WaMH in PC Wales Mental Health in Primary Care
Information Sheet 10

A Briefing Note for GPs and Primary Care Practitioners

Bipolar Disorder in Primary Care

The aims of this Information Sheet are to:

- Improve primary care practitioners' awareness and knowledge of bipolar disorder.
- Provide a pragmatic approach to assessing bipolar disorder in primary care.
- Recommend when patients with a suspected diagnosis should be referred to secondary care.
- Provide sources of information and support for patients and their families affected by bipolar disorder.
- Provide primary care practitioners with sources of further information on diagnosis and management.

How does bipolar disorder present clinically?

Bipolar disorder - previously known as manic depression—is a recurrent disorder of mood characterised by episodes of depression and episodes of mania or hypomania (hypomania is a milder form of mania) **(Figure 1)**. Individuals with the most severe form of bipolar disorder (Bipolar Disorder type I, BD-I) experience both depression and mania whereas individuals with Bipolar Disorder type II (BD-II) experience depression and *hypo*mania. It is estimated that BD-I affects 1% of the population and BD-II at least a further 2-3% [1]. Although many individuals with bipolar disorder manage their illness successfully, the majority will have long– term difficulties with depressive symptoms and intermittent manic and/or hypomanic relapse. Rates of comorbid problems with anxiety disorders and alcohol use disorders are also high and approximately 1 in 15 individuals with bipolar will die by suicide.

Figure 1. Diagnostic criteria for mania/ hypomania

For mania, one week of persistently elevated *or* irritable mood (4 days for hypomania), plus three or more symptoms of: grandiosity, decreased need for sleep, pressured speech, flight of ideas/racing thoughts, distractibility, activation or agitation and the pursuit of 'heedless pleasure'/risk-taking behaviour (e.g. excessive spending and risky sexual behaviour). For mania, these symptoms need to be severe enough to significantly impair functioning or require hospitalisation whereas for hypomania they need not necessarily cause significant impairment.

Why is the recognition of bipolar disorder in primary care important?

Most people with bipolar disorder tend to experience depression much more frequently than hypomania or mania. This means that they often only present to services with depressive (rather than manic) symptoms and it is common for bipolar depression to be missed and misdiagnosed as unipolar depression [2]. We know that many patients with bipolar disorder report long periods of delayed diagnosis, on average approximately 10 years [3]. This is an important issue because the treatment approach for bipolar depression differs from that for unipolar depression. In particular, there is evidence that antidepressants have limited benefit in the treatment of bipolar depression and, for a proportion of patients, they may make the course of their mood disorder worse rather than better [4].

A pragmatic approach to assessing for possible bipolar disorder

A diagnosis of bipolar disorder requires the identification of a past episode of mania or hypomania (Figure 1). Although the manic episodes in BD-I are often easily recognised, individuals with BD-II disorder can have limited insight into their past experiences of hypomania. Diagnostic assessment is therefore greatly enhanced by obtaining a corroborative history from someone (such as a family member) who knows the patient well. There are several other clinical features which are suggestive of bipolar rather than unipolar depression and which can be helpful to explore in the clinical history **(Figure 2).**

Figure 2. Clinical differences between bipolar and unipolar depression

	Bipolar depression	Unipolar depression
Substance abuse	+++	+
Family history of bipolar disorder or psychosis	++++	+
Seasonality	+++	+
Onset of depression before age 25	+++	+
Postpartum onset of depression	+++	+
Psychotic depression < age 35	++++	—
Atypical features of depression (excessive sleeping, excessive eating)	++	+
Rapid on / off pattern of symptoms	++	—
Frequent recurrence of depressive episodes	++	+
Antidepressant associated mania or hypomania	++++	—
Brief episodes of depression (> 3 months)	++	—
Antidepressant wear-off	++	—
Mixed depression (manic features during episode)	++	—

Suspected bipolar disorder in primary care – what next?

All individuals with a possible diagnosis of bipolar disorder need to be referred to a Community Mental Health Team (CMHT) for assessment and diagnosis in order to arrange a comprehensive package of care. The package of care offered by the CMHT will vary depending on the needs of the patient but will often include specialist prescribing, psychoeducational, social work and occupational therapy input. Many individuals with bipolar disorder are managed in a collaborative arrangement between primary and secondary care.

Management of bipolar disorder in primary care

General Practitioners have a key role in monitoring and coordinating the care of patients with bi polar disorder. This will often include monitoring lithium therapy (particularly with respect to the possibility of lithium toxicity, weight gain, renal impairment and hypothyroidism). Many other medications used in bipolar disorder, such as atypical antipsychotics, are associated with significant weight gain and a risk of developing the metabolic syndrome—patients will therefore require long term support with diet, smoking, alcohol use and exercise.

Some patients with less severe forms of bipolar disorder, for example BD-II, may not need to be managed within the CMHT and can be looked after in primary care. In such cases general practitioners obviously have a critical role in monitoring for evidence of depressive or manic relapse, as well as a role in promoting self-management strategies such as mood monitoring, the use of relapse signatures, encouraging regularity of routines, sleep hygiene and promoting anxiety management techniques.

A number of useful resources for managing bipolar disorder in primary care are listed overleaf. With regard to medication, the British Association of Psychopharmacology have recently published comprehensive evidence-based guidelines for managing bipolar disorder (http://www.bap.org.uk/pdfs/Bipolar_guidelines.pdf)

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Further Sources of Information and Support

- **Bipolar UK**
  http//www.mdf.org.uk

Bipolar UK is the United Kingdom's largest user-led voluntary organisation for bipolar disorder. They have a comprehensive programme of support for individuals and families, including advice on medication, psychological treatments and occupational issues. Bipolar UK also run self-management training courses locally across the UK.

In Wales, the website address is
http//www.mdfwales.org.uk

Address :

Floor 4, Clarence House, Clarence Place,
Newport NP19 7AA

Tele: 01633 244244

- **Bipolar Education Programme Cymru (BEP-C)**
  http//www.bep-c.org

The BEP-C programme at Cardiff University run both web-based and group psychoeducational treatment for individuals with bipolar disorder. They have also developed a number of web-based packages of information for service users and professionals:

For families and carers:
http://www.beatingbipolar.org/families_and_carers/

For women with bipolar disorder:
http://www.beatingbipolar.org/women_and_bipolar/

For primary care practitioners:
http://www.beatingbipolar.org/primary_care_practitioners/

- **British Association for Psychopharmacology**
http//www.bap.org.uk/pdfs/Bipolar_guidlines.pdf

Evidence based guidelines for treating bipolar disorder

- **C.A.L.L. Helpline**
  Community Advice & Listening Line
http//www.callhelpline.org.uk

Offers emotional support and information / literature on Mental Health and related matters to the people of Wales.

Anyone concerned about their own mental health or that of a relative or friend can access the service. C.A.L.L. Helpline offers a confidential listening and support service.

Tele: 0800 132 737
Text: 'help' to 81066

- **Hafal**
http://www.hafal.org/hafal/index.php

Hafal is Wales' leading charity for people with serious mental illness and their carers. Covering all areas of Wales, Hafal is an organisation managed by the people they support; individuals whose lives have been affected by serious mental illness.

Tele: 01792 816600

- **Royal College of Psychiatrists**
  'Help is at Hand' leaflet on bipolar disorder:

http://www.rcpsych.ac.uk/mentalhealthinfo/problems/bipolardisorder/bipolardisorder.aspx

References

1. Goodwin, F.K., & Jamison, K.R., *Manic-Depressive Illness: Bipolar Disorders and Recurrent Depression.* 2nd ed2007, New York: Oxford University Press.
2. Smith, D.J., et al., *Unrecognised bipolar disorder in primary care patients with depression.* The British Journal of Psychiatry, 2011. **199**(1): p. 49-56.
3. Lish, J.D., et al., *The National Depressive and Manic-depressive Association (DMDA) survey of bipolar members.* Journal of Affective Disorders, 1994. **31**(4): p. 281-294.
4. Sachs, G.S., Nierenberg, A.A., Calabrese, J.R., Marangell, L.B., Wisniewski, S.R., Gyulai, L., Friedman, E.S., Bowden, C.L., Fossey, M.D., Ostacher, M.J., Ketter, T.A., Patel, J., Hauser, P., Rapport, D., Martinez, J.M., Allen, M.H., Miklowitz, D.J., Otto, M.W., Dennehy, E.B., Thase, M.E., *Effectiveness of Adjunctive Antidepressant Treatment for Bipolar Depression.* N Engl J Med, 2007. **356**(17): p. 1711-1722.