433 Teams

PSYCHIATRY

2. Bipolar Disorders

Lecture contents:

- Manic Episode
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- Etiology of Mood Disorders
- Bipolar I Disorder
- Bipolar II Disorder
- Rapid Cycling Bipolar I or II Mood Disorders
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Manual of Basic Psychiatry

Doctor's notes

Important

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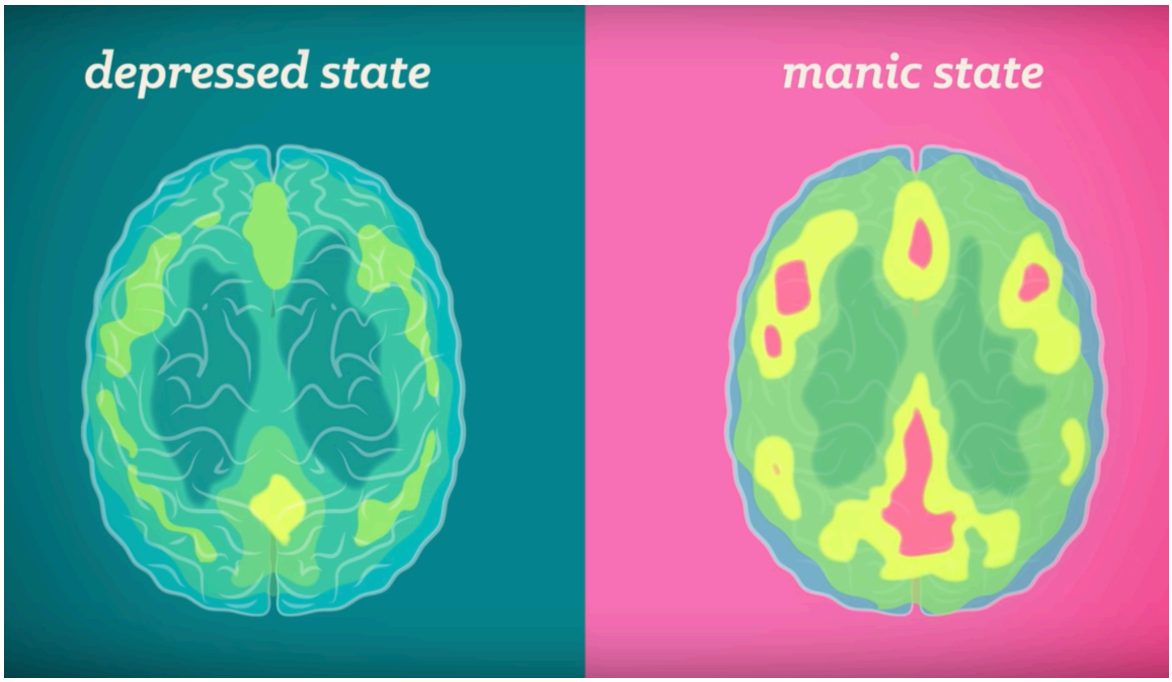
Bipolar

الكاتب تشارلز ديكنز و نزار قباني ، الممثلة مارلينا مونرو و الشاعر المصري صلاح جاهين .

These amazing sketches drawn by our colleague Sara Farhoud (Med430)

A rich imaginative life, all made possible by your mood. 'Jamison "she has Bipolar"



5 misunderstandings about Bipolar Disorder - Kati Morton treatment therapy anxiety mood stabilizers

https://www.youtube.com/watch?v=oUI5xS_IH24

TABLE 6–1. DSM-5 bipolar and related disorders

Bipolar I disorder

Bipolar II disorder

Cyclothymic disorder

Substance/medication-induced bipolar and related disorder

Bipolar and related disorder due to another medical condition

Other specified bipolar and related disorder

Unspecified bipolar and related disorder

Manic Episode:

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least **1 week**. (if it is sever enough that needs immediate admission and met the full criteria; we will not wait for one week, only one day is enough to diagnose it. Remember depression needs 2 weeks).

B. During the period of mood disturbance ≥ 3 of the following (4 if mood is irritable):

1. Inflated self-esteem or grandiosity. يشعر بالعظمة
2. Decreased need for sleep. Very important be carful it is NOT insomnia!
3. Pressured speech. عنده اشياء كثيره يبغى يقولها
4. Racing thoughts or flight of ideas.
5. Distractibility (reduced concentration) مشكلة في التركيز ما يقدر يرجع للنقطة الاصلية .
6. Increase in goal-directed activity (socially, at work, or sexually). طاقة لها هدف بعكس الانفصاميين تكون عشوائية وطاقة غير موجهة لهدف.
7. Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments). And they remember what they did.

C. The symptoms do not meet criteria for a mixed episode. Mood swing at the same day

D. Significant distress or impairment in functioning.

E. Not due to substance abuse, a medication or a general medical condition (e.g., hyperthyroidism).

Note: Manic-like episodes that are clearly caused by antidepressant treatment should not count toward a diagnosis of bipolar I disorder.

Psychiatric interview: Mania: https://www.youtube.com/watch?v=zA-fqvC02oM

Psychotic features may occur in severe cases of mania:

A.Mood - congruent hallucinations; e.g. voices talking to the patient about his special powers. Occasionally visual hallucinations (e.g. seeing Angels).

B.Mood-congruent delusions; usually grandiose delusions (e.g. being a prophet, a prince, ..). Patients with delusional disorder (grandiose type) have long-lasting grandiose delusions but no manic features; pressure of speech, racing thoughts, flight of ideas etc. Some manic patients develop delusions of persecutions or of reference.

Hypomanic vs. manic episode:

	Hypomanic episode	Manic Episode
Minimum Duration	4 days	7 days
Severity	Not severe enough to cause marked impairment in social or occupational functioning	Causes severe impairment in social or occupational functioning.
Features	No psychotic features (hallucinations/delusions).	May have psychotic features.
Diagnosis	Bipolar II disorder	Bipolar I disorder
Management	Does not require hospitalization	Usually necessitates hospitalization to prevent harm to self or others.

Bipolar I: needs one manic episode +- depression.

Bipolar II: Hypomania + depression. (does not reach ever manic features)

How to differentiate between the mania and hypomania clinically?

Severity and violence with mania, Psychosis we don't see it in hypomania .

Mixed Episode

≥ 1 week of both manic and depressive symptoms occurring simultaneously nearly every day (e.g. overactive over talkative patient may have at the same time profound depressive thoughts including suicidal ideas). Bipolar I disorder.

في اليوم الواحد يتغير مزاج المريض . يجي بكامل خصائص الهوس وبنفس اليوم فيه اكتئاب ويفكر بالانتحار

Alternating Affective Sates

Manic and depressive features follow one another in a sequence of rapid changes in a short time (e.g. a manic patient may be intensely depressed for few hours and then quickly becomes manic). Bipolar I disorder

Etiology of mood disorders

Remember, the etiology of mood disorders, like other psychiatric disorders, is multifactorial; Bio - Psycho-Social

- **Genetic:**
  One parent with bipolar I >25 % chance of mood disorder in child.
  Two parents with bipolar I > 50 % chance of **mood disorder** in child.
  Concordance rates for monozygotic twins are approximately 75%, and rates for dizygotic twins are 5 to 25%.
  Some studies found some defects in chromosomes 5, 11 and X.

- **Neurochemical:**
  Disturbance in biogenic amines (norepinephrine, serotonin, and dopamine).
- **Psychosocial:**
  Psychosocial stresses may trigger manic or mixed episode in a vulnerable person.

Manic-like episodes may be induced by

A. Medications; e.g. steroids, antidepressants.
B. Medical diseases; e.g. Hyperthyroidism, SLE, Multiple sclerosis.
C. Substance abuse; e.g. stimulants.

Bipolar I Disorder (It was known as manic-depressive disorder).

Patient has met the criteria for a full manic or mixed episode, usually sufficiently severe to require hospitalization. Depressive episodes may/may not be present (episodes of major depression are not required for the diagnosis). However, most patients with bipolar I disorder experience MDE and manic or mixed episodes (20% of patients experience only manic episodes).
Epidemiology: onset usually 18-30 years. Lifetime prevalence: 1%. ♂ = ♀

- One manic episode to diagnose.
- Can have major depressive episode or more.
- Patients who are having their first episode of bipolar I disorder MDE cannot be distinguished from patients with MDD. Until they have their 1st manic episode.
- Manic episodes are considered *distinct* when they are separated by at least 2 months without significant symptoms of mania or hypomania. اقدر افرق بين النوبات اذا كان عندي نوبه وبعدها شهرين طبيعي بعدين نوبة ثانية .

Bipolar I Disorder: Single Manic Episode

Patients who are having their first episode of bipolar I disorder MDE cannot be distinguished from patients with MDD. Thus, according to DSM-IV-TR, patients must be experiencing their first manic episode to meet the diagnostic criteria for bipolar I disorder.

What are the hints that make me think that a person with depression has bipolar?

- Early age
- Family history
- Atypical manifestation (irritable mood hypersomnia, hyperphagia (carbohydrate craving), weight gain, increased fatigue)

Bipolar I Disorder: Recurrent

When there are other episodes (whether manic, mixed, or MDE) after the first manic episode, DSM-IV-TR specifies diagnostic criteria for recurrent bipolar I disorder. Recurrent bipolar I disorder is specified based on the symptoms of the most recent episode: bipolar I disorder, most recent episode manic; hypomanic; depressed; or mixed. Manic episodes are considered distinct when they are separated by at least 2 months without significant symptoms of mania or hypomania. Between manic episodes, there may be interspersed normal (euthymic) mood or MDEs.

Bipolar II Disorder:

Patient has at least one major depressive episode and at least one hypomanic episode, **but no manic episode.** If there has been a full manic or mixed episode even in the past, then the diagnosis is bipolar I disorder, not bipolar II.
Features are not better accounted for by schizoaffective disorder and are not superimposed on schizophrenia, schizophreniform disorder, delusional disorder. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
Epidemiology; onset usually 18- 30 years. Lifetime prevalence: 0.5%. Slightly more common in women.
يبدأ في عمر اصغر من النوع الاول، نادر تشخيصه لان غالبا يجي باكتئاب

Rapid Cycling Bipolar I or II Mood Disorders:

≥ 4 alternating mood episodes (MDE, Manic, Hypomanic or Mixed) in the previous 12 months, separated by intervals of 2-3 days. Commonly in bipolar, mania and hypomania depression less likely. Around 80 % are lithium-treatment failures. Carbamazepine and sodium valproate are usual agents of choice. It is usually more chronic than non-rapid cycling disorders.

Seasonal affective disorder

Recurrent major depressive episodes that come with shortened day light in winter and disappear during summer (may be followed by hypomania). Absence of clear-cut seasonally changing psychosocial variables.

Characterized by atypical features of depression: hypersomnia, hyperphagia (carbohydrate craving), weight gain, increased fatigue. **Related to abnormal melatonin metabolism. Treated with exposure to light (artificial light for 2 – 6 hours a day).** It may occur as part of bipolar I or II disorders.

Cyclothymic disorder

Less severe bipolar mood disorder with continuous mood swings; alternating periods of hypomania and moderate depression. It is non-psychotic chronic disorder. It starts in late adolescence or early adulthood. The treatment is similar to that of bipolar mood disorder.

Treatment of Bipolar Mood Disorder:

1. **Short-term treatment:** for acute manic or mixed episode

   Manic behavior can be damaging for the patient and others (e.g. loss of career, financial disaster, and sexual insult).

   - **Hospitalization:** can provide a secure, protective environment اذا كان المريض مانام مده طويلة او قام بفوضى
   - **Agitation:** The initial task is to quieten the agitation that commonly occurs. This is usually accomplished with **antipsychotic medication**;
     - Typical: e.g. haloperidol 10 - 20 mg or chlorpromazine 400-800 mg.
     - Atypical: e.g. olanzapine 10-20 mg, or risperidone 4-8 mg.

     They reduce psychotic symptoms and over activity. Thus, they bring the acute symptoms of mania under control. Haloperidol is a potent antipsychotic, less sedative and causes less postural hypotension compared with chlorpromazine, which is sometimes the drug of choice in mania for its sedative property.

   When the manic patient settles (usually within weeks), he can be treated as an outpatient with close observation and frequent assessment. Antipsychotics can then be reduced gradually and carefully.

2. Long-term treatment:

Mood disorders often recur and have relapsing course, thus preventive (prophylactic) treatment is required.

- **Lithium** has been found effective in preventing recurrence of manic-depressive episodes.

Mechanism of action	The exact mechanism is unknown, however it is thought that it stabilizes neuronal activities (decreases sensitivity of postsynaptic receptors and inhibits release of neurotransmitters).
Before starting lithium	A note should be made of any other medications taken by the patient and a physical examination should be carried out. Prerequisite laboratory test: Renal functions and electrolytes, thyroid functions, ECG if cardiac disease is suspected, pregnancy test (if indicated).
Contraindications	Renal or cardiac failure. Recent myocardial infarction. Chronic diarrhea sufficient to alter electrolytes. First trimester of pregnancy (fetal cardiac anomalies). Lithium is not recommended in children.
Side effects	Fine tremor, gastric discomfort and diarrhea, dry mouth, metallic taste, fatigue, weight gain. Reversible hypothyroidism, reversible nephrogenic diabetes insipidus (polyuria – polydepsia) due to blockade of ADH – sensitive adenylcyclase in distal tubules.
Toxicity	Course tremor, ataxia, confusion, diarrhea, vomiting...
Drug interactions	Several drugs increase lithium concentration and may lead to Lithium toxicity: Thiazide diuretics Non - steroidal anti – inflammatory drugs (NSAID)/ Angiotension - converting enzyme inhibitors e.g. lisinopril / Haloperidol high doses (e.g. 40 mg/day). Lithium may potentiate the effect of muscle relaxants. This is important when a patient undergoes an operation or ECT. It may potentiate extrapyramidal side effects of antipsychotics. It may precipitate 5 - HT syndrome if given with SSRIs. The recommended plasma concentrations are: - 0.9 - 1.2 mmol / liter (during acute phase) - 0.4 - 0.8 mmol / liter (for prophylaxis) Dose is 300 - 450 mg twice or three times a day. Plasma concentration requires continuous measurement because the narrow therapeutic index of lithium (therapeutic and toxic levels are close). Toxic levels ≥ 9.9 mmol / liter. Plasma level should be measured 12 hours after the last dose.

- **Carbamazepine (tegretol):** appears to be as effective as lithium in the prophylaxis of bipolar mood disorder, and can be considered in patients who are intolerant of lithium or who respond poorly to lithium (e.g. rapid-cycling mood disorders). **First-line agent for acute and maintenance treatment for bipolar I disorder.**

Overview	Was first used to treat epilepsy and trigeminal neuralgia. Then, it has been used for decades as a first-line agent for acute and maintenance treatment for bipolar I disorder. Studies suggest that carbamazepine may be especially effective in persons who are not responsive to lithium.
In acute mania	Carbamazepine is typically effective within the first 2 weeks of treatment in 50 -70 % of cases.
Prophylaxis	Carbamazepine is effective in preventing relapses, particularly among patients with mood disorders and schizoaffective disorders.
Impulsive and aggressive behavior	It is effective in controlling impulsive and aggressive behavior in persons of all ages who are not psychotic (e.g. borderline personality disorders, mentally retarded, head trauma Sequelae).
Doses	Starting dose is usually 200 mg two times a day. (in children 100 mg/day). It can be increased gradually to 600 – 1000 mg. Therapeutic concentration for psychiatric indications is 8 – 12 ug per mil.
Side effects	It is relatively well tolerated. The most common side effects are mild and transient; Mild GI (gastric discomfort, nausea, vomiting, constipation, diarrhea, and anorexia) and CNS (sedation, drowsiness, vertigo, blurred vision and ataxia). It occasionally causes syndrome of secretion of inappropriate antidiuretic hormone (SIADH) through activation of vasopressin receptor function (hyponatremia +/- water intoxication).
Rarest but serious adverse effects	Hepatitis, pancreatitis, serious skin reactions (Stevens-Johnson syndrome), and blood dyscrasias (agranulocytosis and aplastic anemia).
Drug interactions	As a result of prominent induction of hepatic CYP 3A4, It decreases serum concentrations of numerous drugs (e.g. oral contraceptives, warfarin, haloperidol, valproate). When carbamazepine and valproate are used in combination, the dosage of valproate may need to be increased and the dosage of carbamazepine should be decreased, because valproate displaces carbamazepine binding on proteins. Monitoring for a decrease in clinical effects is frequently indicated because of autoinduction.

- **Sodium valproate:** has been found effective in patients with refractory bipolar illness, even when there has been a poor response to lithium and carbamazepine. Combination of lithium with carbamazepine can be used, particularly in rapid-cycling disorders, and combination of lithium with sodium valproate has been shown to be effective in the treatment of resistant patients.

Overview	(Depakine Depakene, Depakote): It is used for the treatment of acute manic episode associated with mood and schizoaffective disorders.
Doses	Starting dose is usually 250 mg twice/day. It can be increased gradually to 2500 mg/day.
Common side effects	Mild GI (gastric discomfort, nausea, vomiting, and anorexia) and CNS (sedation, drowsiness, dysarthria, and ataxia).
Rarest but serious adverse effects	Fatal hepatotoxicity, pancreatitis, and fetal neural tube defects (e.g., spina bifida), 2-4% in women who take valproate during the first trimester of the pregnancy. Daily folic acid supplements reduce the risk of neural tube defects.

- **Other anticonvulsants used as mood-stabilizers:** Lamotrigine (Lamictal), Topiramate (Topamax), Gabapentin (Neurontin), Pregabalin (Lyrica), Levetiracetam (Keppra), and Tiagabine (Gabitril). **Doctor said only know the names.**

Course and Prognosis of bipolar disorders:

If left untreated, most manic episodes will resolve within 8 -12 weeks (rarely last longer than 24 weeks). The risk of recurrence is particularly high (50 %). About 80 % of manic patients eventually experience a full depressive episode. About 50 % will have multiple relapses with good interepisodic functioning. The prognosis is much better than schizophrenia, but there is a wide variation; some people having their lives repeatedly disturbed, whilst others experience only a single episode. Some individuals have years of normal functioning between episodes. Others have episodes in clusters. Some patients have rapidly cycling episodes. As the disorder progresses, the time between episodes often decreases. After about five episodes, however, the interepisodic interval often stabilizes at 6 - 9 months. Patients with bipolar I disorder have a poorer prognosis than do patients with major depressive disorder. Chronic deterioration may occur in up to 30 % of bipolar patients.

Mood disorders vs. Schizoaffective Disorder.

To differentiate mood disorder with psychotic features from schizoaffective disorder patient with schizoaffective disorder has either major depressive episode, manic episode, or mixed episode during which criteria for schizophrenia are also met.

There should be delusions or hallucinations for at least two weeks in the absence of prominent mood symptoms.

Schizoaffective disorder can be either depressive type or bipolar type.

Course and prognosis is between that of schizophrenia and of bipolar mood disorder.

Treatment includes hospitalization, antipsychotics, mood stabilizers (lithium is a good choice) and antidepressants when needed.

Symptoms not due to general medical condition or drugs.

Done By:

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