Medicine for Managers

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Bipolar Disorder

Bipolar Disorder, formerly known as manic-depressive illness or manic depression, is a mental health condition characterised by extreme changes in mood, and behaviour. The fluctuations in mood, which can last hours, days, months or longer, interrupt normal daily activities and may be described as varying from manic/hypomanic to depressive, and may be interspersed with periods of normal mood, called euthymia.

The frequency and severity of symptoms will vary between individuals but some more affected individuals will have ***manic episodes*** (high mood) and ***depressive episodes*** (low mood), sometimes called ***Bipolar 1***.

If the episodes of are less severe, the condition is called ***hypomania*** or ***Bipolar 2***. In some people, mood swings do occur but are relatively mild and such individuals are described as exhibiting ***cyclothymia***.

It is thought that about ***1.5% of the population*** may exhibit features which could be described as bipolar at some time in their lives. It is equally distributed between men and women and predominantly affects younger people.

The exact cause is not known but it does show ***family*** characteristics and it is more common in people who have a parent, brother or sister with bipolar disorder. It also appears to be more likely in people who suffered ***childhood trauma***, relational breakdown or ***abuse***, or who use ***recreational drugs*** such as cocaine or cannabis. Research has shown a potential link between ***toxoplasmosis*** and bipolar disorder. People infected with ***Toxoplasma gondii*** have a higher incidence of bipolar.

It has been suggested that the parasite may lead to development or exacerbation of bipolar symptoms by affecting the neurotransmitter ***dopamine,*** disrupting nerve transmission and leading to brain inflammation.

Other illnesses may also be a precipitant.

Symptoms of bipolar disorder (mania and hypomania) include an elevated or irritable mood, with extreme changes in emotions, and activity.

They have an energised level of physical and mental activity, talking rapidly, displaying overconfidence, acting extravagantly and possibly suffering from delusions and paranoia. Feelings are of extreme happiness and joy. People speak very quickly and show ‘flight of

ideas' where they flit from topic to topic without ever completing a conversation about any individual issue.

They feel full of energy; they sleep little and may not eat very much. A particular feature of mania is the feelings of having wonderful ideas which may have serious consequences in the decisions that they may make.

The thinking may be completely illogical and sometimes they experience hallucinations. On occasion they may spend large sums of money recklessly and in general may become much more uninhibited.

Symptoms of depressive episodes include withdrawal and sadness. They may feel persistently tired.

Sleep patterns may be disrupted with difficulty in getting to sleep or with early morning wakening. Loss of appetite and weight loss is common.

There is a general loss of interest in everything resulting in lack of enthusiasm for the normal routine of daily living and loss of libido may occur.

The diagnosis of bipolar disorder

> *The defining sign of Bipolar 1 is the individual experiencing at least one manic episode lasting at least a week. The patient may have repeated episodes with periods of euthymia in between. Depressive episodes are a feature of bipolar but do not form part of the definition.*

Diagnosis is made by undertaking:

- A thorough medical history of symptoms and their pattern, previous experiences and family history
- Physical examination
- Medical tests such as blood tests for other disorders which may be causing the symptoms, such as hyperthyroidism

The diagnosis for many patients, is quite clear cut. If the provisional diagnosis is made by the GP, he or she will normally make a referral to secondary care for the opinion of a consultant psychiatrist.

Sometimes a diagnosis is complicated by the individual suffering one or more concurrent medical problems such as:

- Anxiety
- Attention Deficit/Hyperactivity Disorder
- Post-Traumatic Stress Disorder
- Substance abuse disorders

It is also the case that patients with bipolar who are experiencing a severe manic episode and in whom the history is unclear, may be diagnosed with schizophrenia or Borderline Personality Disorder.

The Treatment of Bipolar Disorder.

Bipolar disorder cannot be cured but, these days, there are a range of available treatments to assist in its management. Because of its lifelong nature, the treatment is lifelong and, sometimes, it may take a specialist some time to find the best and most effective treatment.

Typically, the episodes of mania and depression recur over varying periods of time and, between these periods, the mood will be stable, although some people will experience lingering symptoms.

It is important for treatment to be continued, even when feeling well, unless advised to do so by a doctor.

In general, management uses one of two approaches:

- Various talking and support therapies
- Medication

Psychotherapy uses a variety of techniques to provide support, education and guidance for the individual and other family members.

- ***Psychoeducation*** is the technique used by mental health professionals to help affected adults and children individually or in family sessions how to understand the condition, how it affects day-to-day activity and how all those affected can cope with the symptoms.

- ***Cognitive Behavioural Therapy*** is a structured therapy where a therapist reviews the nature of the emotions and how they influence actions. The objective is to eliminate negative thoughts and behaviour and to adopt better thinking patterns and habits.

Medication is used to stabilise mood and manage the intervening episodes.

Lithium (*Priadel*) A mainstay of treatment which has been commonly used as a mood stabiliser for over sixty years. It is used to treat manic and depressive episodes and is prescribed on a daily basis for a minimum of 12-24 months after a single episode or five years if there have been frequent relapses or psychotic episodes.

It is particularly important with lithium to ensure that the dose is correct because the incorrect dose may cause side effects, most frequently diarrhoea and vomiting, but also muscle weakness and twitching and confusion.

In order to achieve the correct dosage it is necessary to titrate the lithium against blood levels of the drug by regular blood testing. The objective is to keep the drug within the therapeutic level (that is that the concentration in the blood is neither too high nor too low).

Blood tests are normally done initially every 4-8 weeks but less frequently once the dose is stabilised.

The drug is normally started by a psychiatrist and, once the drug blood levels are stable, its prescription and monitoring is taken over by the GP who will undertake a routine check every year of blood pressure and weight, question about the use of alcohol and cigarettes and also monitor kidney and thyroid function whilst the patient is being prescribed the drug.

Lithium blood levels will continue to be checked every 3-6 months.

Other drugs may be used for the treatment of manic episodes. Anticonvulsant drugs may be helpful and sodium valproate (*Epilim*), carbamazepine and lamotrigine may be given,

usually instigated by the psychiatrist, either instead of or combined with lithium.

Antipsychotic medication may also be given to manage manic or depressive swings and olanzapine and quetiapine may be the drugs of choice. They can be employed to provide long-term mood stabilisation but their use may be limited by their side effects.

Symptom control can often be difficult to achieve in some people because they exhibit 'rapid cycling' which means that they change quickly between highs and lows. Such individuals experiencing a period of depression may be tipped into a manic phase by the deployment of an anti-depressant.

Those who suffer repeated manic and depressive episodes may need to be maintained on a mood stabiliser and an anti-depressant long-term.

Patients with bipolar disorder may be able to recognise the warning signs of an approaching episode of mania or depression.

Developing the ability may allow them to get help before more severe symptoms develop and therefore avoid full-blown episodes and hospital admissions. It is also helpful to avoid the triggers that can precipitate an episode, such as stress (although this is often easier said than done).

People who know they may exhibit the symptoms should try to adjust their work-life balance to avoid becoming too busy and setting off an episode of mania.

Controlling the symptoms may be helped by exercise and by psychotherapy. It is often good advice to suggest that they should regularly do things that they enjoy, though again this may not be so easily achieved.

Severe mood swings may constitute a medical emergency when sufferers may become hostile or aggressive, very depressed or suicidal.

Sometimes they may simply stop looking after themselves, resulting in serious neglect. Such circumstances require immediate medical assistance.

Modern treatment has helped to control the symptoms and most sufferers can live a normal life.

However, it has been suggested that some of the greatest work of those diagnosed as bipolar has been done at times when they were experiencing manic episodes; if true perhaps the world would not have had Beethoven's ninth or Milligan's great humour.

How much would we all have lost without the talents of Stephen Fry, Elgar, Hemingway, Isaac Newton, Dusty Springfield or Florence Nightingale?

John Keats, who tragically died aged 25 of tuberculosis, perhaps may not have given us;

"A thing of beauty is a joy forever; its loveliness increases; it will never pass into nothingness"

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