

Bipolar Disorder

- Diagnosis based on 2 sources of data: The current clinical picture (depression or mania) and a clear history of both manic and depressive episodes. A key thing to ask is if they have ever had a time in their life when they didn't need much sleep.
- Depressive episodes may range from minor to major depressive syndromes
- Manic episodes typically are described as full blown or less intense manic episodes, referred to as hypomania

Common Disorders that may cause Mania

- Brain tumors
- CNS syphilis
- Delirium (due to various causes)
- Encephalitis
- Influenza
- Metabolic changes associated with hemodialysis
- Multiple sclerosis

Drugs that may cause Mania

- Amphetamines
- Bromides
- Cocaine
- Antidepressants
- Isoniazid
- Steroids

Classification Schemes: Bipolar I & II

- Multiple episodes including depressive episodes common in both
- Bipolar I (0.04%-1.6%)
 - Fits more classic description of bipolar illness with clearly recognized episodes of depression and mania
 - Hx of at least 1 manic episode in lifetime
 - Manic episode of at least 7 days of severe sx of elated mood or irritability & major impairment
- Bipolar II (0.5%)
 - Presents with hx of obvious major depressive episodes & at least 1 hypo-manic episode
 - Manic phases are often less intense, unrecognized and thus unreported by patient
 - More common in women-typically more depressive episodes & more severe depression

Other Gender Differences in Bipolar Disorder

- Women more likely to experience mixed mania and rapid cycling (4 or more episodes per yr.) that tends to be more depressive than manic
- Women are often misdiagnosed and given inappropriate meds
- Men and women differ in how they present with mania
- When inquiring about manic episodes patient often denies any.

- Best way to diagnose is to witness a hypomanic episode clinically or to carefully inquire about the history - In particular, if hypomanic episodes are suspected, the most important question to ask is: *“Have you every had a period of time when you didn’t need as much sleep?”* A decrease need for sleep and a lack of daytime fatigue are red flags for hypomania. The pt will not be TIRED with little sleep.

Typical Bipolar vs. Rapid Cycling Bipolar Disorders

- In the typical BP patient, depressive and manic episodes last for several weeks or months, often with periods of normal mood occurring between periods of depression and mania.
- When there are two or more episodes of both depression and mania (e.g., depression-mania-depression-mania) within a year – referred to as “rapid cycling”. Sometimes rapid cyclers can dramatically switch moods from week to week or even day to day.

Dysphoric Mania (or Mixed Mania)

- Diagnostic term which describes patients that have concurrent manic and depressive symptoms (e.g., increased activity, pressured speech, suicidal ideas, and feelings of worthlessness). Pt is irritated and agitated...Belinda!
- The subclassifications of Bipolar I and Bipolar II, typical vs. rapid cycling, and dysphoric mania are important because they have different treatment implications.

Target Symptoms

- Vary depending on the current phase of the illness

Clinical Features of Mania

- A pronounced and persistent mood of euphoria (elevated or expansive mood) or irritability and at least 3 of the following:
 - Grandiosity or elevated self-esteem
 - Decreased need for sleep
 - Rapid, pressured speech (often these people are hard, if not impossible to interrupt)
 - Racing thoughts
 - Distractibility
 - Increased activity or psychomotor agitation
 - Behavior that reflects expansiveness (lacking restraint in emotional expression, will get right up in your face!) and poor judgment, such as increased sexual promiscuity, gambling, buying sprees, giving away money, etc.
 - Flight of ideas (sound got lost here, so look this up!)
 - Sometimes have psychotic features including delusions (usually grandiose or paranoid) and command hallucinations may be present – may give rise to self-injury, suicide and danger to client’s safety

Medications Used to Treat Bipolar Illness

- Treatment of Bipolar illness has two goals: Reduction of current symptoms and prevention of relapse
- Episodes are invariably recurring and thus prophylactic treatment is important
- Research indicates that failure to treat leads to relapse and to progressively worsening condition
- Subsequent episodes tend to become more and more severe & can, at times, become treatment refractory

Medications Used

- Lithium is primary...it stabilizes mood, can prevent relapse (or lessen intensity of subsequent episodes) if tx is on an ongoing basis. Lithium seems to be somewhat more effective in preventing relapse of mania rather than depression

Medication Regimen for Mania

- Other drugs are used as adjunctive or alternatives
- If patient quite agitated, out of control or psychotic the initial plan is to begin treatment with both a mood stabilizer and an antipsychotic medication.
- The atypical anti-psychotics seem to improve behavioral control more rapidly

Atypical Antipsychotics (All Good Zoos Save Rare Cats)

- Risperidone (Risperdal); Olanzapine (Zyprexa); Quetiapine (Seroquel); Ziprasidone (Geodon); Aripiprazole (Abilify)

Mood Stabilizers/Anticonvulsants: Atypicals

- Carbamazepine; Divalproex sodium; Valproic Na/Valproic acid; Gabapentin; Lamotrigine; Levetiracetam; Oxcarbazepine; Tiagabine HCl; Topiramate
- With most mood stabilizers the patient may require 10 days to show a clinical response so an antipsychotic is used on a short term basis. Once the mood is stabilized, the antipsychotic may be phased out. Alternatively, high potency benzodiazepines can be used in place of antipsychotics (e.g. clonazepam [Klonopin])
- Treatment with lithium is initiated after necessary lab tests are conducted; Generally starting dose is 600-900mgm/day given in divided doses.
 - Therapeutic and toxic range are very close to one another – thus it is necessary to gradually increase the dose while carefully monitoring blood levels. Most patients must reach a level between 1.0 and 1.2 mEq/L.
 - Not infrequently the level may need to be higher to obtain symptomatic improvement (1.2 to 1.6), but on these higher levels, side effects are more common and adherence is poor.
 - On occasion, patients may need and tolerate blood levels up to 2.0 mEq/L, however there is higher risk of toxicity at such doses. Generally, daily doses range from 1200-3000 mgm.
 - Once mood is adequately stabilized, the dose can be lowered somewhat (0.8 – 1.0 mEq/L) for maintenance treatment

If Presenting Phase is a Depressive Episode

- Antidepressants alone in the treatment of bipolar depression can cause significant problems, by provoking a rapid shift into mania (as well as increasing frequency of episodes; i.e., causing cycle acceleration).
- The treatment of choice therefore is to use a mood stabilizer in combination with an antidepressant (e.g., imipramine (Tofranil); amitriptyline (Elavil)).
- There are also 2 mood stabilizers that contain antidepressant properties that may be effective (lamotrigine [Lamictal] and divalproex [Depakote-SR]).

Side Effects of Lithium and Signs of Toxicity

- Side Effects: Nausea, diarrhea, vomiting, fine hand tremor, sedation, muscular weakness, polyuria, polydipsia, edema, weight gain, and a dry mouth

- Adverse Effects from chronic use: Leukocytosis (reversible if discontinued), hypothyroidism and goiter, acne, psoriasis, teratogenesis (first trimester, although risk is low) and kidney damage.
- Signs of Toxicity: Lethargy, ataxia, slurred speech, tinnitus, severe nausea/vomiting, tremor, arrhythmias, hypotension, seizures, shock, delirium, coma and even death. Since the toxic range is near to the therapeutic range, blood levels and adverse effects must be monitored closely

Nursing Considerations in Mania

- Patient safety first (may need one-to-one in manic phase)
- Basic needs a priority
- Medication adherence
- Monitor for side effects, adverse effects and toxicity
- Patient education
- Outpatient support groups and self-help groups

Key Points in Patient Education

- Lithium is a medication that treats your current emotional problem and will also be helpful in preventing relapse. So it will be important to continue with treatment after the current episode is resolved
- Since the therapeutic and toxic ranges are so close, we must monitor your blood level closely. This will be done more frequently at first and every several months thereafter. Never increase your dose without first consulting with your health care provider.
- Lithium and other mood stabilizers *are not addictive*
- Many side effects can be reduced/minimized by taking divided doses or may subside as treatment progresses
- Bipolar disorders often run in families. Any relatives that have pronounced mood swings should be alerted to the possibility of a treatable condition and the need for professional evaluation (the yield on this maneuver is high, since medical awareness of bipolar disorder is still low, especially with milder forms, and family history is impressively often positive for this disorder)
- You and your family need to be aware that this is a biological disorder, not a moral defect or a character flaw. When severe, you may not always be able to control your behavior, necessitating that practical steps be taken to protect all concerned from poor judgment during episodes
- Many self-help groups have been developed to provide support for bipolar patients and their families. In this community the local mental health association can help you find groups in your area (Mental Health Association of Sacramento County (MHASC.org) – (916) 366-4600) also Sacramento County Family Alliance for the Mentally Ill – (916) 874-9416

Cyclothymic Disorder

- Characterized by mood swing that alternates between mania and depression
- Milder than mania
- Mood swings have occurred for at least 2 years without symptom remission for 2 months
- Can be a precursor to mania
- Constantly need attention, can lead to poor interpersonal relations (especially at work)

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