Bipolar disorder
what the GP needs to know

Most GPs will have some involvement in the care of patients with bipolar disorder – either on an ongoing basis or during crises such as mania or suicidal depression. This article focuses on the diagnosis and common comorbidities of the illness and management of its various phases.

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Bipolar disorder (previously known as manic depressive illness) afflicts between 1 and 2% of the population at some stage of their life. Well known sufferers include comedian Spike Milligan and actors Vivien Leigh and Carrie Fisher. In Australia, one in 200 people will have active symptoms of bipolar disorder in any one year.[1]

The impact of bipolar disorder on an individual and the people who are close to him or her is marked. Disrupted relationships are common – even more so than with depression. Rates of unemployment are high; at the least, career progression is severely limited. Many are forced onto government benefits, or need to take positions that are less skilled or less financially remunerative. Furthermore, mortality rates are increased – mainly due to suicide. At least one-quarter of patients with bipolar disorder will attempt suicide, and between 10 and 20% will finally die by their own hand. There is also increased mortality due to cardiovascular disease.

This high morbidity and mortality behoves the GP to ensure early diagnosis and the implementation of an appropriate ongoing management strategy – be that in the primary care or specialist psychiatric setting. The initial presentation of bipolar disorder is usually in young adult life, so the potential for long lasting damage to many aspects of day to day functioning is profound. Most of those who experience mania will go on to have further episodes of mania or depression. It is

IN SUMMARY

- **Patients with bipolar disorder may have episodes of mania, hypomania or bipolar depression, or mixed episodes. Interepisodic features, such as mild depression and anxiety, are common.**
- **Pharmacotherapy is the centrepiece of management.**
- **Psychological therapies shown to be effective for bipolar disorder in randomised controlled trials include psychoeducation and cognitive behavioural therapy.**
- **Effective management of patients with bipolar disorder must address comorbidities, such as anxiety disorders and substance abuse.**
- **It is important to remember that a patient's behaviour inside the surgery during an episode of mania or hypomania might appear more normal than his or her behaviour occurring outside.**
- **For patients who are prone to spending large amounts of money during manic episodes, consideration should be given to strategies for reducing access to large sums.**
- **Poor adherence to medications is common in bipolar disorder, with nonadherence rates of up to 50% frequently reported. Substance abuse may be a related issue.**

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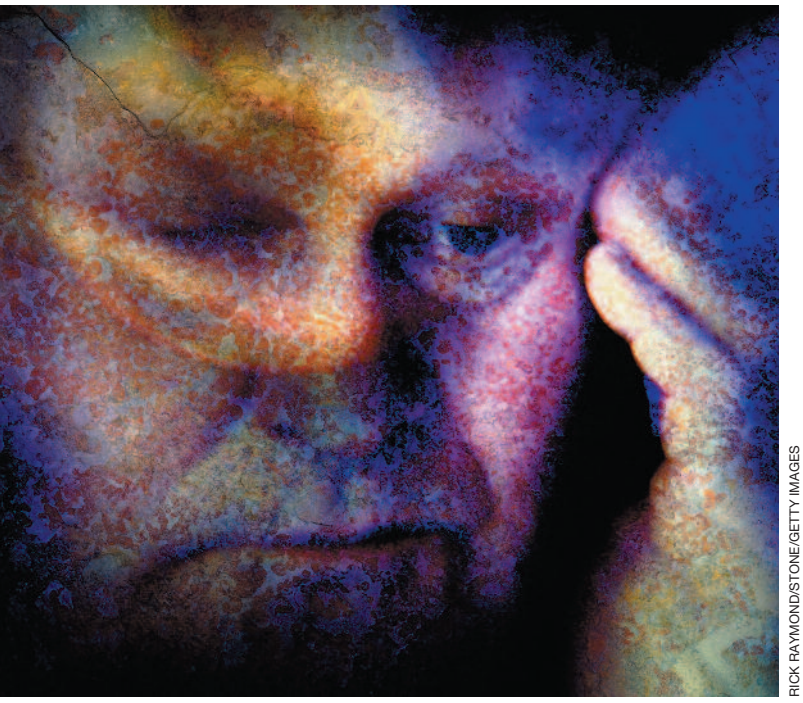
important for patients and their families to be aware that this is by nature a recurrent disorder.

Diagnosis

Patients with bipolar disorder may have periods of mania, hypomania, bipolar depression or mixed episodes – these are described in the box below. The illness is usually categorised into two types:

- bipolar I disorder – at least one lifetime episode of mania, and usually episodes of depression
- bipolar II disorder – episodes of both hypomania and depression, but no manic episodes.

Bipolar I disorder is diagnosed if the patient has had an episode of mania at some stage. It is sometimes difficult to distinguish mild bipolar II disorder from episodes of depression with subsequent relief after recovery and a desire to 'make up for lost time'. Compared to people with unipolar depression, individuals with bipolar depression (the depressed phase of bipolar disorder) are more likely to sleep and eat excessively (rather than less), to be physically slowed, and to experience psychotic features such as delusions and hallucinations.



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Comorbidities

It has become increasingly apparent that anxiety disorders and substance abuse are common comorbidities in people with bipolar disorder.[1] About 50% of patients have a concurrent anxiety

Clinical features of bipolar disorder

Mania and hypomania

In episodes of either mania or hypomania, an individual's mood is pathologically elevated or euphoric, or irritable. Characteristic symptoms and behavioural changes include:

- an inflated sense of one's own abilities or capabilities (grandiosity)
- disinhibition, which may manifest as increased libido, increased spending, tendency to make overly frank comments about others, or impaired judgement in work or relationships
- increased speed of thoughts, becoming increasingly talkative (perhaps associated with 'flight of ideas')
- increased activity levels and increased subjective energy (occasionally associated with physical agitation)
- lack of focus and distractibility
- reduced need for sleep.

Distinguishing between mania and hypomania may be difficult, but there are differences. In mania, there is evidence of marked impairment of functioning – delusions or hallucinations may occur and hospitalisation may be necessary. In hypomania, mood and behaviour are distinctly different to normal, but functioning is not severely impaired – psychotic features do not occur and hospitalisation is unnecessary. Episodes of mania last at least one week, whereas episodes of hypomania are of shorter duration (but lasting at least a few days).

Bipolar depression

Bipolar depression is often characterised by a slowing of physical and cognitive functions and increased sleep and appetite. Suicidal thoughts and attempts are common, and psychotic features may occur.

Mixed episodes

Mixed episodes are characterised by concurrent mania or hypomania and depressed features, usually with the manic or hypomanic features predominating. It is sometimes referred to as 'dysphoric mania'.

Rapid-cycling bipolar disorder

Rapid-cycling bipolar disorder is defined as at least four episodes of mania, hypomania, depression or mixed episodes in a 12-month period. It is occasionally caused by continued prescription of antidepressants.

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condition – panic disorder, generalised anxiety disorder and social phobia are the most common. About 40% of patients have a substance use disorder (alcohol or drugs).

Differential diagnosis

The most common misdiagnoses are schizophrenia (particularly in males) and depression (particularly in females). The former probably reflects the common similarity of cross-sectional presentation between acute mania and paranoid schizophrenia, whereas the latter is more likely when past episodes of hypomania or mania are not actively explored in those presenting with depression. Other common misdiagnoses are anxiety disorders and substance abuse, perhaps reflecting a lack of appreciation that these frequently coexist with bipolar disorder. Sometimes patients will be misdiagnosed as having personality disorders, particularly of the borderline or antisocial type.

Many patients have ongoing mild 'subsyndromal' symptoms between frank major episodes of mania and depression. Common interepisodic features include mild depression and anxiety. These symptoms are responsible for much of the disability due to the illness.

Medications

Bipolar disorder is a biological condition with strong genetic roots, so it is not surprising that the centrepiece of treatment is pharmacological. Many medications have been shown to be effective in randomised controlled trials – these are listed in the Table. Recommendations on blood monitoring for mood stabilising medications are detailed in the box below. Further information can be obtained from the clinical practice guidelines that were recently published by the Royal Australian and New Zealand College of Psychiatrists,[3] or *Therapeutic Guidelines*: *Psychotropic*.[4]

Psychological therapies

There are important psychological issues relevant to bipolar disorder, and the testing of psychological therapies in randomised controlled trials has been a key development of recent years. Episodes are

Table. Medications for bipolar disorder

Acute treatment of mania
- Lithium (Lithicarb, Quilonum SR)
- Sodium valproate (Epilim, Valpro)
- Carbamazepine (Tegretol, Teril)
- Olanzapine (Zyprexa)
- Risperidone (Risperdal, Risperdal Consta)
- Aripiprazole (Abilify)
- Quetiapine (Seroquel)

Acute treatment of bipolar depression
- Most antidepressants
- Lamotrigine (Lamictal)
- Olanzapine with or without fluoxetine

Acute treatment of mixed episodes
- Sodium valproate

Long term preventive treatment*
- Lithium
- Lamotrigine (particularly for preventing depressive episodes)
- Olanzapine

* Although sodium valproate and carbamazepine have not been shown to be effective in long term placebo-controlled trials, widespread clinical experience suggests they are effective in maintenance treatment for this condition.

Recommended testing for patients on maintenance mood stabilisers[2]

Lithium
- Serum lithium concentrations every three months for patients on a regular dosage (aim for 0.6 to 0.8 mmol/L)
- Thyroid stimulating hormone (TSH) and electrolytes, urea and creatinine levels every six to 12 months, to exclude hypothyroidism or declining renal function

Carbamazepine
- Serum carbamazepine concentrations every three months (aim for 17 to 50 µmol/L)
- Liver function tests every three to six months, to exclude hepatotoxicity
- Full blood count every three to six months, to exclude aplastic anaemia and other haematological dyscrasias
- Electrolytes every three to six months, to exclude hyponatraemia

Sodium valproate
- Serum valproate concentrations every three months (aim for 300 to 700 µmol/L)
- Liver function tests every three to six months, to exclude hepatotoxicity
- Full blood count every three to six months, to exclude thrombocytopenia

Lamotrigine
- No regular testing necessary – there is no utility in serum level monitoring

Atypical antipsychotics (olanzapine, risperidone, aripiprazole, quetiapine)
- Blood sugar and serum lipid concentrations every six months, to exclude diabetes and hyperlipidaemias

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frequently triggered by acute stresses or by changes in daily patterns or rhythms (such as sleep–wake cycles). Furthermore, there are considerable difficulties for most patients in adjusting to suffering from a major mental illness and in coping with the ramifications of their behaviour, particularly during episodes of mania.

The main areas of focus in psychological therapies have been:

- education about the condition for patients and their families
- interpersonal and social rhythms therapy, including identifying early warning signs of impending relapse into mania (such as reduced need for sleep or increased activity)
- cognitive behavioural therapy dealing with symptoms and the impact of the illness on individuals.

Any psychological therapy should also address the presence of comorbid conditions such as anxiety disorders or substance abuse.

Management issues in general practice

There is a welcome and increasing interest in shared care between the primary and secondary care sectors for patients with mental health conditions. We suggest that a psychiatrist assess most patients with bipolar disorder at least once early in the course, with recommendations being made for pharmacological and psychological management. Bipolar disorder is a complex mental illness, and most GPs treat relatively few patients over their professional careers. Ongoing care of patients with severe or markedly recurrent illness is probably best managed in the mental health sector. Those with illness that is either less severe or very responsive to treatment are probably best managed primarily by the GP, with the psychiatrist providing occasional clinical review, and 'back up' when complications or major recurrences occur.

Both the patient and the professionals involved in his or her care can benefit from the use of management plans, and the GP, psychiatrist and patient need to be involved in the development of such plans. Specific strategies should be included for relapse, and it can be helpful to include agreed guidelines for contacting relations or friends and the circumstances that should precipitate involuntary intervention during a relapse with loss of insight. After consultation, the plan should be distributed to the patient and his or her carers or family, as well as the professionals involved in the care of that patient. Any major change in treatment is probably best undertaken after review by the specialist.

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Identifying early warning signs of relapse

Some patients switch into mania rapidly and without warning, losing insight quickly. A considerable proportion, however, have a 'transitional' phase with early warning signs that begin hours, days or weeks prior to the onset of frank manic symptoms. (Interestingly, early warning signs rarely occur prior to a bipolar depressive episode.)

With training, the patient and family can identify this transitional phase. Common early behavioural changes are insomnia, a reduced need for sleep, increased energy and irritability. If such warning signs can be identified reliably, countervailing strategies can be developed. For example, behavioural methods of improving sleep can be instituted, associated stresses (such as relationship or work difficulties) addressed, or medications such as hypnotics or antipsychotics commenced with the intent of aborting progression to a full manic episode. As GPs have a greater awareness of the day to day clinical status and life context of each patient, they are often in a better situation than the specialist to identify and deal with such early signs. Other techniques, such as daily mood charts completed by the patient, may assist in identifying early features of a 'slide' into a manic or depressive relapse.

Dealing with loss of insight and patient confidentiality

An issue central to the nature of bipolar disorder is the loss of insight during mania or hypomania, although it should be noted that some patients rarely lose insight during hypomania. The GP must consider as paramount the ongoing welfare of the patient because behaviour may be markedly disturbed during episodes. Patients may engage in behaviour that will have severe future ramifications, such as embarking upon unwise business schemes, spending large amounts of money, or becoming aggressive with a real potential of physically harming others. Despite the patient's protestations at the time, the clinician has an imperative duty to intervene in such situations – even though this may arouse considerable anger or irritation in the patient. It may be necessary to invoke local mental health legislation to enforce treatment.

Sometimes, however, patients will reluctantly comply with the instructions of the clinician and/or family in order to avoid involuntary treatment. Such a response is more likely if strong trust has been nurtured in the doctor–patient relationship. The GP should always be aware that a patient's behaviour in the surgery might appear more normal than that actually occurring in their day to day lives. As a general principle, an account of disturbed or disrupted behaviour by a sensible friend or relative should always be taken seriously if there is conflict with the claims of the manic patient.

A related and complex issue is what information should be communicated to the family if a manic patient refuses such contact, or when the family attempts to speak to the practitioner without the patient's approval or awareness. In traditional health legislation, the rights of the patient to privacy are given primacy in these situations. The authors of this article would contend, however, that respect of such 'rights' may not always be appropriate or in the patient's long term interest – particularly when the patient lives with the family or when the family has ongoing financial or other responsibilities for the patient. In such situations, it may be more appropriate to consider the whole family context as 'the patient'. Although such an approach would be regarded as controversial, it is being considered seriously as an option in the up-coming revision of the NSW Mental Health Act. (Note that mental health legislation differs among the States and Territories.)

There has been considerable recent discussion about strategies such as advance directives, whereby patients indicate desired treatment in the possible advent of a future manic episode. Although such strategies are commendable, at present they have no legal legitimacy and would not stand challenge in court. It is to be hoped that such creative and sensible approaches will be incorporated into future mental health legislation.

'Financial planning'

For patients who are prone to spending or borrowing large amounts of money during manic episodes, serious consideration should be given to strategies such as arranging for a power of attorney by another family member or using State or Territory bodies to take over the patient's financial affairs (such as the Protective Estates Commissioner in NSW). Simple actions for reducing the ease of spending large amounts of money can be tried, such as encouraging the patient to give up credit cards.

Poor adherence with treatment

Poor adherence to medications is common in bipolar disorder; nonadherence rates of up to 50% are frequently reported. These high rates mainly reflect the difficulty most patients have in accepting the diagnosis and need for treatment. Other issues include particular side effects of treatment (such as weight gain, tremor, subtle effects on co-ordination and attenuation of the normal emotional range), and a yearning for the 'lost pleasures' of mania.

One ramification of poor compliance is the well documented lithium discontinuation syndrome, whereby there is rapid relapse, particularly into mania, with 50% of patients becoming manic within five months of rapid cessation. Poor adherence should be addressed by the practitioner openly exploring relevant issues with the patient and devising strategies to deal with these (e.g. reducing the drug dosage to reduce side effects, if relevant). If the doctor determines that slow withdrawal is clinically reasonable, this should be carried out over at least a month, and preferably longer.

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Resources for patients, family and friends

- *An unquiet mind,* by Kay R. Jamison. New York: Knopf; 1997.
- *Life on a roller coaster: living well with depression and manic depression,* by Madeleine Kelly. Sydney: Simon & Shuster; 2000.
- *Fairytales in reality,* by Margo Orum. Sydney: Pan Macmillan; 1996.

A related issue is substance abuse, with the chronological sequence of drug use and poor compliance often being difficult to determine. Relapses into mania are precipitated by the use of drugs such as marijuana or stimulants like amphetamine, cocaine and their derivatives. This is more commonly seen in younger patients. For these individuals, any comprehensive management program must seriously address substance use issues.

Conclusion

Although bipolar disorder is often complex to diagnose and treat, effective management can make a profound difference to the lives of sufferers and their families. GPs and psychiatrists are critical players in the process. Some resources for patients and their families and friends are listed in the box on this page. MT

Acknowledgement

The authors are grateful to Dr Margaret Mitchell for helpful comments on an early draft of this article.

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Further reading

1. Joyce PR, Mitchell PB, eds. Mood disorders: recognition and treatment. Sydney: UNSW Press; 2004.

DECLARATION OF INTEREST: Professor Mitchell has received honoraria from AstraZeneca and GlaxoSmithKline. Dr Gould: None.

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