Part 9. Final Summary Chapters -Lessons for GPs

Understanding the bipolar spectrum: implications for management and diagnosis in primary care

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Abstract

Understanding the bipolar spectrum has significant implications for the management of affective disorders in primary care. In this article, we summarise the main consequences for the treatment of patients with bipolar and unipolar depression within the context of general practice. By having an integrated and coherent care pathway between primary and secondary care to treat unipolar depression and bipolar disorder, treatment can be optimised, comorbidities can be identified, iatrogenic disorders can be minimised and the risk of suicide can be reduced.

Key words: bipolar disorder, unipolar depression, diagnosis, treatment, guidelines, suicidality.

Our present understanding of the bipolar spectrum has many implications for the treatment of affective disorders in primary care. For example, there is now evidence that an illness that was previously thought to be a recurrent depressive disorder, may evolve into a bipolar illness. Furthermore, bipolar II disorders may develop into bipolar I (1-7). Additionally, it has been suggested that there may be important similarities between bipolar disorder and the mood lability of borderline personality disorder suggesting, controversially, that borderline personality disorder could be included in the bipolar spectrum (8,9).

Bipolar disorder, especially bipolar II disorder, remains an underdiagnosed condition and is frequently treated in an inappropriate way (10-13). Evidence has shown that many patients with bipolar disorder have a long period of untreated illness which parallels the duration of untreated psychosis in other psychotic illnesses (10,14,15). Agitated depression may be a mixed affective state, and the imprudent use of potent antidepressants in people with undiagnosed bipolar disorder may result in the development of mixed states or rapid cycling illness (which are linked to an increased suicide risk), in addition to a switch from depression to mania (16).

In recent years, the appropriate diagnosis and effective treatment of unipolar depression has come under scrutiny in the context of primary care (17). It has been demonstrated that often antidepressants in primary care may be prescribed for too short a time and, in the case of tricyclics, at too low a dose (17). Additionally, the NICE guidelines for unipolar depression and bipolar illness are distinct from each other, which may make management of these conditions more demanding unless the diagnosis has been made carefully, after having taken a longitudinal history. Guidelines for unipolar depression advocate a 'stepped care' model, which is centred around primary care, and which depends on the appropriate treatment with an adequate dose of antidepressants for six months, whereas for bipolar disorder, NICE emphasises the careful prescription of antidepressants and mood stabilisers to prevent 'switching' to mania (18-20).

General practitioners have not been advised to take a full longitudinal history in patients with depression in order to identify patients with bipolar illness. This makes diagnosis of these conditions for primary care physicians challenging. This is further augmented by an absence of clear direction on

the use of mood stabilisers in patients with bipolar II disorder, which may result in the inappropriate use of antidepressants. There appears to be a strong argument for providing general practitioners with further support to assist in the management of both unipolar depression and bipolar illness in an appropriate manner.

In practice, early bipolar disorder will be identified and treated correctly if primary care doctors are provided with the appropriate guidance and training so that these conditions can be diagnosed promptly (20). We would suggest that care should be taken to identify any period of elated mood which a patient who presents with major depression has experienced, both in primary and secondary care, even if this has lasted for only a few days. Previous episodes of hypomania, at least three recurrent depressive episodes, cyclothymia, a family history of bipolar illness or suicide, and a seasonal onset [winter in bipolar II and summer in bipolar I patients], and migraine have been acknowledged as possible indicators of bipolar illness (21). If these factors can be recognised in primary care, it may enable earlier diagnosis of bipolar disorder to be made (22-25).

As hypomanic or mixed states are strongly correlated with self-harm and completed suicide (26,27) there are concerns about the use of antidepressant monotherapy for bipolar disorder as this may trigger these states. Venlafaxine as well as tricyclic antidepressants (28) seem more likely than other antidepressants to produce a switch to mania in bipolar depression. Consequently, once bipolar depression is identified, guidelines should be in place that, where necessary, advise the use of mood stabilisers, including lithium, valproate, carbamazepine or atypical antipsychotics in order to treat bipolar disorder instead of antidepressant monotherapy. Thus, we would suggest that early diagnosis and appropriate treatment of bipolar disorder is likely to be the most effective way of reducing the risk of suicide in these patients (26,27,29). Additionally, the appropriate use and monitoring of venlafaxine as a first-line treatment in unipolar depression must be seen as secondary to this (14,30).
Since bipolar disorder has an inflammatory component, it would be prudent for physicians to consider whether patients with bipolar disorder have an autoimmune condition such as thyroiditis, Crohn's disease or ulcerative colitis, once their bipolar symptoms have improved (31,32). Finally, because of the possible toxicity of lithium it is necessary, in both primary and secondary care, for patients on lithium to have lithium levels, urea and electrolytes monitored every 3 months as well as thyroxine and TSH every 6 months. Each patient should have a shared care card to ensure both primary and secondary care are aware of all the results. (See paper: "Lithium therapy – from monitoring to shared care" in this focus issue.)

In summary, it is necessary to have an integrated care pathway to treat both unipolar depression and bipolar disorder in primary and secondary care in order to optimise the management of such patients (32). This will allow the identification of any comorbidities, prevent any iatrogenic disorders and reduce the risk of suicide.

GP Comment

What have I learned from this paper?

This paper highlights the importance of taking a longitudinal history in patients with depression to ensure that episodes of mania or hypomania, are not missed. To diagnose bipolar disorder promptly and therefore treat patients correctly we must remember to enquire about previous episodes of elated mood, recurrent depressive episodes, cyclothymia, a family history of bipolar illness or suicide, and seasonal onset as possible indicators of bipolar illness.

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