

# **Bipolar Disorders - 2006**

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# Epidemiology

## 1. Lifetime prevalence :

bipolar I : 0.8%

bipolar II : 0.6% (Murphy, 2000)

## 2. Bipolar disorder is the 6<sup>th</sup> leading cause of disability, ages 15-44, worldwide...

depression is 2<sup>nd</sup>!

## 3. At any given point in time, 60% of bipolars are not in treatment

# **Epidemiology**

- 1. Course of bipolar I is 9-10 cycles during a lifetime – often stabilizing after 4-5 cycles**
- 2. Without treatment – average depressive episode is 10 weeks, average manic episode is 5 weeks**
- 3. Sixty percent of patients have an increase in episode intensity/duration with age**

# **Genetics of Bipolar Illness**

- 1. Polygenic inheritance. Fifty percent of bipolar patients have a family history of bipolar illness.**
- 2. Linkage studies (in several studies) have identified markers on chromosome 18 & 22.**
- 3. Near future is identifying individuals at risk; long term future – superior treatments.**

# **What about the role of 'stress' in bipolar illness?**

- 1. Disruption in sleep, but not 'stress' per se can lead to a bipolar relapse.**
- 2. Early childhood 'trauma' is NOT causative in bipolar illness. However,**
  - a. sexual abuse – may increase risk of suicide attempts**
  - b. physical abuse – may increase risk of manic relapses**
  - c. sexual/physical abuse – may lead to earlier illness onset**

# Diagnosis of depression

**1. A distinct mood change (depressed, irritable, anxious, etc) for at least two weeks**

**2. Four or more SIGECAPS :**

**S**leep

**C**oncentration

**I**nterest

**A**ppetite

**G**uilt

**P**sychemotor activity

**E**nergy

**S**uicide

# Diagnosis of mania/hypomania

**1. A distinct mood change (elated, irritable, expansive, etc) for > one week (four days for hypomania)**

**2. Three or more GST RAID :**

**G** randiosity

**S** leep(decreased)

**T** alkative

**R** apid thoughts

**A** gitation

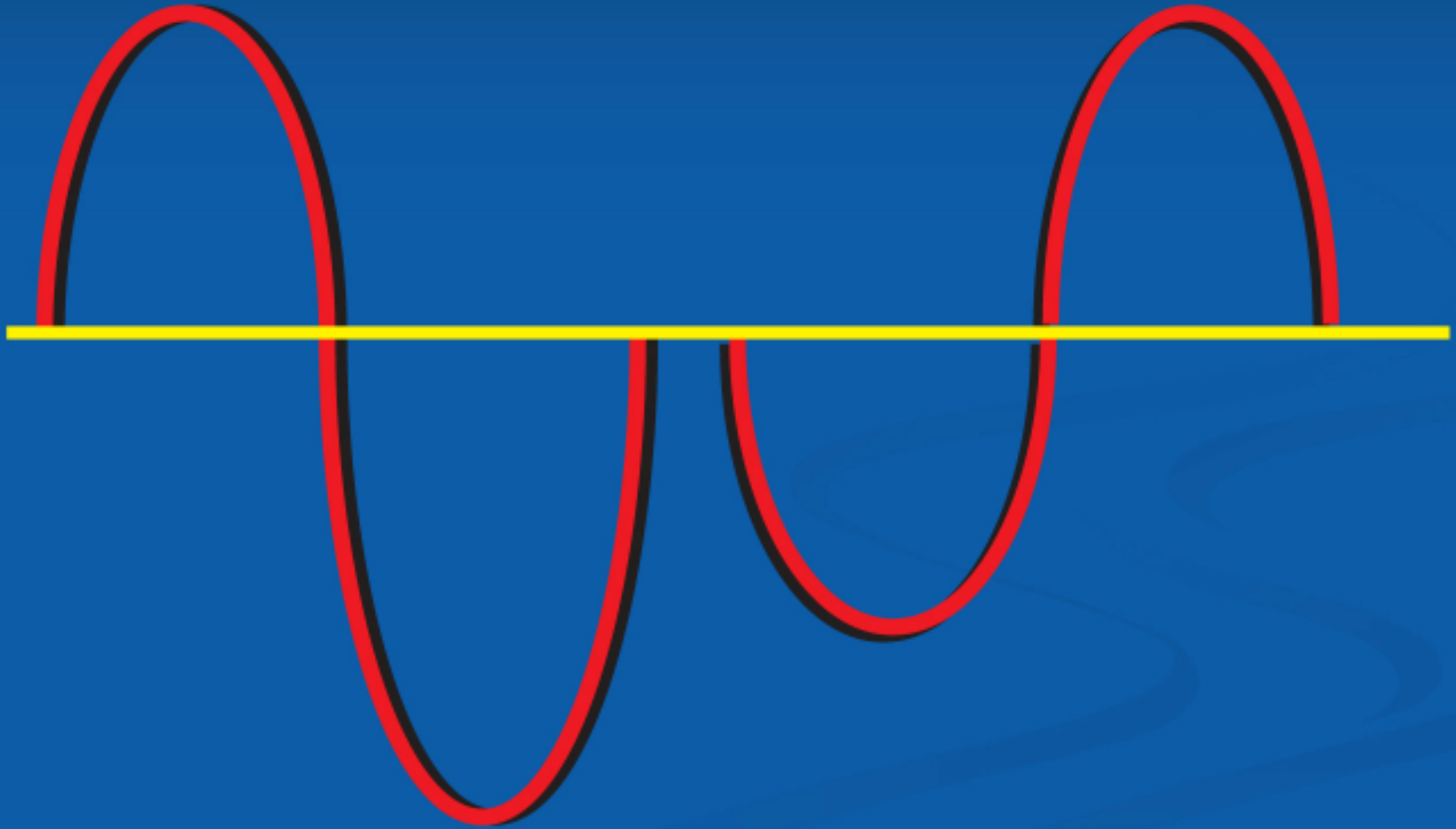
**I** mpaired judgement

**D** istractable

# **Diagnosing bipolar illness**

- 1. Distinguish bipolar I (mania) from bipolar II (hypomania)**
- 2. Bipolar II is among the most frequently missed diagnoses in psychiatry**
- 3. The diagnosis of bipolar II disorder is risky, at best, without collateral information.**

# BIPOLAR I



# BIPOLAR II



# **Diagnosis of hypomania**

**Doctors often fail to ask key questions that assist in the diagnosis of bipolar II disorder :**

**“ Has there been a period of time when you were feeling so good or hyper that other people thought you were not your normal self, or were so hyper you got into trouble?”**

**“ What about a period of time when you were so irritable that you would shout at people or start fights or arguments?”**

# Treatment of Bipolar Disorders

- 1. Bipolar disorder is a chronic illness:**
  - a) Expect exacerbations and remissions**
  - b) Long term chemotherapy is the rule not the exception**
- 2. It is risky, at best, to treat bipolar patients in a vacuum i.e. without the involvement of family/significant others**

# **Treatment of bipolar illness**

**1. PSYCHOLOGICAL INTERVENTIONS**

**2. BIOLOGICAL INTERVENTIONS**

# Treatment of bipolar illness

## PSYCHOLOGICAL TREATMENTS

### 1. Psycho education :

- a. Mood Disorders Assoc of British Columbia
- b. internet/ readings, etc

### 2. Psychotherapy :

- a. Cognitive Behavioral Therapy (CBT) for the depressive phase of illness
- b. Cognitive Behavioral Therapy (CBT) to prevent manic relapses

# **Cognitive Behavioral Therapy**

- 1. The evidence based psychotherapies (CBT – cognitive behavioral therapy; IPT-interpersonal psychotherapy; PST- problem-solving therapy) are AS EFFECTIVE as antidepressants in mild/moderate MDD.**
- 2. Cognitive therapy (CBT) is accessible in British Columbia.**

# **Cognitive Behavioral Therapy**

## **1. Core features:**

- a. identify automatic maladaptive thoughts and distorted beliefs that lead to depressive moods**
- b. learn strategies to modify these beliefs and practice adaptive thinking patterns**
- c. use a systematic approach to reinforce positive coping behaviors**

# **Cognitive Behavioral Therapy (cont)**

**2. 65% response rate to 8-12 weekly CBT sessions**

**3. consider referral to Change ways, a group-based best practice psycho educational/CBT program offered in many hospitals/community health centers in British Columbia**

**[www.changeways.com](http://www.changeways.com)**

# **BIPOLAR DISORDERS**

## **BIOLOGICAL INTERVENTIONS:**

**1. LITHIUM**

**2. VALPROIC ACID**

**3. CARBAMAZEPINE**

**4. LAMOTROGINE**

**5. ATYPICAL ANTIPSYCHOTICS**

**6. OTHER ANTICONVULSANTS**

Lithium – wherefore art  
thou?

# LITHIUM

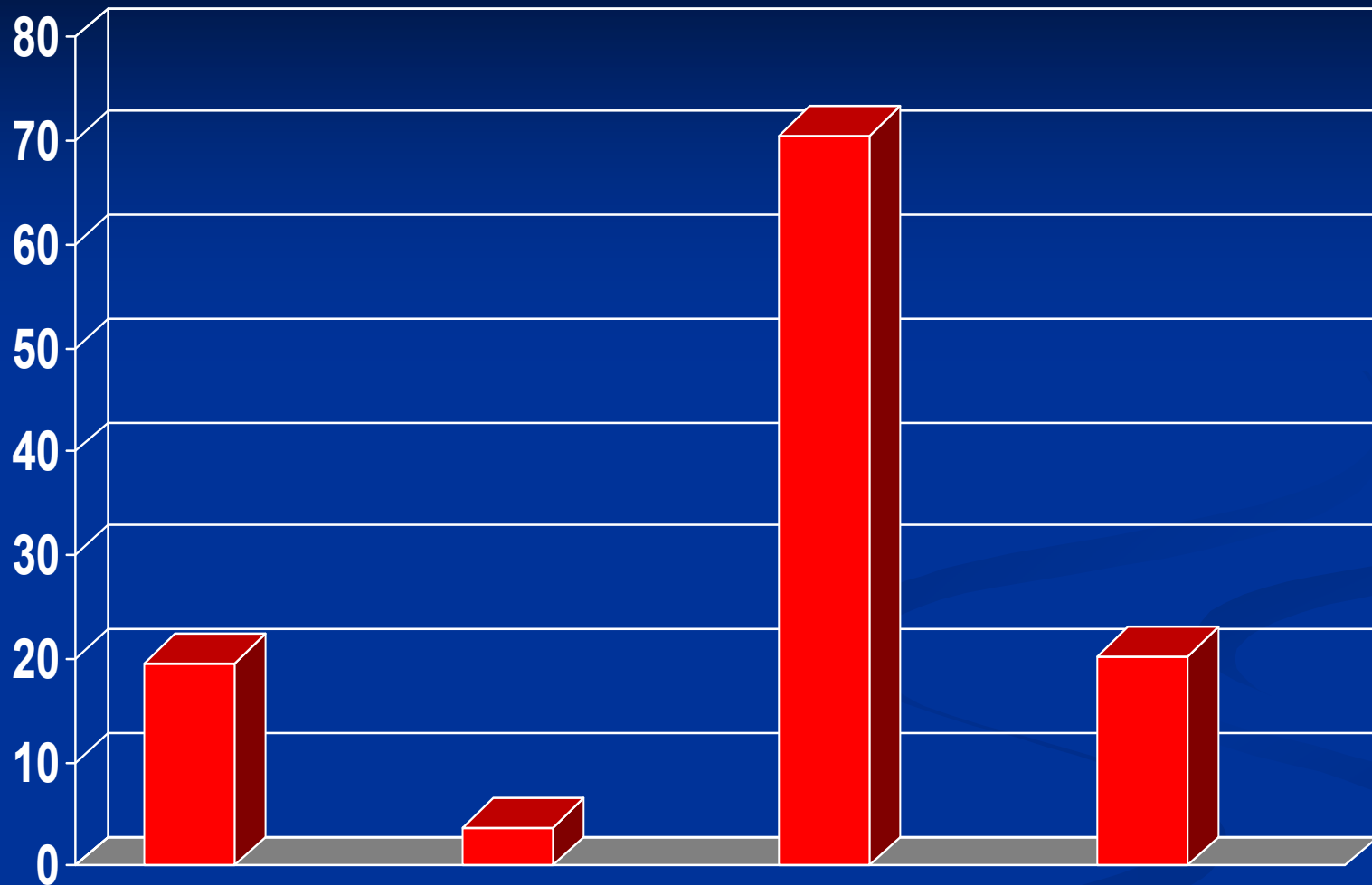
## 1. Expect “two thirds” response to lithium:

**33% - complete response**

**33% - significant mood  
attenuation**

**33% - no response/intolerance**

## 2. “anti-suicide” effect of lithium



**Suicide attempts before, during, one year, and two years post lithium treatment**

# Valproic Acid

- 1. Valproic acid (divalproex; Depokoate; Epival) is an effective antimanic agent**
- 2. The evidence for the prophylactic efficacy of valproic is still not clear (one short RCT, pharmaceutical company sponsored)**
- 3. Valproic is far superior as an anti manic rather than an antidepressant preventative agent**
- 4. Serum levels appropriate (versus no defined therapeutic range with carbamazepine)**

# **Carbamazepine**

- 1. Carbamazepine (Tegretol) is an effective antimanic agent (19 studies)**
- 2. Carbamazepine is an effective prophylactic agent (10 RCTs), but likely less effective than lithium (Davis et al, 1999)**
- 3. Carbamazepine appears to be a forgotten (yet very effective) treatment in bipolar illness**
- 4. Oxcarbazepine (Trileptil) is being touted as a 'similar' but 'superior' medication to carbamazepine, but recent studies shed some doubt**

# Lamotrogine (Lamictal)

- 1. There is increasing evidence that lamotrogine is an effective agent in treating both bipolar I and II depression.**
- 2. There is very limited (but some) evidence that lamotrogine is an effective anti-manic or prophylactic agent.**
- 3. Lamotrogine has a relatively benign (e.g. non sedative, weight neutral) side effect profile. Dose range not determined but likely 100-300mg/day**

## **Other anticonvulsants in bipolar disorder**

**There is NO evidence that gabapentin (Neurontin) or topiramate (Topramax) has any benefit at all in the treatment of bipolar depression, bipolar mania, and/or the preventative/prophylactic treatment of bipolar illness**

# **Typical/Atypical Antipsychotics**

- 1. All are effective in mania. Limited evidence for effectiveness in prophylaxis or in depressive episodes.**
- 2. All atypical antipsychotic research is pharmaceutical industry sponsored .**
- 3. Significant concerns about weight gain, dyslipidemia, & diabetes with atypicals; especially olanzapine(Zyprexa) and clozapine(Clozaril) but also risperidone(Risperdol) and quetiapine (Seroquel)**

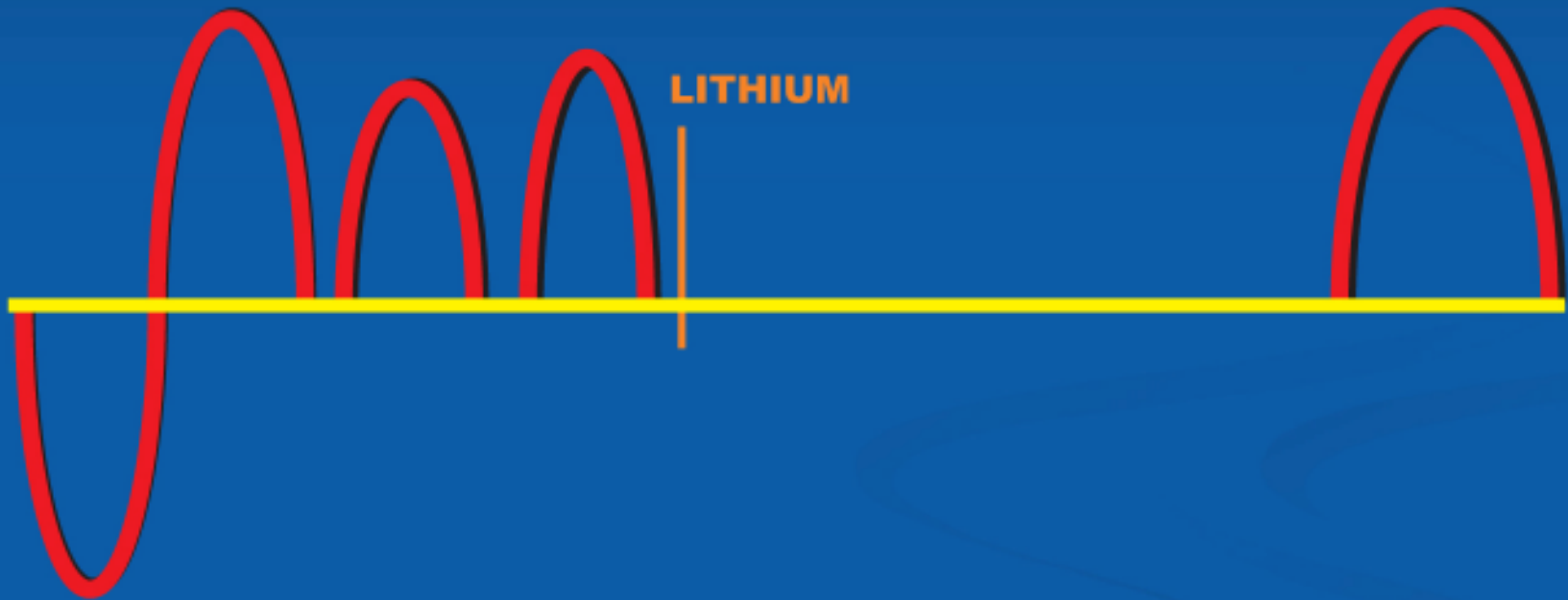
**Do not rashly use every new product of which the peripatetic siren sings. Consider what surprising reactions may occur in the laboratory from the careless mixing of unknown substances. Be as considerate of your patient and yourself as you are of the test tube.**

**- Sir William Osler**

# **Managing depressive and manic relapses**

**“don’t throw out the baby with the bathwater”**

**Don't throw out the baby  
with the bathwater.**



# Managing Depressive Relapse

- 1. Don't throw out the baby with the bathwater!**
- 2. The risk of an antidepressant induced manic switch in both bipolar I/II is < 10%**
- 3. Treatment options:**
  - a. second mood stabilizer (I), especially lamotrogine**
  - b. antidepressant (II,I)/lamotrogine**
  - c. CBT(I,II)**
  - d. ECT(I,II)**

# Managing Manic/Hypomanic Relapse

**1. Don't throw out the baby with the bath water.**

**2. Other treatment options :**

**a. hospital care (I)**

**b. no treatment intervention (II)**

**c. second mood stabilizer (I/II)**

**d. atypical / typical antipsychotic (I/II)**

**e. benzodiazepine (II)**

**f. ECT (I)**

# **Prevention of future manic relapses – Ulysses Agreement**

- 1. Set it up BEFORE manic relapse with doctors, family, employers, etc.**
- 2. Put it in writing...outline the type of treatment e.g. hospitalization, antipsychotic medication, etc.**

# **“Grey zones” in bipolar illness...or topics for future presentations**

- 1. “Stressful life problems” versus mild depressive relapse**
- 2. The role of psychological “adversity” in bipolar illness**
- 3.. To treat or not treat hypomania**
- 4. Social/family/vocational stigma**
- 5. “ Doctor should we have children?”**
- 6. Bipolar illness and creativity**

# Resources

- The Mood Disorders Association of BC offers:
- Over 65 General and Special Interest Support groups throughout BC
- Support and information via our website at: [www.mdabc.net](http://www.mdabc.net)
- A weekly walk-in psychiatric clinic
- For more information about the Mood Disorders Association of BC call our office at 604.873.0103