Bipolar Affective Disorder

Key facts and treatment options for GPs

Introduction

Bipolar affective disorder (commonly known as manic depression) is one of the most common, severe and persistent psychiatric illnesses. In the public mind, it is associated with notions of 'creative madness', and indeed it has affected many creative people both past and present. However, the
condition is very damaging, with associated high morbidity, in terms of lost work, lost productivity, effects
on marriage and the family and a high mortality rate, with completed suicide occurring in up to 10% of
sufferers.

Making the Diagnosis

The variety of presentations make this one of the most difficult conditions to diagnose accurately. More than any other psychiatric disorder the clinician needs to pay attention to the life history of the patient and to third party information from family and friends. Classically, periods of prolonged and profound depression alternate with periods of excessively elevated and/or irritable mood, known as mania. The symptoms of mania characteristically include a decreased need for sleep, pressured speech, increased libido, reckless behaviour, and grandiosity. In more severe cases, there can be marked thought disturbances and even psychotic symptoms. Between these 'highs and lows' patients usually experience periods of full remission. This classic presentation – the occurrence of one or more episodes of mania with or without a history of one or more depressive episodes - is defined as Bipolar I Disorder, although this appears to be one pole of a spectrum of mood disorders. A milder form of mania (hypomania), associated with episodes of depression, also occurs, with this condition being known as Bipolar II Disorder. Although Bipolar I Disorder is more severe, often resulting in hospital admissions to manage mania, Bipolar II Disorder outcomes are no better, and this is mostly on account of the prevalence and intensity of the depressive episodes within this subtype. Manic symptoms and depressive presentations can blur together into mixed affective states, and there is a subclinical presentation cyclothymia – in which an individual may experience oscillating high and low moods without ever having a significant manic or depressive episode.

Differential Diagnosis

Unipolar Depression; Emotionally Unstable Personality Disorder, borderline subtype; ADHD (commonly co-morbid with Bipolar Disorder); Anxiety Disorders/PTSD; Schizophrenia (in more severe cases); Alcohol or drug misuse; Physical Illness (eg hyper/hypothyroidism, Cushing's Syndrome, SLE, MS, head injury, brain tumour, epilepsy, HIV and other encephalopathies).

Medications that may induce symptoms of mania/hypomania (eg antidepressants; anti-parkinsonian medication; cardiovascular drugs including digoxin, clonidine, captopril; respiratory medications including aminophylline, salbutamol; Anti-TB medication; zidovudine; analgesics including codeine and tramadol; gastrointestinal drugs including ranitidine and cimetidine; steroids; cyclizine; interferon.

Key Facts for GPs

- Age of onset – often 15-20 years old.
- 40% of individuals with Bipolar Disorder are initially diagnosed with unipolar depression.
- One must always enquire about a history of elevated mood in patients presenting with depression
- Patients with Bipolar Disorder frequently do not respond well to standard antidepressant treatments.
- There is a risk of inducing mania/hypomania in a patient with an underlying vulnerability to Bipolar Disorder through the prescribing of an antidepressant in this group.
- Bipolar I Disorder is a relatively rare and frequently psychotic disorder.
- Bipolar II Disorder is a stable diagnosis, now being made more frequently and associated with a chronic course in which depression is the dominant polarity.
- Long treatment delays are common.
- Childbirth is both a risk factor for the development of the condition and associated with high rates of relapse in patients with established Bipolar Disorder.

Treatment Options

Treatment options for Bipolar Disorder have evolved greatly in recent years:-

Pharmacological Treatments

- Treatment of Manic Episodes – Mood Stabilisers eg Lithium, Valproate (in particular Depakote which is only the version of Valproate licensed for use in Bipolar Disorder in UK); Antipsychotics; Benzodiazepines.
- Treatment of Depressive Episodes – strong evidence for use of Quetiapine or Lamotrigine. Antidepressants less effective than in unipolar depression generally and may induce manic switch. However, can be considered if patient protected with mood stabiliser(s).
- Rapid cycling or mixed affective states – more evidence for use of Valproate and Carbamazepine than Lithium.
- Prophylaxis for Bipolar Disorder – general principle is ‘what gets them well, keeps them well’. Chronic condition with very high rates of relapse so long term treatment important.

Psychological Treatments

- CBT
- Psycho-education
- Monitoring of triggers, early warning signs and management of routines and lifestyles all play a role. Medico-legal aspects important to consider, as well as close liaison with employers to plan return to work.

For more details on treatment options or to refer a patient please, call our Enquires & Admissions Department on 020 7535 7700 (24hrs).

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