthly
	Thyroid-stimulating hormone and urea, creatinine and electrolytes (to monitor the toxic effects of lithium on thyroid and renal function)	6-12 monthly
Carbamazepine	Serum carbamazepine (aim for 17-50 µmol/l)	3 monthly
	Liver functions to exclude hepatotoxicity, full blood count to exclude aplastic anaemia and other blood dyscrasias, electrolytes to exclude hyponatraemia	6-12 monthly
Valproate	Valproate concentration (aim for 300-700 µmol/l)	3-6 monthly
	Liver functions to exclude hepatotoxicity, full blood count to exclude thrombocytopenia	
Lamotrigine	No testing necessary	
Atypical antipsychotic drugs	Serum glucose and lipid concentrations to exclude diabetes and hyperlipidaemia	6 monthly

allows prompt intervention, and can minimise disruption in their lives.

Patients should avoid triggers such as sleep deprivation; medications that might destabilise their mood, such as cortisone; and some malaria prophylactics and various supplements, especially those that are used for weight loss, or “gym supplements”. The use of recreational drugs can worsen the condition considerably. Regular sleep, exercise, and healthy eating patterns, can assist in regulating circadian rhythms, and help patients to manage their moods.

Mood diaries are extremely helpful in assisting patients and their physicians to identify patterns, and triggers, of the illness. Regular review by the doctor and patient can often identify patterns.

Bipolar disorder is a complex disorder that requires accurate diagnosis, careful follow-up, and effective management.

This is a disorder that is either the master or the slave, and it can be a cruel master. Effective management allows patients to gain mastery over the illness.

Note

The following resources are recommended for additional information:

- Center for Environmental Therapeutics [homepage on the Internet]. Available from: www.chronotherapeutics.org.
- Jamieson KR. An unquiet mind: a memoir of moods and madness. New York: Knopf, 1995.
- Black Dog Institute [homepage on the Internet]. Available from: <http://www.blackdoginstitute.org.au>.
- Kelly M. Life on a roller coaster: living well with depression and manic depression. Sydney: Simon and Schuster, 2000.
- Fieve RR. Moodswing. William Morrow and Company; Rev Exp Su edition, 1989.

References

1. Yatham L, Malhi G. Bipolar disorder. Oxford: Oxford University Press, 2011.
2. Mitchell P, Ball J, Best J, et al. The management of bipolar disorder in general practice. *Med J Aust.* 2006;184(11): 566-570.
3. Piterman L, Jones K, Castle D. Bipolar disorder in general practice: challenges and opportunities. *Med J Aust.* 2010;193(4 Suppl); S14-S17.
4. Krishnan KR. Psychiatric and medical comorbidities of bipolar disorder. *Psychosom Med.* 2005;67(1):1-8.
5. Berk M, Dodd S. Diagnosis and management of patients with bipolar disorder in primary care. *Br J Gen Pract.* 2005;55(518):662-664.



The Medihelp documentary DVD “Living with Bipolar Disorder” explains the fundamentals of this serious condition. It is an honest, intimate and often graphic account of a young life interrupted by a condition affecting an estimated 1% of our population. Visit www.medihelplivingwith.co.za or phone 0800 203 048 to order a copy of the DVD.