Recognizing the Problem: BD in Your Patients

Hanna O. Woldeyohannes, HBSc; and Roger S. McIntyre, MD, FRCPC

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Bipolar disorder (BD) is a highly prevalent and complex syndrome of multifactorial origin. BD is estimated to affect approximately 2% to 4% of the general population and possibly 30% of all individuals treated for depression in the primary care setting. The standardized all-cause mortality ratio among patients with BD has increased approximately two-fold. It remains inexorably true that despite the increasing awareness of bipolar spectrum conditions, the majority of affected individuals remain unrecognized. Actuarial estimates position BD as possibly the most costly mental disorder.

Symptomatic structure of BD

The symptomatic structure of BD is comprised largely of subsyndromal depressive and anxious symptoms that rapidly shift in polarity and severity. For most affected individuals, BD is accompanied by a progressive increase in:

- vulnerability to recurrence,
- neurocognitive impairment and
- psychosocial dysfunction.

Taken together, it is essential to detect and diagnose BD early in its course to prevent the harmful dysfunction associated with this condition.

Diagnosing BD

BD is a heterogenous group of disorders often referred to as the bipolar spectrum. Subtypes of BD include:

- Bipolar I and II disorders,
- cyclothymia and
- bipolar not otherwise specified.

Despite the ubiquity of BD in primary care, the majority of affected individuals remain underrecognized. Each individual presenting in the therapeutic environment with depressive symptoms should be systematically screened for hypomanic symptoms.

Further assisting the assessment process is the use of screening tools, such as the Mood Disorders Questionnaire (MDQ). The MDQ is an easy-to-use, facile instrument completed by patients in the waiting room requiring only a few minutes (a copy can be obtained at www.mdpu.ca).

Clinical features

Clinical features which suggest, but do not confirm a diagnosis of BD are:

- early onset of depression,
- atypical features, such as:
  - increased appetite,
  - carbohydrate craving,
  - weight gain,
  - excessive sleep,
  - extreme fatigue and
  - interpersonal sensitivity,
- recurrent or chronic major depressive episodes and
- treatment-resistant depression.

Other possible indicators of bipolar illness are:

- substance abuse,
- family history,
- postpartum illness,
- rapid cycling pattern and
- mixed depression.

Suicide

BD poses the highest risk of suicide (25% to 50% suicide attempts; 10% to 15% completed suicide) compared to most other psychiatric disorders. Suicidal attempts are highly associated with depressive symptoms as part of a depressive or mixed episode. Since depressive episodes dominate the course of BD, unrecognized illness may expose bipolar individuals to an increased risk of suicide.

Management

A chronic disease management model is encouraged for any syndrome, disorder or disease characterized by:

- multifaceted illness presentation,
- psychosocial burden and
- chronic course.

The treatment objectives in BD are to suppress acute manic and depressive symptoms and to prevent their recurrence.

Over the past decade, there have been several evidence-based, consensus-based and combined evidence/consensus-based guidelines for the treatment of BD. The expanding pharmacopeia and the development of psychosocial treatment strategies for BD have provided clinicians with more treatment alternatives to benefit patients (see www.canmat.org).

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Treatment algorithm

See www.mdpu.ca for a medication dosing reference card.

Lithium

A commonly prescribed mood stabilizer, lithium has demonstrated efficacy in the treatment of manic and depressive symptoms. Furthermore, emerging evidence shows that lithium, via an antidepressant-independent pathway, offers an antisuicidal effect in mood disorders. Increased incidences of altered renal and thyroid function call for the monitored use of lithium (Table 1).

Antiepileptic drugs

The second generation antiepileptic agents, divalproex and carbamazepine, have proven efficacy in acute mania. Lamotrigine seems to

Table 1

Predictors of acute nonresponse to lithium

- Mixed status
- Rapid cycling
- Comorbid medical disorder
- Substance abuse
- Negative family history
- Frequent prior episodes

be an effective agent for depressive symptoms and episodes, but is not reliable for manic symptoms. With lamotrigine, cutaneous reactions have been reported in 10% of treated cases with higher risks in preadolescents and in combination with agents that interfere with its metabolism. As an alternative to benzodiazepines, gabapentin and pregabalin may be used off-label to manage anxiety symptoms which frequently complicate BD.

Clinical studies suggest that oxcarbazepine, a keto analog of carbamazepine, is efficacious in the treatment of manic, mixed and possibly depressive states of BD. The more favourable pharmacokinetic properties, fewer drug interactions and fewer central nervous side-effects associated with oxcarbazepine make it preferable over carbamazepine.

Conventional antipsychotics

Although frequently used to treat bipolar mania, the treatment or prophylactic efficacy of this class of drugs has not been demonstrated. The use of this treatment modality has been limited due to reports of:

- dysphoric properties,
- increased risk of acute extrapyramidal syndrome and
- tardive dyskinesia.

Ms. Woldeyohannes is a Research Assistant, Mood Disorders Psychopharmacology Unit, Toronto Western Hospital, Toronto, Ontario.

Dr. McIntyre is an Associate Professor of Psychiatry and Pharmacology, University of Toronto and Head of the Mood Disorders Psychopharmacology Unit, University Health Network, Toronto, Ontario.

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Generally speaking, conventional antipsychotics are not recommended in the early treatment of BD due to their unfavourable therapeutic index.

Novel antipsychotics

The available drugs (*i.e.*, olanzapine, quetiapine, risperidone) show antimanic efficacy, independent of their antipsychotic effects, suggesting mood-stabilizing properties. Studies suggest that some of these drugs may also have antidepressant effects as monotherapy (*e.g.*, quetiapine) or in combination with selective serotonin reuptake inhibitors (*e.g.*, olanzapine) in acute bipolar depression. It is not infrequent for many individuals with BD to be treated with an atypical antipsychotic as the foundational mood stabilizer. The selection of an atypical antipsychotic is based on:

- patient profile,
- preference,
- comorbidity,
- cost,
- tolerability and
- safety profiles.

Psychosocial treatments

Also established as effective adjunctive therapies in the treatment of BD are psychosocial

treatments, such as:

- manual-based cognitive behavioural therapy,
- interpersonal therapy,
- family therapy and
- psychoeducation.

The following are all therapeutic targets with psychosocial treatments:

- high rates of non-adherence,
- interpersonal dysfunction,
- vocational impairment,
- suboptimal stress resilience,
- medical comorbidity,
- adverse health behaviours and
- suicidal ideation.

BD is a complex multidimensional syndrome associated with substantial morbidity and mortality. The encompassing aim of managing a patient with BD is to achieve wellness, defined as the absence of symptoms and restoration of normal function. The use of evidence-based guidelines to inform the selection and sequencing of treatment in BD is highly recommended.

Mortality

The most common cause of premature mortality in BD is from cardiometabolic syndrome. The high rates of general medical conditions in this patient population invite the need for routine surveillance and opportunistic screening for traditional and emerging risk factors for medical disorders. Greater attention to the depressive symptoms and somatic health issues in the BD population have been identified as modifiable unmet needs. Dx

Resources

1. McIntyre RS, Soczynska JK, Konarski J: Bipolar Disorder: Defining remission and selecting treatment. Psychiatric Times 2006; 23(11):1-2. http://www.psychiatrictimes.com/showArticle.jhtml;jsessionid=PCIB4SL511BXUQSNDLRCKH0CJUNN2JVN?articleID=193400986.
2. Kaye NS: Is your depressed patient bipolar? J Am Board Fam Pract 2005; 18(4):271-81.
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4. Yatham LN, Kennedy SH, O'Donovan C, et al: Canadian network for mood and anxiety treatments (CANMAT) guidelines for the management of patients with bipolar disorder: Update 2007. Bipolar Disord 2006; 8(6):721-39.