CURRENT THINKING ON... BIPOLAR DISORDER

Welcome to our CPD module series for community pharmacy technicians. Written in conjunction with the ***Pharmacy Magazine*** CPD series, it will mirror the magazine's programme throughout the year. The series has been designed for you to use as part of your continuing professional development. Reflection exercises have been included to help start you off in the CPD learning cycle.

Contributing author: Julie Haste, lead mental health pharmacist (Brighton & Hove).

Bipolar disorder is a complex condition that has an early age of onset. The peak rate of onset is between the ages of 15 and 19 years, with prevalence similar in both sexes.

Bipolar patients have between 10 and 20 years premature mortality, partly due to cardiovascular disease (driven by weight gain) but also suicide, which is among the highest for any psychiatric disorder. Approximately 17 per cent of patients with bipolar I disorder and 24 per cent of those with bipolar II disorder attempt suicide during the course of their illness.

The clinical problem

Bipolar disorder is a cyclical mood disorder that involves episodes of disruption to mood and behaviour, interspersed with periods of recovery. These disruptive episodes can either be depressive or manic (either mania or hypomania).

The Diagnostic and Statistical Manual of Mental Disorders (DSM-V) defines bipolar disorder as:

Bipolar I disorder: at least one manic episode is experienced

Bipolar II disorder: at least one major depressive episode and at least one hypomanic episode are experienced.

Mania

In mania the mood is elevated to a level out of keeping with the patient's circumstances/character. Symptoms include grandiose ideas and over confidence, loss of social inhibitions, increased energy resulting in over activity, pressure of speech, decreased need for sleep, short attention span and marked distractibility.

Psychotic symptoms can additionally be present, for example delusions (usually grandiose), hallucinations (usually voices speaking directly to the patient), excitement, excessive pacing or running around and moving from one idea to the next (flight of ideas).

A diagnosis of mania is made when symptoms last for seven days or more. Hospital admission or intensive community management is always considered in such cases.

Mania-like symptoms can be the result of using stimulant drugs, such as cocaine, khat, ecstasy or amphetamine, so it is important to clarify if any agent has been taken. Medications such as corticosteroids (especially in high doses), levodopa and prescribed stimulants (e.g. methylphenidate) can also cause manic-like symptoms.

Hypomania

Hypomania is an elated state without significant function impairment (i.e. no disruption to work or social rejection). Hypomania is diagnosed when symptoms last for four days or more. Hallucinations and delusion are not experienced.

Depression

Depressive symptoms are commoner than manic symptoms and the risk of suicide is greatly elevated during depressive episodes. Common symptoms include lowering of mood, poor concentration, disturbed sleep, loss of appetite and weight loss, reduced self-esteem and self-confidence, some ideas of guilt or worthlessness, slowed down thoughts and movements, agitation and loss of libido.

When adults present with depression it is important to ask about periods of over activity or disinhibited behaviour, especially if over four days, as this may alter the diagnosis.

Symptom management

The treatment of bipolar disorder includes:

- Management of acute manic episodes
- Management of the acute depressive episodes
- Long-term treatment.

Acute manic episode

Most patients with mania will require short-term medication to reduce the severity and duration of the acute episode. Patients should stop taking any substances known to cause mania when an episode begins.

The antipsychotics haloperidol, olanzapine, quetiapine and risperidone are most effective in the short-term reduction of manic symptoms. Lithium, valproate or aripiprazole can be used if antipsychotics are ineffective. Benzodiazepines may also be used short-term to promote sleep for agitated overactive patients.

Patients who experience a manic or hypomanic episode while taking medication should have their dose adjusted. If symptoms are inadequately controlled with optimal doses, or the mania is very severe, another medicine is often prescribed.

Acute depressive episode

Bipolar depression can be treated with psychological interventions such as family focused therapy (FFT), cognitive behavioural therapy (CBT) or interpersonal and social rhythm therapy (IPSRT). This can include monitoring for signs of mania or hypomania and deterioration of the depressive symptoms. CBT therapy can be used alone, whereas the other psychological therapies should be used alongside medication.

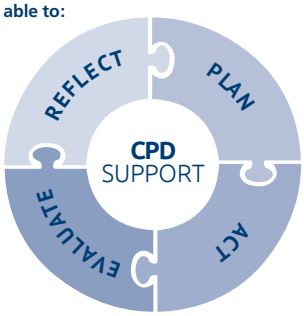
Antidepressants have not been adequately studied in bipolar depression and they can induce mania in some patients. Only the combination of fluoxetine with olanzapine has shown effectiveness in treating bipolar depression.

MODULE NUMBER: 79

AIM: To help you understand the treatment strategies for bipolar disorder.

OBJECTIVES: After reading this module pharmacy technicians will be able to:

- List the key symptoms of bipolar disorder
- Explain the treatment strategies for acute mania, acute bipolar depression and longer term treatment
- Understand the challenges patients with bipolar disorder face.



Key facts

- Haloperidol, olanzapine, quetiapine and risperidone are the antipsychotics of choice for the treatment of mania
- Antidepressants should only be used for treating bipolar depression or long-term treatment if they are prescribed in combination with an antipsychotic
- Lithium is the most effective long-term treatment for bipolar disorder
- Sodium valproate should be avoided in women of child-bearing age
- If lithium is used, plasma levels, thyroid function and electrolyte levels should be checked regularly
- Adherence to medication is crucial in the long term as the risk of relapse remains high even after many years of sustained remission

Other treatments of bipolar depression include quetiapine, lurasidone, olanzapine (without fluoxetine) or lamotrigine. If lamotrigine is prescribed it is often combined with an antipsychotic, lithium or valproate to protect against mania.

Patients with bipolar depression taking lithium, valproate or antipsychotics should have their doses and plasma levels checked to see if they are within the usual target. If this treatment is still not effective, quetiapine, olanzapine (with or without fluoxetine) or lamotrigine can be added as concomitant therapy.

Long-term treatment

Long-term treatment aims to prevent either manic or depressive episodes. Structured psychological interventions (individual, group or family) are designed to prevent relapse by improving knowledge of bipolar disorder. Group psychoeducation appears to be a highly effective adjunct to pharmacotherapy in relapse prevention.

Medication that has been effective during episodes of mania or bipolar depression is often continued as long-term therapy. Lithium, the most effective long-term treatment for bipolar disorder, is associated with a reduced risk of suicide, and is the treatment of choice for most patients. Lithium is not recommended for patients with poor adherence as rapid discontinuation may increase the risk of relapse. When lithium is ineffective, poorly tolerated or used in a patient unlikely to be adherent, valproate or an antipsychotic may be prescribed.

Patients primarily affected by mania should be treated with the predominantly antimanic medicines lithium, olanzapine, quetiapine, risperidone long-acting injection or valproate. Those primarily affected by depressive episodes should be prescribed lamotrigine, lithium or quetiapine.

In bipolar I disorder, lamotrigine is usually used in combination with an antipsychotic medicine. In patients with bipolar II disorder, lamotrigine and quetiapine may be effective monotherapies.

Antipsychotics

The main mode of action of antipsychotics is antagonism at dopamine D2 receptors but there are other pharmacological differences between them, hence their use in different phases of bipolar disorder.

Lithium

Lithium modifies the production and turnover of neurotransmitters, particularly serotonin, and may also block dopamine receptors.

Lithium has side-effects affecting the kidneys and the thyroid gland, so renal and thyroid function needs to be assessed prior to starting with it, and repeated every six months during treatment. Patients with cardiovascular disease or risk factors should have an electrocardiogram (ECG) prior to starting lithium treatment.

Patients on lithium should have a record booklet which prescribers and pharmacists can use to check that blood tests are monitored regularly.

Valproate

There are significant risks for the unborn child if valproate is taken during pregnancy, including the risk of congenital malformations and developmental delay. Use should therefore be avoided in women of child-bearing age. Valproate is also associated with polycystic ovary disease so should not be considered in females under 18 years of age. Semi sodium valproate (Depakote) is the only valproate preparation licensed for the treatment of manic episodes associated with bipolar disorder.

Lamotrigine

Lamotrigine can cause a rash, which can lead to serious conditions such as Stevens-Johnson syndrome. This side-effect is most common in the first eight weeks of therapy so the dose should be increased very slowly when treatment is started to minimise risk. When used with valproate, the titration should be even slower at half the rate.

Discontinuation of treatment

Acute treatment for mania and depression should be continued for four weeks after symptoms resolve (usually between three and six months) at which point long-term drug treatment options should be considered.

Discontinuation of long-term treatment for bipolar disorder must be done carefully, as relapses can occur even after many years of sustained remission. Abrupt discontinuation of treatment is associated with an increased risk of early relapse of mania so doses should be gradually tapered over at least four weeks, preferably longer. For lithium discontinuation over three months is preferable.

Patients should be monitored for signs of relapse, emerging symptoms, mood and mental state while discontinuing treatment, and for up to two years after treatment has stopped.

How pharmacy can help

Important roles for the community pharmacy team are:

- Knowing the interactions of the medications used in bipolar disorder, especially lithium
- Knowing the signs of lithium toxicity
- Checking lithium booklets are complete and counselling on any signs of toxicity
- Counselling on the use of medication, including standby medication for mania (especially insomnia) or depressive symptoms
- Informing patients about the importance of adherence with medication
- Giving advice on side-effects and how to minimise or treat them
- Monitoring physical health and providing lifestyle advice – particularly smoking cessation.

reflective exercise

How can you use a patient's lithium record and patient information booklet to help them understand more about their treatment and the importance of adherence?

Go to www.tmmagazine.co.uk to answer the CPD questions. When you pass, you'll be able to download a certificate to showcase your learning. You can also add this to your online, personalised learning log.

Next month: we focus on improving patient safety: reporting medication incidents.