Bipolar disorder and acute mania

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Abstract

Acute mania is described as it presents in bipolar I affective disorder. The Young Mania rating scale is described as a way of assessing mania clinically.

Key Words: mania, bipolar disorder, young mania rating scale.

Bipolar disorder (historically known as manic-depressive disorder) is a serious mental illness involving a mood disorder in which people experience disruptive mood swings, that is characterized by episodes of a frenzied state known as mania (or hypomania) and, usually, symptoms of depression. It often has a long course and for many people the predominant experience is of low mood. Its occurrence is often defined by the presence of one or more episodes of abnormally elevated energy levels, cognition, and mood with or without one or more depressive episodes. In its more severe forms, bipolar disorder is associated with significant impairment of personal and social functioning.
At the lower levels of elevated mood, such as hypomania, individuals may appear energetic and excitable. At a higher level, individuals may behave erratically and impulsively, often making poor decisions due to unrealistic ideas about the future, and may have great difficulty with sleep. At the highest level, individuals can show psychotic behaviour, including violence.
The lifetime prevalence of all types of bipolar disorder is thought to be about 4% (3). The peak age of onset is in late adolescence or early adult life, with a further small increase in incidence in mid to late life. Prevalence is similar in men and women and, broadly, across different cultures and ethnic groups. Genetic factors contribute substantially to the likelihood of developing bipolar disorder. Environmental factors are also implicated.
Bipolar 1 is usually diagnosed if a person has at least two manic episodes. The episodes can last between two weeks and four to five months. Depression usually lasts longer than six months.

These are the usual diagnostic criteria for mania.
Must: (A). Mood predominantly elevated, expansive or irritable and definitely abnormal for the person concerned. Must be sustained for at least one week.
At least three of the following: (B).
Increased activity or restlessness.
Increased talkativeness ("pressure of speech").
Increased thoughts (flight of ideas/thoughts racing).
Increasingly awake (less need for sleep).
Increased self-esteem (grandiosity).
Increased sexual energy (libido).
Distractibility or constant changes in activity or plans.
Loss of normal social inhibitions with inappropriate behaviour.
Foolhardy/recklessness and risks subjects do not recognize, eg. spending spree, driving.

These factors lead to a severe interference with personal functioning in daily living.
Severity of manic symptoms can be measured by clinician-based Young Mania Rating Scale.
The Young Mania Rating Scale (abbreviated YMRS) is an eleven-item, multiple-choice diagnostic questionnaire which psychiatrists use to measure the severity of manic episodes in patients. It was first published in 1978. This is based on the patient's subjective report of his or her clinical condition over the previous 48 hours (1).

The purpose of each item is to rate the severity of that abnormality in the patient. When several keys are given for a particular grade of severity, the presence of only one is required to qualify for that rating.

The keys provided are guides. The keys can be ignored if that is necessary to indicate severity (2). Scoring between the points given (whole or half points) is possible and encouraged after experience with the scale is acquired. This is particularly useful when severity of a particular item in a patient does not follow the progression indicated by the keys (6).

1. Elevated Mood (0-4): Absent – Euphoric (continuous excitement).

2. Increased Motor Activity-Energy (0-4): Absent –Motor excitement (continuous hyperactivity).

3. Sexual Interest (0-4): Normal-Overt sexual acts.

4. Sleep (0-4): No decrease-Denies need for sleep.

5. Irritability (0-8): Absent-Hostile.

6. Speech-Rate and Amount (0-8): No increase-pressured.

7. Language-Thought Disorder (0-4): Absent-Incoherent.

8. Content (0-8): Normal-Delusions.

9. Disruptive-Aggressive Behavior (0-8): Absent-Assaultive.

10. Appearance (0-4): Appropriate-Completely unkempt.

11. Insight (0-4): Present-Denies any behaviour change.

The following drugs have UK marketing authorisation for use in bipolar disorder (5).

For treatment of mania: lithium, olanzapine, quetiapine, risperidone, and valproate
For prophylaxis: lithium and olanzapine
For prophylaxis of bipolar disorder unresponsive to lithium: carbamazepine.

If a severely disturbed patient with bipolar disorder cannot be effectively managed with oral medication and rapid tranquillisation is needed, intramuscular olanzapine (10 mg), lorazepam (2 mg) or haloperidol (2-10 mg) should be considered, wherever possible as a single agent. When making the choice of drug, the clinician should take into account the follwing.

That olanzapine and lorazepam are preferable to haloperidol because of the risk of movement disorders (particularly acute dystonia and akathisia) with haloperidol.
That olanzapine and benzodiazepines should not be given intramuscularly within one hour of each other.
That repeat intramuscular doses can be given up to 20 mg per day (olanzapine), 4 mg per day (lorazepam), or 18 mg per day (haloperidol) - the total daily dose including concurrent oral medication should not normally exceed the British National Formulary (BNF) limit.

GP Comment

What have I learned from this paper?

The diagnostic and severity criteria questionnaires were new to me and could be useful tools in primary care to screen patients who are concerned they may be suffering from bipolar disorder prior to a decision whether or not to refer them to the psychiatric clinic.

I was also interested in the overview of the drug treatment of acute mania. This will help in decisions about which emergency drugs to carry, especially for out of hours cover.

Dr Stephen Cakebread, GP, Bedfordshire.

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