

Bipolar Disorders

DSM-IV-TR Diagnostic Code:	296.xx Bipolar I disorder
	.0x single manic episode
	.40 most recent episode hypomanic
	.4x most recent episode manic
	.6x most recent episode mixed
	.5x most recent episode depressed
	.7 most recent episode unspecified
	296.89 Bipolar II disorder
	Specify hypomanic/depressed
	301.13, Cyclothymic disorder
	296.80, Bipolar disorder NOS

Diagnostic Guidelines:

1. Establish diagnostic accuracy as defined in DSM-IV-TR.
2. Bipolar I Disorder: At least one manic episode with or without history of major depressive episode.
3. Bipolar II Disorder: One or more Major Depressive Episodes accompanied by at least one Hypomanic Episode, *no* history of Manic or Mixed Episodes.
4. Cyclothymic Disorder: Numerous periods of hypomanic and depressive symptoms, *no* history of manic or major depressive episodes.
5. Evaluate for comorbid substance abuse, including withdrawal syndromes.
6. Manic or mixed episodes can not be due to a medical condition, medication, toxins, or treatment for depression.
7. Interviews with family and friends of the individual may be extremely valuable, as many individuals with bipolar disorders have limited insight into their illness, especially during manic episodes.
8. The Mood Disorder Questionnaire may be a useful screening tool for bipolar disorders.

Treatment Guidelines:

1. Medication is a key component of treatment. Stabilization of symptoms and achievement of therapeutic medication blood levels is necessary for successful treatment. Stabilization with medication in significantly symptomatic individuals is often needed before psychotherapy can be effective.
2. Obtain medical clearance prior to initiating medication, per the discretion of the treating physician. Obtain CBC, electrolytes, BUN/Creatinine, urinalysis, liver function tests, TSH, and EKG.
3. Initial medication therapy is generally monotherapy with one of the first line mood stabilizers (lithium, divalproex, carbamazepine, or olanzapine). Lithium appears to be more efficacious with classic Bipolar I Disorder than with Bipolar II or rapid cycling. It

is the only medication clearly associated with a decreased risk of suicide in bipolar disorder over long periods of treatment. Blood levels (excluding olanzapine) are to be drawn at least every 6 months once the dose is relatively stable. Initial drug levels will be drawn more frequently.

4. With lithium therapy, CBC, electrolytes, BUN/Creatinine, urinalysis and TSH need also to be drawn on a regular basis. The individual will also be educated on the signs and symptoms of lithium toxicity and interaction of lithium with other drugs, including over the counter medications and caffeine. Education should include the risks of drastically decreasing dietary sodium intake once on an established dose of lithium.
5. Divalproex and carbamazepine therapy require additional monitoring of CBC, and liver function tests at least every 6 months. The individual will be educated on the signs and symptoms of hepatic, pancreatic and hematologic dysfunction, and in the case of carbamazepine, the risk of low sodium levels and severe rashes. Education will also include drug interactions common to both medications.
6. Olanzapine therapy requires additional blood monitoring for risks of increased vulnerability to type II diabetes and hyperlipidemia. Frequently, prominent weight gain (>40 lbs) is a side effect that also needs to be addressed.
7. While monotherapy is preferred, many bipolar disorders require combination drug therapies. Anti-depressants may precipitate a manic episode or shorten cycles and thus need to be used judiciously. A combination of two mood stabilizers may offer greater stability.
8. Off label use of lamotrogine (Lamictal), topiramate (Topamax), clozapine, quetiapine, ziprasidone, oxcarbenzypine (Trileptal), and risperidone (Risperdal) have shown variable efficacy as mood stabilizers. Lamotrogine needs to be initiated at very low doses (i.e. 25 mg qd for 2 weeks then 50 mg qd for 2 weeks...) to avoid a severe rash; clozapine needs close monitoring for potentially life threatening hemolytic changes.
9. Omega 3 fatty acids (fish oil or flaxseed oil supplements) have shown efficacy as a mood stabilizer in several small controlled studies, is very well tolerated and may be considered as an adjunctive therapy with numerous other health benefits. Recommended doses vary from 2,000-3,000 mg three times a day.
10. Sleep-wake cycles are known to influence mood cycling. To help the individual maintain consistent sleep-wake cycles, the clinician may consider the adjunctive use of hypnotic sleep aides (i.e. Ambien) or melatonin supplements (bipolar patients often have depressed melatonin levels). Lifestyle considerations in avoiding the disruption of sleep-wake cycles need to be encouraged (i.e. Consider the effects of postpartum recovery, jet lag, variable work shifts, etc.).

11. Therapy is primarily supportive and psychoeducational, including raising individual and family awareness of mood cycle patterns, development of coping skills, and understanding the importance of medication compliance. Individual therapy is most effective during the depressive phase of the illness. Assessment of suicidality is essential; suicidal ideation and intent should be evaluated. Psychosocial rehabilitation and pre-vocational skills training should be considered.
12. For many bipolar individuals there are physiological and/or environmental “triggers” for mood episodes (e.g., stressful events, changes in routine). Treatment should assist individuals and their families in identifying these triggers. Mood and behavior charting can be helpful.
13. Bipolar individuals may benefit from regular patterns of daily activities, including sleeping, eating, physical activity, and social and/or emotional stimulation. The clinician’s challenge is in assisting the individual in developing a lifestyle that is routine enough to encourage stability and improve functioning. The WRAP plan may be a valuable tool for this activity.
14. ECT may be indicated in severe, treatment-resistant, life-threatening mood states, or if medications are contraindicated.

Bipolar Bibliography

American Psychiatry Association. Practice Guideline for the Treatment of Patients with Bipolar Disorder. APA Press, 1996.

Frederick E. Goodwin and Kay Redfield Jamison. Manic-Depressive Illness. Oxford University Press, 1990.

Hahn, Rhonda et al. (2008). *Psychiatry.* Blue Jay, CA: Current Clinical Strategies Publishing.

*National Depressive and Manic-Depressive Association. Depressive Illness: The Medical Facts, the Human Challenge. Revised edition.*1996.

Leibenluft, Ellen and Suppes, Trisha. Treating Bipolar Illness: Focus on Treatment Algorithms and Management of the Sleep-Wake Cycle. Am J Psychiatry 156:1976-1981, December 1999.

Hirshfeld, Robert et al. Development and Validation of a Screening Instrument for Bipolar Spectrum Disorder: The Mood Disorder Questionnaire. Am J Psychiatry 157:1873-1875, November 2000.

Stoll, Andrew et al. Omega 3 Fatty Acids in Bipolar Disorder. Arch Gen Psychiatry. May 1999;56: 407-412.

Malkoff-Schwartz, Susan et al. Stressful Life Events and Social Rhythm Disruption in the Onset of Manic and Depressive Bipolar Episodes. Arch Gen Psychiatry. 1998;55: 702-707.

Swendsen, J et al. Correlates of Stress Reactivity in Patients with Bipolar Disorder. Am J Psychiatry 1995;152: 795-797.

Calabrese, Joseph et al. Spectrum of Activity of Lamotrigine in Treatment-Refractory Bipolar Disorder. Am J Psychiatry;156: 1019-1023, July 1999.

Calabrese, Joseph et al. Topiramate in Severe Refractory Mania. Scientific Abstracts of the 37th Annual Meeting of the American College of Neuropsychopharmacology. Nashville, TN ACNP, 1998, p. 303.

Marcotte, D. Use of Topiramate, a New Anti-epileptic as a Mood Stabilizer. J Affect Disord 1998; 50:245-251.

Bauer, MS et al. Manual-based Group Therapy for Bipolar Disorder; A Feasibility Study. J Clin Psychiatry 1998; 59:449-455.

Nurnberger, John et al. Melatonin Suppression by Light in Euthymic Bipolar and Unipolar Patients. Arch Gen Psychiatry vol 57; 572, June 2000