Roles of primary care physicians in managing bipolar disorders in adults

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Abstract

Management of bipolar disorder (BD) is challenging due to its multiple and complex facets of presentations as well as various levels of interventions. There is also limitation of treatment accessibility especially at the primary care level. Local evidence-based clinical practice guidelines address the importance of integrated care of BD at various levels. Primary care physicians hold pertinent role in maintaining remission and preventing relapse by providing systematic monitoring of people with BD. Pharmacological treatment in particular mood stabilisers remain the most effective management with psychosocial interventions as adjunct. This paper highlights the role of primary care physicians in the management of BD.

Introduction

Management of BD is inherently challenging as the understanding of the disease is still limited even amongst the healthcare providers. The lifetime prevalence of BD I is 0.6% and BD II 0.4%, while mean age of onset is 18.2 years for BD I and 20.3 years for BD II (refer to Table 1). Women are slightly more affected than men. BD is highly heritable and the risk is inversely related to age, educational level and employment.

In Malaysia, BD has a potentially significant impact on current utilisation of mental health services due to delay in seeking treatment, recurrent relapses or admissions, concurrent substance misuse and the need for long-term psychosocial interventions. Majority of people with BD are treated in the hospitals by psychiatrists. Subsequently, those who are stable and in full remission are being treated at the primary care clinics; however the continuity of care such as treatment compliance, blood monitoring and regular supervision are lacking due to various limitations. The patients may first been seen in primary care setting and thus it is important for primary care physicians to recognise and refer accordingly.

Screening

BD is frequently mistaken with other psychiatric problems especially when patients often present with prominent depressive symptoms initially. A few tools have been identified to screen for BD [(e.g. Mood Disorder Questionnaire (MDQ), Bipolar Spectrum Diagnostic Scale (BSDS), Hypomania Checklist (HCL-32)], however their applicability in primary health care settings are limited. For example, the use of MDQ has been studied at the psychiatric outpatient clinics only. Thus, it's difficult to generate inference on its applicability in primary care. However, it may facilitate the doctors to suspect BD early and refer the patients for further psychiatric evaluation.

Diagnostic criteria for BD

BD is an illness characterised by patients experiencing recurrent mood episodes. The diagnosis necessitates the presence of mania or hypomania apart from depressive episodes. An episode is defined as a distinctive period of mood disturbance fulfilling the diagnostic criteria (Table 1). An interval of at least two months free of symptoms is required to distinguish between episodes.

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Table 1. Diagnostic Criteria for BD

Mania	Depression
Symptoms • Increased energy • Over-activity • Reduced sleep • Inflated self-esteem • Grandiose ideas • Loss of social inhibitions ± psychotic symptoms (delusions or hallucinations) Symptoms persist **at least 1 week.** In **hypomania**, symptoms are milder, without psychotic symptoms and of shorter duration.	Symptoms • Low mood • Loss of interest and enjoyment • Reduced energy and activity • Poor concentration • Sleep disturbance • Change in appetite • Feeling worthless or guilty • Psychomotor retardation or agitation • Thoughts of death, suicidal ideas or acts ± with or without psychotic symptoms (delusions or hallucinations) Symptoms persist **at least for 2 weeks.**
BD I*: • requires at least one manic episode • doesn't require depressive episode • manic symptoms of at least one week duration • symptoms severe enough to cause impairment of functions Hypomania may occur in BD I but not required to make a diagnosis.	
BD II*: • requires hypomanic symptoms and at least one major depressive episode • manic symptoms never documented • hypomanic symptoms of at least four days duration • hypomanic symptoms not severe enough to cause major impairment of functions Patients may have only one episode of hypomania with recurrent major depression	

* *It may not be critical to differentiate between BD I and II at primary care. Many patients with BD II are being misdiagnosed as major depressive disorder, hence inadequate treatment may cause chronicity. Treatment at primary care of all BD cases emphasises on maintaining remission after acute care.*

Referral criteria

Newly diagnosed or undiagnosed people with BD should be referred to psychiatric services. People with BD on maintenance treatment can be managed at primary care level. However, certain individuals need more specialised psychiatric care due to:

- acute exacerbation of symptoms
- decline in functioning
- increased risk of harm to self or others
- treatment non-adherence
- inadequate response to treatment
- ambivalence about or wanting to discontinue medication
- concomitant or suspected substance misuse
- complex presentations of mood episodes
- psychoeducational and psychotherapeutic needs

Admission criteria

The criteria for admission of people with BD are based on the Malaysian Mental Health Act 2001 (Act 615) and Regulations which are:-

- risk of harm to self or others
- treatment is not suitable to be started as outpatient such as patients who are physically violent and those who require close monitoring with multiple medications, serious side effects or frequent blood monitoring

Management

Management of BD can be divided into acute and maintenance phase. Patients in acute phase are usually managed in hospitals until their conditions are stabilised. It is very important to ensure the continuity of care for these patients in order to

prevent relapse and optimise functionality. Continuing care can be provided at the primary care clinics. There is no consensus on the duration of treatment, however long-term care is warranted as BD is a recurrent and life-long disorder. Details of medications in maintenance phase are shown in Table 2 and Table 3. The principles of management in BD should incorporate regular monitoring of the parameters as stated in Table 4.

Table 2. Pharmacological treatment of maintenance phase

First line	
Monotherapy	Lithium, lamotrigine (limited efficacy in preventing mania), valproate, olanzapine, quetiapine, risperidone long acting injection (LAI), aripiprazole,
Combination therapy	Adjunctive therapy with (lithium or valproate) + quetiapine/ risperidone LAI/ aripiprazole,/ ziprasidone
Second line	
Monotherapy	Carbamazepine, paliperidone
Combination therapy	• Lithium + valproate • Lithium + carbamazepine • Lithium or valproate + olanzapine • Lithium + risperidone • Lithium + lamotrigine • Olanzapine + fluoxetine
Third line	
Monotherapy	Asenapine
Combination therapy	Adjunctive therapy with lithium or valproate + asenapine

Table 3. Drugs dosages and adverse effects

NAME	DOSE RANGE	ADVERSE EFFECTS
MOOD STABILISERS		
Lithium	**Acute mania:** 600 - 1800 mg/day in divided doses **Maintenance dose:** 300 - 1200 mg/day in divided doses (Desired serum level : 0.6 – 1.2 mEq/L not exceeding 1.5 mEq/L). To be used with caution and correlate clinically	Gastrointestinal (GI) upset, polyuria and polydipsia, weight gain, hypothyroidism, hyperparathyroidism
Valproate	**Acute Mania:** 600 - 2500 mg/day in divided doses **Maintenance dose:** 400 - 2000 mg/day in divided doses (Desired serum level 50 - 100 µg/mL @ 347 - 693 µmol/L)	GI upset, sedation, weight gain, tremor, thrombocytopenia, raised liver enzymes
Lamotrigine	Maintenance dose: 100 - 400 mg/day in divided doses	Skin rash, insomnia, GI upset, blurred vision, diplopia, Steven Johnson's Syndrome
ANTIPSYCHOTICS		
Quetiapine	**Acute bipolar depression:** 50 - 300 mg/day in divided doses **Acute mania:** 300 - 800 mg/day in divided doses **Maintenance** 400 - 800 mg/day in divided doses	Orthostatic hypotension (for quetiapine), somnolence, weight gain, dizziness, dyslipidaemia, hyperglycaemia
Olanzapine	5 - 20 mg/day	
Paliperidone	6 - 12 mg/day	Extrapyramidal symptoms (EPS), tachycardia, somnolence, headache, weight gain, hyperprolactinaemia
Risperidone	2 - 6 mg/day in divided doses (oral) 25 - 75 mg/2 weekly (injections)	

Table 3. Drugs dosages and adverse effects (Contineud)

NAME	DOSE RANGE	ADVERSE EFFECTS
ANTIPSYCHOTICS		
Aripiprazole	5 - 30 mg/day	Agitation, akathisia, headache, insomnia, anxiety
Haloperido	3 - 30 mg/day	EPS, hypotension, akathisia, cardiac abnormalities
Asenapine	10 - 20 mg/day sublingually in divided doses	Bitter taste, oral hypoesthesia, akathisia, EPS, somnolence

Table 4. Parameters for regular monitoring

Parameter	For all patients at first visit	Antipsychotics	Lithium	Valproate	Carbamazepine
Body mass index (BMI) and waist circumference	Yes	At initiation and every 3 months for first year; more often if patient gains weight rapidly	At initiation and when needed if the patient gains weight rapidly	At initiation and at 6 months if patient gains weight rapidly	
Blood pressure	Yes	At every visit			
Fasting blood sugar	Yes	At initiation and at 3 months (1 month for olanzapine); more often if levels are elevated			
ECG	If indicated by history or clinical picture	At initiation if there are risk factors for or existing cardiovascular disease	At initiation if there are risk factors for or existing cardiovascular disease		
Full blood count	Yes		Only if clinically indicated	At initiation and 6 months	
Thyroid function	Yes		At initiation and every 6 months, more often if evidence of deterioration		
Renal function	Yes		At initiation and every 6 months; more often if there is evidence of deterioration or patients on other medications such as anticholinesterase inhibitors, diuretics or Non steroidal anti-inflammatory drugs		Urea and electrolytes every 6 months
Liver function	Yes	At initiation and when necessary		At initiation and 6 months	
Lipid profile	Yes	At initiation and at least yearly; more often if levels are elevated			

Table 4. Parameters for regular monitoring (Continued)

Parameter	For all patients at first visit	Antipsychotics	Lithium	Valproate	Carbamazepine
Drug serum level			1 week after initiation and 1 week after every dose change until level stable, then every 3 to 6 months	Every 6 months. Only if there is ineffectiveness, poor adherence or toxicity	
Serum calcium level			At initiation and yearly		

Psychosocial interventions

Psychological approaches in preventing relapse in patients with BD have been proven to enhance symptomatic outcomes and the quality of life. They are such as Cognitive Behavioural Therapy, Interpersonal Social Rhythm Therapy, Group Psychoeducation/Group-based Psychotherapy, Family-oriented Interventions and Early Warning Signal.

Summary

BD is a life-long illness. Hence, the collaborative effort between mental health professionals and primary care providers are fundamental in ensuring comprehensive care for people with the condition. Primary care physicians have important role in the management of BD especially in maintenance phase.

Acknowledgement

Details of the evidence supporting these recommendations can be found in Clinical Practice Guidelines on the Management of Bipolar Disorder in Adults (2014), available on the following website: Ministry of Health Malaysia: http:// www.moh.gov.my and Academy of Medicine: http://www.acadmed.org.my. Corresponding organisation: CPG Secretariat, Health Technology Assessment Section, Medical Development Division, Ministry of Health Malaysia and contactable at htamalaysia@moh.gov.my.