Bipolar Disorder: How to Recognize and Treat in Primary Care

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Patients with psychiatric disorders often present a diagnostic challenge— even for psychiatrists. Their demeanor may not readily reveal the nature or severity of the problem. Nevertheless, there are clues that can help you sort through the differential and arrive at the correct diagnosis.

Here, I focus on how to recognize bipolar disorder, and I also offer recommendations for treatment.

PREVALENCE AND IMPACT
The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR), characterizes mood disorders as primarily disturbances of emotions and feelings. The 2 principal mood disorders are major depressive disorder and bipolar disorder. Patients with bipolar disorder have recurrent episodes of both depression and mania (and sometimes the 2 combined-- called a "mixed episode"). Bipolar disorder will develop in approximately 1% of Americans at some point in their lives. The age of onset is typically young adulthood— with 30 years the mean—and the disorder affects men and women equally. Genetics play a significant role in transmission of this illness. If one parent in a couple has bipolar disorder, there is a 25% risk that their children will have a mood disorder. If both parents have bipolar disorder, the risk increases to between 50% and 75%.

Persons with bipolar disorder tend to be bright, driven, and quick-witted. However, the effects of their illness often prevent them from fulfilling their potential. The disorder also contributes to the disruption of social relations and marriages; divorces are common. Between 10% and 15% of persons with bipolar disorder commit suicide.

TYPES OF BIPOLAR DISORDER
There are several types of bipolar disorder, which are distinguished by the nature of the episodes and by the pattern with which they recur.

Bipolar I disorder. This is "classic" bipolar disorder and is also referred to as manic-depressive illness. Diagnosis requires the occurrence of one or more manic episodes or mixed episodes and at least one major depressive episode. (A mixed episode is one in which the patient experiences quick shifts in mood over a week or more, and the opposite poles of these rapid fluctuations meet the criteria for manic and depressive episodes. Clinical signs of a mixed episode include agitation, insomnia, psychosis, and suicidal speculation.) Patients who have bipolar I disorder usually exhibit significant social and occupational dysfunction.

Bipolar II disorder. Affected patients have had a mood cycle or cycles that range from a major depressive episode to hypomania, yet never extend beyond hypomania to mania. (Hypomania is a persistently energized, elevated, or irritable mood that lasts several days and is not related to ingestion of a particular substance or to a medical condition. Hypomanic patients do not have psychotic symptoms— which are common in those with mania—and they are able to maintain self-control.)

Bipolar I or II disorder with rapid cycling. Patients have 4 or more episodes of mood disturbance within 1 year. The chaotic mood instability seen in these patients can mimic borderline personality disorder. Women are more likely to have rapid-cycling bipolar disorder than men.

DIAGNOSIS OF MANIA
The diagnosis of mania or hypomania depends almost entirely on the clinical history and presentation. There are no pathognomonic laboratory tests to identify bipolar disorder. However, certain laboratory tests should be ordered if bipolar disorder— manic or hypomanic phase—is suspected. These include a complete blood cell count, comprehensive metabolic panel, and urine drug screen. The purpose of such tests is primarily to rule out medical conditions in the differential (Table 1).
Behaviors and speech patterns. Many behavioral clues to a manic or hypomanic episode can be observed during an office visit. Bipolar patients in a manic phase typically appear energized and upbeat but may also be irritable. They may exhibit distinctive, inflated mannerisms. As mania progresses, patients may also choose clothes, jewelry, hairstyles, and body piercings or tattoos that call attention to their presence. Restless behaviors, such as nail-biting or pacing, and signs of inattentiveness and distractibility, such as mismatched socks, misapplied makeup, or unkempt hair, may be evident, especially in more advanced stages.

A patient's speech provides especially important clues to the diagnosis of a manic or hypomanic bipolar episode. Perhaps most apparent is that such patients simply tend to talk too much. Word choice may be very expressive or even flowery; there may be liberal use of puns or risque humor. The pace may be rapid and pressured. The tone is likely to be tense and loud. Occasionally, affected patients may laugh infectiously and display a deceptive lightheartedness.
The speech of patients in a manic or hypomanic phase also typically shows signs of a breakdown of focus, clarity, and direction. Such signs, in roughly ascending order of seriousness, include:

- Overinclusiveness and circumstantiality— the inclusion of many irrelevant and tedious details.
- Tangentiality—a tendency to drop the principal theme of a conversation in order to follow a new, obliquely related topic suggested by a remark.
- Looseness of associations--shifting thoughts without logical connections.
- Flight of ideas—loose associations that occur in very rapid succession; pressured, fast-paced “fibrillation” of thought.

In addition, these patients are likely to exhibit signs of grandiosity in their speech. In more advanced stages there may be delusions, common themes of which include far-reaching financial successes, corporate conquests, athletic prowess, and sexual allure.

**Clues from the history.** The presentation of a number of psychiatric and medical conditions is similar to that of the manic or hypomanic phase of bipolar disorder. An astute and careful history taking is key to proper diagnosis.

- Identify medical problems that predispose to psychiatric disorders. Explore the patient's personal and family history of psychiatric treatment, substance abuse, and even civil arrests.
- Ask whether the patient can identify past periods of a week or longer of persistently elevated or irritable moods that are not secondary to alcohol, drugs, or another medical condition.
- Inquire about prolonged sleeplessness, heightened energy, and weight loss (which often results from reduced sleep and hyperactivity).
- Ask about errant sexuality, spending sprees, traffic violations, and other evidence of impulsive, reckless behavior.
- Question the patient about such signs of distractibility and inattentiveness as forgetting a purse or wallet, failing to hang up the telephone, and leaving doors open or electrical appliances running. Throughout, keep in mind that patients have difficulty identifying a manic or hypomanic phase as an illness.
- You may also want to question a patient about hallucinations, which can be present in more advanced manic episodes. Manic hallucinations are typically auditory—"voices" that may call the patient to action or reincriminate him or her for failures to achieve. In some patients, mania may progress to frank psychosis (psychotic mania); in fact, 50% of patients with bipolar disorder will display psychotic symptoms at some time during the course of their illness. Patients who exhibit symptoms of psychosis should be referred to a psychiatrist.

A mnemonic that can be helpful in the diagnosis of mania is DIGFAST. It identifies the primary symptoms of a manic state:

D - distractibility
I - insomnia
G - grandiosity
F - flight of ideas
A - activity increased
S - speech (anxiously pressured and talkative)
T - thoughtlessness (poor judgment and pleasure seeking)

**Differential diagnosis.** In addition to bipolar disorder, the causes of manic behavior most likely to be seen in the primary care setting include alcohol, cocaine, amphetamine, and caffeine intoxications; substance withdrawal syndromes; anxiety disorders; personality disorders (such as histrionic, borderline, narcissistic, or antisocial personality disorders); schizophrenia; and delirium that results from various medical conditions (Table 2).
Disorder or condition

Similarities to bipolar disorder

How to distinguish from bipolar disorder

Alcohol/drug intoxication

Elevated, expanded mood or irritability

Sleeplessness, psychomotor agitation, and disorientation
Substance withdrawal syndromes

Withdrawal from amphetamines or cocaine can resemble a depressive episode; withdrawal from alcohol or opioids can cause anxiety and agitation, as are sometimes seen in a manic phase.

Page 5 of 17
Anxiety disorders

Symptoms of anxiety, such as choking, light headedness, chest pain, trembling, or palpitations; panic attacks; blushing; and diffe
Delirium can result from substance withdrawal or various medical conditions; hallucinations, agitation, confusion, and delusions in all phases.
Alcohol/drug intoxication. Substance abuse can mimic many psychiatric disorders. Intoxication with amphetamines, cocaine, or ephedrine-based compounds is most likely to produce signs and symptoms that resemble those of bipolar disorder. Alcohol intoxication can also elevate and expand mood or cause irritability that mimics the irritable mood associated with bipolar disorder. However, intoxicated persons are more likely to slur their words and appear uncoordinated than are those in a manic or hypomanic state, and persons who have used cocaine or amphetamines are more likely to exhibit mydriasis.

Bipolar disorder may also coexist with substance abuse. In fact, bipolar disorder is the axis I psychiatric diagnosis most frequently associated with substance abuse.

Substance withdrawal syndromes. Withdrawal from a psychoactive substance is typically characterized by signs and symptoms opposite those seen during an episode of intoxication. For example, amphetamines and cocaine are CNS stimulants. During withdrawal from these substances, individuals tend to become sad, fatigued, and somnolent; withdrawal may last several days and resemble a major depression. Alcohol and opioids, on the other hand, are CNS depressants; withdrawal from these substances tends to be activating and can cause sleep fragmentation, diaphoresis, and GI distress. A careful history taking that involves the family and friends of the patient—together with a urine drug screen and measurement of blood alcohol level—can help confirm the diagnosis.

Anxiety disorders. These are among the most common psychiatric disorders. The anxiety can be linked to a specific fear, as in a phobia, or to recollections of a past traumatic event, as in post-traumatic stress disorder. The symptoms are typically physical, such as choking, lightheadedness, chest pain, or autonomic arousal (eg, trembling or palpitations). When the anxiety-provoking stimulus is removed, symptoms lessen and disappear. In patients who have bipolar disorder, symptoms of anxiety are more constantly present and are likely to be accompanied by depressive symptoms. Anxiety disorders can be differentiated from mania by the absence of...
delusions and hallucinations and by the ability of patients to take direction and maintain self-control. **Personality disorders.** Patients with histrionic, borderline, narcissistic, or antisocial personality disorders often exhibit erratic behaviors and self-dramatization similar to those seen in a manic or hypomanic phase of bipolar disorder. However, patients with personality disorders tend to display less energy and exuberance and are directable and capable of maintaining control. Also, the histories of patients with personality disorders reveal long-standing maladaptive behaviors that were probably first recognized in early adulthood and that are not simply transient responses to stress. Bear in mind that patients may simultaneously meet the criteria for both bipolar disorder and a personality disorder.

**Schizophrenia.** This illness may resemble a bipolar manic episode that has escalated to the point of psychosis. However, the premorbid history of a patient with schizophrenia usually reveals a person who was less animated, more withdrawn, and more behaviorally peculiar than someone before the onset of a manic episode. Also, more bizarre and less grandiose than those of patients in a manic phase of bipolar disorder.

**Delirium.** This agitated, confused state can resemble mania. It is often caused by substance withdrawal but can be a result of other medical conditions, such as encephalitis, syphilis, or hypoglycemia. However, unlike patients in a manic state, delirious patients are often disoriented in all spheres and tend to have vivid tactile and visual—rather than auditory—hallucinations. Tests that can determine the cause of delirium—and rule out mania—include a urine drug screen, measurement of electrolyte and magnesium levels, basic metabolic profile, rapid plasma reagin, and complete blood cell count.

**DIAGNOSING BIPOLAR DEPRESSION**

The symptoms of bipolar depression are identical to those of a unipolar depression (also called a major depressive episode) and include sadness, anhedonia, anergy, anorexia, weight loss, insomnia or hypersomnia, psychomotor agitation or retardation, a sense of worthlessness, decreased concentration, and suicidal ideation. Patients with bipolar disorder, depressed phase, are more likely to appear physically ill, and symptoms are apt to be more entrenched and profound. As with mania, the key to diagnosis of a bipolar depressive episode is a careful history. Explore the patient's background for evidence of polarity, such as mood swings. **TREATMENT**

**Acute mania.** The principal classes of drugs used to treat acute mania include mood stabilizers, antipsychotics, and anxiolytics. Antipsychotic medications such as phenothiazines, haloperidol, or the newer agents olanzapine, risperidone, and ziprasidone—along with a benzodiazepine such as clonazepam—can rapidly harness such manic symptoms as hyperactivity, agitation, restlessness, flight of ideas, hallucinations, delusions, and sleeplessness. Administer a mood stabilizer (for example, lithium carbonate, valproic acid, or carbamazepine) at the same time. Mood stabilizers have a delayed onset of action but become increasingly effective over time. Once the mood stabilizer reaches a therapeutic blood level, antipsychotic and anxiolytic medications can usually be tapered and discontinued.

Refer to a psychiatrist any patient who does not respond to mood stabilizers or anxiolytics. Patients who display severe manic symptoms often require hospitalization. When patients are in any way threatening to themselves or others, hospitalization is necessary.

**Acute depression.** As with unipolar depression, the mainstay of treatment of bipolar depression is antidepressant therapy. However, it is imperative to keep in mind that in bipolar patients, antidepressant medications can sometimes rapidly transform a depressed mood into mania. Once a patient's mood is normalized, antidepressants should be tapered or discontinued. If a patient does not respond to antidepressant therapy, refer him to a psychiatrist.

Psychiatrists are able to offer alternatives to pharmacologic therapy. One treatment modality that can be effective in patients with bipolar disorder is electroconvulsive therapy (ECT). ECT is often effective in resolving a refractory bipolar depressive or manic episode. In fact, because severe bipolar depression—especially a depressive episode with psychotic features—seldom responds to antidepressants alone, ECT is recommended as first-line therapy in this setting. Other treatment options for patients whose depression is unresponsive to antidepressants include therapy, sleep deprivation therapy, and such experimental therapies as transcranial magnetic stimulation and vagus nerve stimulation.

Finally, hospitalization may be required in severe bipolar depression to ensure a patient's safety. **Long-term prophylaxis.** Bipolar disorder is a chronic illness and affected patients require continued therapeutic maintenance. Initiate prophylactic treatment when patients recover from an episode of mania or depression. Keep in mind that if prophylaxis is discontinued, patients are likely to succumb to further episodes.
Mood stabilizers are the mainstay of prophylactic therapy. For many patients with bipolar disorder, a maintenance dosage of a single mood stabilizer can largely prevent future episodes. Patients whose illness is more complex may require low-dose antipsychotic medications along with 1 or 2 mood stabilizers to achieve longer periods of maintenance. The therapeutic goal should be compliant stabilization with minimal medication.

All mood stabilizers are efficacious, although patients may tolerate one better than another. Lithium carbonate has been in use the longest and is the most cost-effective; however, renal and thyroid function studies should be routinely ordered. Monitor hepatic function in patients who take valproic acid. Carbamazepine therapy may result in neutropenia; order white blood cell counts regularly. Serum drug levels can be obtained for each of the mood stabilizers.

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