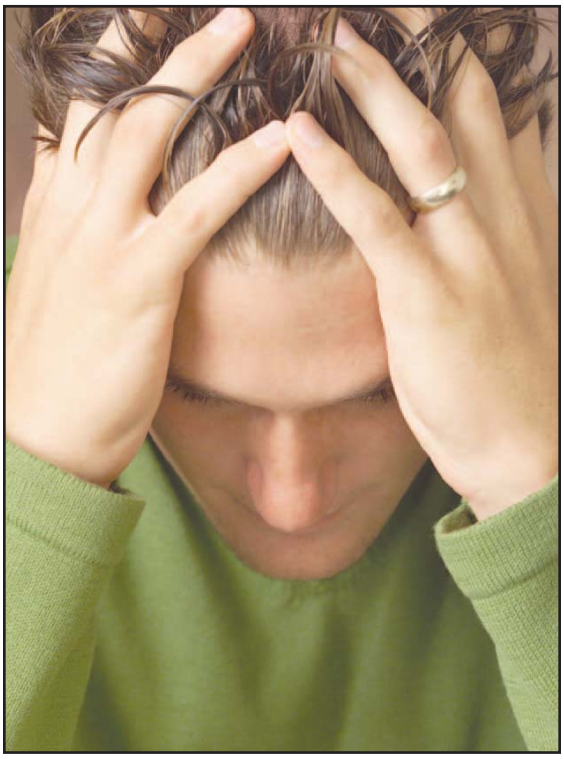
How Can I Help Patients With Bipolar Disorder?



In this article:

1. Can I diagnose BD from laboratory investigations?
2. What are the medical interventions?
3. How important is psychotherapy?

By Chris Gorman, MD, FRCPC

Bipolar disorders (BD) are a group of heterogeneous mood disorders characterised by cyclical episodes of disturbed mood, behaviour, and thinking. The presence of manic symptoms distinguishes BD from other mood disorders. Some experts have suggested that having mania or hypomania (mild mania without functional disability) is akin to only diagnosing diabetes if ketoacidosis occurs.

A useful pneumonic to help identify many of the classical manic symptoms is DIGFAST (how a patient with mania would dig a hole). Symptoms include elation, anger and hyperactivity (Table 1). Manic symptoms can occur separately from depressive symptoms, or can occur along with depressive symptoms in a condition known as a mixed state. A useful pneumonic for classical symptoms of depression is SIGECAPS (Table 2).

A mixture of depression and mania occurs in up to 40% of patients and is often confused with depression and co-morbid anxiety. Previous work suggests that anxiety disorders are twice as common in BD versus unipolar disorders, and makes distinguishing the previous two syndromes (depression and anxiety versus depression and mania/agitation) less significant.

Table 1
DIGFAST- Manic Symptoms

- **D**istractibility
- **I**ndiscretions (pleasure seeking but risky behaviour)
- **G**randiosity (for example, the patient always "knows" more than the doctor)
- **F**light of ideas (increase in number or rate of thoughts)
- **A**ctivity increase (a very important symptom)
- **S**leep deficit (lots of energy with only a few hours of sleep)
- **T**alking increase (talking more than usual, others have difficulty interrupting)

Table 2
SIGECAPS- Symptoms of Depression

- **S**adness and/or loss of interest in things (bored, not motivated, reduced pleasure or pursuit of pleasure)
- **I**nsomnia (trouble falling and/or staying asleep)
- **G**uilt and worthlessness (blames self for many things, diminished self-esteem)
- **E**nergy deficit (fatigue)
- **C**oncentration, memory and decisiveness deficits
- **A**ppetite for food can be increased or decreased with weight gain or loss
- **P**sychomotor agitation (restless, pacing, wringing hands) or retardation (thinking or moving slower than usual)
- **S**uicidality (from being less careful than usual to intent to take one's life)

Can I diagnose BD from laboratory investigations?

To date, the ability to diagnose BD from laboratory investigations is not possible. More and more, biological investigations are aiming to find a lab test to help diagnostically, and to guide treatment. Fortunately, in Canada, we have experts in psychopharmacology, like Dr. Trevor Young, who are working towards finding more answers to these important questions and issues.[1] Numerous studies highlight both important biological and environmental factors that contribute to our etiological understanding (Table 3).

How important is psychotherapy?

Without psychotherapy, it is rare for a patient to recover. Psychotherapy helps with patient rapport, which is the key ingredient in helping the patient comply with treatment. Support, encouragement, understanding, and respect are the

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Table 3
Medical Interventions

Lithium (Li)
- Li continues to be the gold standard for treatment of BD and is often part of planned poly-pharmacy, but lack of efficacy in prophylaxis (as high as 40%) and the lack of efficacy for mixed states, and even phases of BD are principal reasons for pursuing alternatives.[2]
- Anti-suicide and prophylactic effect in both BD and unipolar patients.[3]

Carbamazepine (CBZ)
- Demonstrated efficacy for acute mania and prophylaxis in double-blind trials with a trial population larger than 50 people.
- No double-blind placebo-controlled studies of CBZ for the treatment of depression with trial populations greater than 50 people.
- Hematologic side effects include agranulocytosis and aplastic anemia. As a result, although these side effects are rare, many clinicians hesitate to use this as a first-line drug.
- Other side effects include sedation, diplopia, ataxia, and rash.

Valproate
- There have been three double-blind placebo-controlled anti-manic studies with a trial population greater than 50, demonstrating valproate (an anticonvulsant) efficacy, and one study demonstrating a similar to placebo effect for prophylaxis.[4]
- No double-blind, placebo-controlled treatment studies for the depressive phase of BD with valproate where the trial population is larger than 50.
- Side effects include gastrointestinal distress (change in appetite, nausea, vomiting, and diarrhea), sedation, tremor, hair loss, hepatic problems (varying from asymptomatic enzyme elevations to fatal hepatitis), asymptomatic thrombocytopenia or leucopenia, pancreatitis, and agranulocytosis.
- Concerns have also been raised regarding polycystic ovarian disease, thus there is potential for fertility issues.
- Only effective for treatment of mania.
- Lack of antidepressant efficacy clinically, and lack of studies are serious concerns.

Olanzapine
- FDA approved use of olanzapine for short-term treatment of BD type I. First and only atypical antipsychotic medication to achieve this indication.
- Three double-blind, (two-placebo-controlled trials with populations greater than 50, and one compared to Li in each arm with a trial population of 15 people) for the treatment of mania.[5,6]
- Side effects include somnolence, constipation, dry mouth, increased appetite, and weight gain.[7]
- Initially, dose titration may lead to orthostatic hypotension causing tachycardia, dizziness or, rarely, syncope.
- Caution should be applied in the use of olanzapine in epileptic patients (seizures have occurred in up to 0.9% of patients).
- In studies over two and a half years, the mean weight gain was 6.26 kg. Weight gain factors were not dose related, occurred most frequently in the first 39 weeks, were greatest in patients with the lowest body mass index, and were not correlated with increases in serum glucose.[6]
- Increase in serum glucose was not significantly greater in olanzapine compared to haloperidol.[8]

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Table 3 Continued

Medical Interventions

Risperidone

- This medication can be an invaluable addition to the acute and sometimes long-term management of mania.
- Effective doses are between 0.5 mg/day and 4 mg/day.
- Higher doses have greater potential for ill effects, such as extrapyramidal side effects (EPS- such as dystonia, Parkinson's and akathisia, or restless legs) and elevated prolactin with possible ammenorrhea and enlarged breasts with lactation.

Quetiapine

- This medication can be an invaluable addition to the acute and sometimes long-term management of mania.
- Doses are between 100 mg/day and 600 mg/day on average.
- Side effects mostly related to sedation.
- Out of all the atypicals, quetiapine has the least potential for EPS.

Lamotrigine

- Although three out of four studies looking at the efficacy of lamotrigine for mania found it to be ineffective, this medication demonstrated the most potent effect in treating the depressions suffered by bipolar patients.[9]
- Effective dose is between 50 mg/day and 300 mg/day.
- Caution is necessary in prescribing this drug to diminish a serious autoimmune rash incidence that starts in the head and neck region or mucous membranes.
- Start at 12.5 mg/day and increase at 12.5 mg increments on a weekly basis. The risk of serious rash is greater if the dose rises too quickly.
- Be very cautious in prescribing this medication with valproate, as the blood levels of lamotrigine rise with this combination.

Gabapentin

- Results of double-blind placebo-controlled trials have suggested that this drug is ineffective in BD.[10]
- Helpful in the many bipolar patients that have concomitant anxiety, and it does not have the depressogenic ill effect of benzodiazepines.

Topiramate

- Anticonvulsant that has demonstrated an effect in bipolar patients in mostly open label trials.
- One double-blind study with fewer than 50 patients showed a non-significant effect by the end of the trial.[11]
- Most patients seem to lose weight and this in itself may improve one's mood.
- Some find this drug very helpful but neurologic side effects can be significant if dose escalation is too rapid.

EPS = extrapyrimidal symptoms, FDA = The Food and Drug Administration

Take-home message

- BD is one of the most difficult psychiatric and medical conditions to treat. The severity of manic, depressive and mixed states cannot be over emphasised. While obviously harmful to the patient, these conditions can be equally as damaging for their loved ones, sometimes more so.
- It is difficult to recognise the beneficial side of hypomania or mania. At least when hypo-manic, the patient's capacity for creativity, perseverance and achievement are so significant that it can be difficult for physicians to acknowledge the potential liability side of this condition. There is no question that BD is clearly a condition with significant evolutionary advantages.
- The goal is to eliminate the dysfunctional and painful parts of the syndrome while preserving the assets and soul of these special people. With many of the pharmacologic tools and reasoned psychotherapy, many of these people can return to a healthy state of loving and working.

building blocks of the therapeutic alliance. At our clinic we provide group cognitive therapy which seems to help address significant issues such as low self-esteem and anxiety symptoms. Being firm and learning to say no (without explanation) seems to work when patients are manic and they can think faster than the physician or therapist. Dx

Bipolar Disorders

References

1. Bezchlibnyk Y, Young LT: The Neurobiology of Bipolar Disorder: Focus on Signal Transduction Pathyways and the Regulation of Gene Expression. Can J Psychiatry 2002; 47(2):135-148.
2. Dunner: "Clinical factors in Li prophylaxis failure, Arch of Gen Psych 30 1974: 229-233. Himmelhoch JM, Garfinkel ME: Sources of Li resistance in mixed mania. Psychopharmacol Bull 1986; 22(3):613-20.
3, Tondo L, Hennen J, Baldessarini: Lower suicide risk with long-term Li treatment in major affective illness: a meta-analysis. Acta Psychaitr Scand 2001; 104(3):163-72.
4. Bowden CL, Calabrese JR, McElroy SL, et al: A Randomized, Placebo Controlled 12-Month Trial of Divalproex and Li in Treatment of Outpatients with BD. Arch Gen Psychiatry 2000; 57(5):481-92.
5. Tohen M, Sanger TM, McElroy SL, et. al: Olanzapine vs. placebo in the treatment of acute mania. Am J Psychiatry 1999; 156(5):702-9. Tohen M, Jacobs TG, Grundy SL, et. al: Efficacy of olanzapine in acute bipolar mania: a double blind, placebo controlled study. Arch Gen Psychiatry 2000; 57(9):841-49.
6. Berk M, Ichim L, Brook S: Olanzapine compared to Li in mania: a double blind randomized controlled trial. Int Clin Psychopharmacol 1999; 14(6):339-43.
7. Calabrese JR, Kimmel SE, Woyshville, et. al: Clozapine for treatment-refractory mania. Am J Psychiatry 1996. 153(6):759-64.
8. Sanger, TM,Grundy SL, Gibson PJ, et al: Long-term olanzapine in the treatment of bipolar 1 disorder: an open label continuation phase study. J Clin Psychiatry 2001; 62:273-281.
9. Sajatovic M, Brescan DW, Perez DE, et. al: Quetiapine alone and added to a mood-stabilizer for serious mood disorders. J Clin Psychiatry 2001; 629(9):728-32.
10. Bentley, B. et. al. "A one year open-label study of the safety and efficacy of lamotrigine in the treatment of bipolar depression," Int J Neuropsychopharmacol 2000; 3:S340.
11. Pande, AC, Crockatt JG, Janney CA, et al: Gabapentin in bipolar disorder: a placebo controlled trial of adjunctive therapy. Bipolar Disord 2000; 2(3 Pt 2):249-55.

Frequently Asked Questions

How can I Help Patients With Bipolar Disorder?

1. What are bipolar disorders?

Bipolar disorders are a group of heterogeneous mood disorders characterised by cyclical episodes of disturbed mood, behaviour and thinking. The presence of manic symptoms distinguishes bipolar disorders from other mood disorders.

As presented at the University of Calgary

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2. What are some manic symptoms?

Manic symptoms include distractibility, indiscretions (pleasure seeking but risky behaviour), grandiosity (*i.e.,* the patient always "knows" more than the doctor), flight of ideas (increase in number or rate of thoughts), activity increase (a very important symptom), sleep deficit (lots of energy with only a few hours of sleep), talking increase (talking more than usual, others have difficulty interrupting), elation or irritability, and hyperreactivity (frequently related to activity increase).

For an in-depth article on bipolar disorders, please go to page 93.

3. What are some depressive symptoms?

- Sadness or loss of interest in things (bored, not motivated, reduced pleasure or pursuit of pleasure)
- Insomnia (trouble falling and/or staying asleep)
- Guilt and worthlessness (blames self for many things, diminished self-esteem)
- Energy deficit (fatigue)
- Concentration, memory and decisiveness deficits
- Appetite for food can be increased or decreased with weight gain or loss
- Psychomotor agitation (restless, pacing, wringing hands) or retardation (thinking or moving slower than usual), suicidality (from being less careful than usual to intent to take one's life)