Part 5. Treatment of Bipolar Disorder

Treatment of acute mania: an article for the General Practitioner

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Abstract

Guidance, mainly intended for GPs, is provided on the treatment of acute mania. Mania is a state of elevated mood and excitable behaviour. Elevated mood can be classified as hypomania or mania, depending on severity. The treatment depends upon whether the patient is already on antimanic drugs. If a patient is not taking any antimanic medication then the first-line treatment is with an antipsychotic or a mood stabiliser such as lithium or valproate. Benzodiazepines can also be used at initial presentation if required. If the patient is already on antimanic medication then either dose increments of existing medication or the addition of adjuvant medication should be considered. Depot antipsychotic medication is also an option if compliance with oral medication is an issue. This article will expand on all of these options and provide further discussion on the subject of acute mania management.

Key Words: mania, hypomania, bipolar affective disorder, antipsychotic, mood stabilisers; lithium and valproate.

Introduction

The aim of this paper is to provide a succinct and useful guide on the treatment of acute mania. We discuss the causes and presentation of mania/hypomania and the treatment of the acutely manic patient. This includes guidance on when to refer to specialist psychiatric services and when management within the community will suffice.

What is mania?

Mania is a state of elevated mood, characterised by irritability, excess anger and/or happiness. The patient has high levels of energy and may put themselves or others at risk. They may also exhibit delusional beliefs; most commonly grandiose in nature. Dependent on the severity of the symptoms, this can be described as either hypomania or mania. Hypomania is a disorder characterised by a persistent mild elevation of mood, increased energy and marked feelings of wellbeing. There is typically increased sociability, talkativeness and a decreased need for sleep but not to the extent that these characteristics lead to severe disruption of work or result in social rejection. There is no clear psychosis in hypomania. In mania the mood is elevated out of keeping with the patient's circumstances and may vary from carefree joviality to almost uncontrollable excitement. The patient may also act in a disinhibited manner. Signs include pressure of speech, flight of ideas and loose associations. Self-esteem is often inflated, with grandiose ideas and overconfidence. Psychotic symptoms can be present in mania; and they can be defined as either mood-congruent or mood-incongruent.

Causes of mania

There are few causes of mania. The patient may have an affective disorder; in this instance mania is most commonly associated with bipolar affective disorder (ICD-10 F31), where periods of mania alternate with periods of severe depression. For the diagnosis of bipolar affective disorder to be made there must be two or more episodes in which the patient's mood and activity levels are significantly

disturbed. Where a patient presents with first-episode mania and no previous depressive episodes the diagnosis of Mania (ICD-10 F30) can be made. This diagnosis exists as some patients have only one episode of mania, without recurrence.

Other causes include drug-induced mania, commonly due to stimulants, such as cocaine; or as a adverse effect of medications, including antidepressants and steroids. Thyroid dysfunction can also induce a state of mania.

Treatment

There are extensive options for the treatment of acute mania. It is of the utmost importance to understand these medications and which are used as the first line.

Treatment of acute mania and hypomania

The drug treatment depends on the severity of symptoms and whether the patient is currently taking antimanic drugs. Clinicians should be guided by current medication doses and previous response. Only lithium, olanzapine, quetiapine, risperidone and valproate semisodium (Depakote) are licensed for the treatment of acute mania in the UK.

(i). General advice

To help reduce the negative consequences of manic symptoms, healthcare professionals should consider advising patients to avoid excessive stimulation, to engage in calming activities, to delay important decisions and to establish a structured routine, incorporating regular sleep and reduced activity levels.

If a patient is taking an antidepressant at the onset of an acute manic episode, the antidepressant should be stopped. The discontinuation of the antidepressant can be gradual, depending on the patient's current clinical need and previous experience of discontinuation/withdrawal symptoms from that antidepressant.

(ii) Drug treatment for those not taking antimanic medication.

a) Options include starting an antipsychotic, valproate or lithium.

Consider:
• Prescribing an atypical antipsychotic if there are severe manic symptoms or marked behavioural disturbance. However, in the initial stage, if there is severe agitation, prescribing a first-generation antipsychotic (typical) such as haloperidol or chlorpromazine is advised.
• Prescribing a mood stabiliser such as valproate or lithium if the symptoms have responded to these drugs before.

b) In the initial management of acute behavioural disturbance or agitation, the short-term use of a benzodiazepine (such as lorazepam or diazepam) should be considered.

c) If treating acute mania with antipsychotics; olanzapine, quetiapine or risperidone should normally be used, and the following should be taken into account:

• Individual risk factors for adverse effects.
• The need to initiate treatment at the lower end of the therapeutic dose range.
• If an antipsychotic proves ineffective, augmenting it with valproate or lithium should be considered.

d) Carbamazepine should not be routinely used for treating acute mania. Gabapentin, lamotrigine and topiramate are not recommended.

e) Drug treatment for those already taking antimanic medication:

• If a patient is already being treated with any antipsychotic, the dose should be increased if necessary. If there is no improvement following this, the addition of lithium or valproate should be considered.
• If a patient already taking lithium has a manic episode, plasma lithium levels should be checked. If levels are suboptimal (<0.8 mmol/L) the dose should normally be increased to a maximum blood level of 1.0mmol/L, provided there are no unacceptable adverse effects. If the response is not adequate, augmenting lithium with an antipsychotic should be considered.
• If a patient is already taking valproate the dose should be increased until either the symptoms improve or adverse effects restrict further dose increments. If there are no signs of improvement, the addition of olanzapine, quetiapine or risperidone should be considered. Patients taking >45mg/kg should be monitored carefully.

NB – If quetiapine is used it should be at a high dose, as lower doses are recommended in the treatment of depression and can induce mania.

d) For patients already taking lithium or valproate, adding an antipsychotic should be considered at the same time as gradually increasing the dose of lithium or valproate.

e) If any of the oral atypical antipsychotics are not producing the desired effect, then an antipsychotic depot injection, such as zuclopenthixol or flupenthixol should be considered.

f) For patients who present with mania when already taking carbamazepine, the dose should not routinely be increased. Adding an antipsychotic should be considered, depending on the severity of mania and the current dose of carbamazepine. Interactions with other medications are common with carbamazepine, and doses should be adjusted as necessary.

g) The use of ECT is only considered to achieve rapid and short-term improvement of severe symptoms. It is only used rarely, in cases of prolonged or severe mania. This, however, would only be considered once the patient has been assessed by a specialist.

Special attention

Valproate should not be prescribed routinely for women of child-bearing potential. If no effective alternative is available, adequate contraception should be used and the risks of taking valproate during pregnancy should be explained.

If a pregnant woman develops acute mania an atypical or typical antipsychotic should be considered. The dose should be kept as low as possible and the woman monitored carefully.

(iii). Drug treatment of acute mania in children and adolescents
When prescribing medication for children or adolescents with an acute manic episode, the recommendations for adults, as discussed above, should be followed. The only difference is that drugs should be initiated at lower doses. At initial presentation:

• Height and weight should be checked (and monitored regularly).
• Prolactin levels should be measured.
• When considering an antipsychotic, the risk of increased prolactin levels with risperidone and weight gain with olanzapine should be considered.
• Where there is an inadequate response to an antipsychotic, adding lithium or valproate should be considered. Valproate should normally be avoided in girls and young woman because of risks to the foetus during pregnancy and risk of polycystic ovary syndrome.

Drug treatment after recovery from an acute episode.

1. Prescribers should consider starting long-term treatment for bipolar disorder:

- After a manic episode that was associated with significant risk.
- When a patient with bipolar I has had two or more acute episodes.
- When a patient with bipolar II has significant functional impairment, risk of suicide or rapid cycling.

2. Lithium, olanzapine or valproate should be considered for long-term treatment of bipolar disorder. The choice should depend on:

- Response to previous treatment.
- Relative risk.
- Known precipitants of manic versus depressive relapse.
- Physical risk factors (particularly renal disease, obesity and diabetes).
- The patient's preference.
- History of adherence.
- Gender.
- A brief assessment of cognitive state (MMSE).

If oral treatment fails, then consider antipsychotic depot medication.

3. If the patient has frequent relapses or symptoms continue to cause functional impairment, switching to an alternative monotherapy or adding a second prophylactic agent (lithium, olanzapine or valproate) should be considered. Possible combinations are:

- Lithium with valproate.
- Lithium with olanzapine.
- Valproate with olanzapine.

4. If a trial of a combination of prophylactic agents proves ineffective, the following should be considered:
- Consulting with, or referring the patient to a clinician with expertise in the drug treatment of bipolar disorder.
- Prescribing lamotrigine (especially is the patient has bipolar II disorder) or carbamazepine.

Long-term drug treatment should normally continue for at least 2 years after an episode of bipolar disorder and up to 5 years if the person has risk factors for relapse. This should be discussed with the patient and there should be regular reviews. Patients who wish to stop medication early should be encouraged to discuss this with their psychiatrist.

Psychological therapy after recovery from an acute episode

Psychological interventions should be considered for people with bipolar disorder who are relatively stable but experiencing mild to moderate affective symptoms. The patient must possess the necessary motivation for this therapy to be successful. The therapy should be in addition to prophylactic medications and be at least 16 sessions over 6-9 months. It should include psychoeducation about the illness, mood monitoring and enhance general coping strategies.

Focused family intervention could also be of value. This should also take place over 6-9 months. It should include psychoeducation, ways to improve communication and problem solving.

When to admit

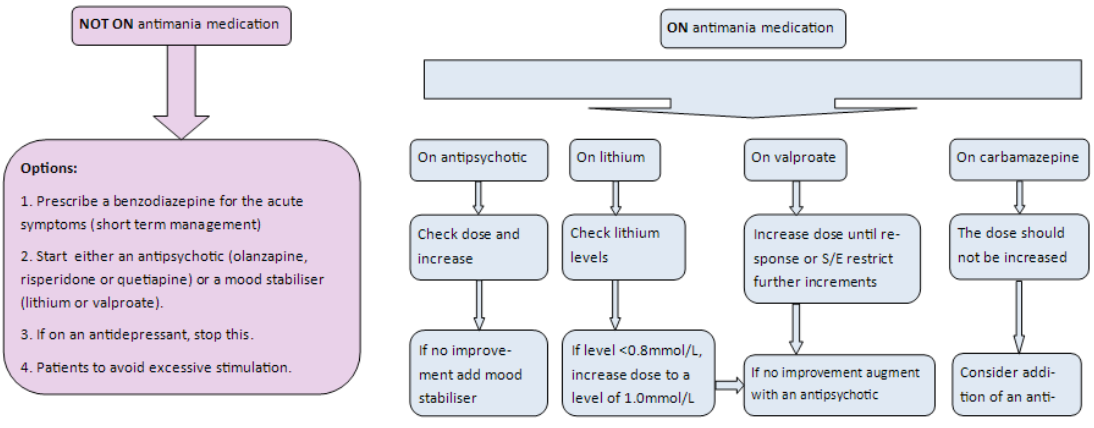
Admission to an inpatient unit should be considered for patients with bipolar disorder at significant risk of harm to themselves or others. The unit should provide facilities for containment within a supportive, low-stimulation environment, including access to a psychiatric intensive care unit. The inpatient service should seek to provide an emotionally warm, safe, culturally sensitive and supportive environment, with high levels of positive engagement between staff and patients.

Acute day hospitals should be considered, as an alternative to inpatient care and to facilitate early discharge from inpatient care.

Admission for children and adolescents should be considered for those at risk of suicide or other serious harm.

Conclusion

The diagram below gives a summary of all of the main treatment options discussed within this article. It serves as a quick, easy visual reference to use in clinics. When all of the treatment options discussed here have been tried without positive effect or if the patient is at extreme risk then they must be referred to the psychiatric services.



GP Comment

What have I learned from this paper?

This was a good paper to read right through. It was very clear and gave a basic working knowledge about management of acute mania in primary care, providing most of the answers to common management problems faced in day to day practice.
The comprehensive treatment plans have been presented in a very simplified manner.

Dr Roshan Jayalath, GP.

References

1. ICD-10 Classification of Mental and Behavioural Disorders, Churchill Livingstone.
2. NICE guidelines July 2006: Bipolar Disorder, The management of bipolar disorder in adults, children and adolescents, in primary and secondary care.