Looking back

In this ongoing series, we look back at the key messages and practice points from selected articles in BPJ 62 (July, 2014).

We have added some suggested discussion questions for peer groups, or for personal review.

As this is a new feature of Best Practice Journal, we would be very interested in getting feedback from our readers as to whether this is useful. Please email your comments to: **editor@bpac.org.nz**

Tear off along perforation

Supporting patients with bipolar disorder in primary care

Bipolar disorder is characterised by extreme mood swings, but some patients may have milder symptoms, making detection and diagnosis more challenging. The first mood disturbance often occurs during adolescence, however, first onset bipolar disorder may also occur in older people. The cause of the disorder is unknown, although there is a strong inheritable component.

Bipolar I disorder is diagnosed when patients have experienced at least one episode of mania.

Bipolar II disorder is diagnosed when patients have had at least one episode of depression and one episode of hypomania (a mild episode of mania), but have never experienced an episode of full mania.

A "mixed episode" is where the patient experiences mania and depression during the same period. For example, feeling hopeless with suicidal thoughts while also feeling highly energised. During a mixed episode, if the patient has reduced sleep and is drinking alcohol their risk of committing suicide is greatly increased.

Depression is the most common mood disturbance in people with bipolar disorder and therefore the disorder is often initially diagnosed as depression. Treatment for depression with antidepressant monotherapy can worsen the status of patients with bipolar disorder, as they usually also require a mood stabiliser.

A formal diagnosis of bipolar disorder is generally carried out by a Psychiatrist. People with bipolar disorder often have:

- A personal history of mania
- A family history of bipolar disorder
- Problems with alcohol
- Displayed risk taking behaviour, e.g. sexual or financial
- A history of complicated and disrupted circumstances, e.g. multiple relationships

The management of patients with bipolar disorder is usually led by a Psychiatrist. General Practitioners can anticipate changes in circumstances that make a relapse more likely. At each consultation the clinician should consider:

1. Are the patient's symptoms under control?
2. Has there been any change in circumstances that may cause the patient excess stress, e.g. relationship status?
3. Has the overall health of the patient changed, e.g. substance use?

Medicines are the mainstay of bipolar disorder treatment, however, self-management is also essential. Patients, with the help of their families, can improve mood stability by maintaining daily routines including: medicine use, healthy sleep patterns, exercise and avoidance of alcohol.

Lithium is an effective treatment for acute mania, acute depression and long-term mood stabilisation in people with bipolar disorder. It has a narrow therapeutic index and patients need to be monitored. Lithium will take up to ten days to produce an effect in patients who are manic, and up to eight weeks for patients with bipolar depression. Generally, the patient's serum lithium is titrated to 0.6 – 0.8 mmol/L; a higher concentration is recommended for acute episodes of mania, and for patients who have experienced a relapse. Fine tremor and nausea are dose-dependent adverse effects of lithium treatment that often pass after one to two days. Adverse effects should be anticipated when doses are increased.

Other medicines used in the management of patients with bipolar disorder include: mood stablisers, e.g. valproate and carbamazepine, atypical antipsychotics, e.g. olanzapine and quetiapine, and antidepressants, e.g. fluoxetine. Patients will usually require ongoing laboratory monitoring while taking these medicines

Patients with bipolar disorder can be expected to develop more than one psychiatric disorder during their lives, e.g. anxiety disorder.

Peer group discussion points

1. Are you currently involved in the management of any patients with bipolar disorder? If so, what is your role?
2. Do you routinely ask patients with depressive symptoms about any history of mania/hypomania?
3. Were you aware that maintaining daily routines is thought to provide a clinical benefit to patients with bipolar disorder, independent to the influence of any pharmacological treatment?
4. Local guidelines often vary regarding the titration and monitoring of lithium treatment. What is your experience of lithium treatment and does it differ to what is outlined in the article?
5. Valproate, carbamazepine and lamotrigine are all rated pregnancy risk category D. Do you routinely advise effective contraception when prescribing any of these medicines to pre-menopausal females?