Bipolar Disorder – Guidance on recognition in Primary Care

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Abstract

Bipolar Disorder (BPD) is a complex condition with variable clinical presentations and diagnosis can be difficult. In particular, recognising new or previously undiagnosed BPD can be especially challenging within the pressures of primary care where patients present with a wide variety of medical or social issues rather than with diagnostic labels. Moreover, there may be conceptual difficulties between the academic classification of emotional and mental health symptoms into discrete entities versus the broader contexts that GPs encounter daily. It should also be noted that GPs are adept at managing uncertainty with pragmatism.

Key words: bipolar disorder, depression, cycling, diagnosis, treatment, primary care.

Introduction

It has been shown that the clinical features and time course of BPD (especially Bipolar-II, which GPs are likely to encounter fairly frequently) differ from unipolar depression in several key ways and, crucially, BPD carries a much higher suicide risk (1–8). However, because the diagnosis is difficult, BPD is frequently, although unintentionally, misdiagnosed as unipolar depression with anxiety and consequently incorrectly treated in both primary and specialist care. This leads to long delays and protracted suffering and, for some patients, increased risk of suicide (4,9–13).

GPs have a key role in recognising possible Bipolar Disorder (BPD) - ask about a family history of BPD and screen for a history of mania/hypomania in individuals with anxiety, depression or irritability, especially if there are recurrent episodes, suicidal thoughts or previous suicides attempt.

This brief paper therefore aims to help GPs recognise when a patient might have BPD. Referral to a psychiatrist (where referral pathways allow, ideally with expertise in mood disorders) for formal diagnosis is recommended. For further discussion of aetiology, treatment issues, BPD in pregnancy, children and in individuals with comorbid alcohol/substance misuse, see later: "Selected Resources" and also the relevant papers in this focus issue.

Key points

1. Bipolar Disorder is a relatively common but complex group ('spectrum') of conditions that cause recurrent changes in mood and energy. Mania or hypomania are the defining features but diagnosis can be difficult because depression and anxiety are far commoner (14–16).

Bipolar subtypes (figures 1-3)

Bipolar I (BD-1) Mania (≥7 days, see box below) with or without major depression. Diagnosis usually straightforward: behaviour often markedly disturbed. Help often sought via a third party as patients usually have impaired insight. The prodrome of mania may be misdiagnosed as anxiety or an anger management problem.

Bipolar II (BD-II) Hypomania (≥4 days) and recurrent major depression, often severe, with a high suicide risk. Diagnosis difficult – often misdiagnosed as unipolar depression - hypomania undetected as patients may not seek help. Hypomania may be misdiagnosed as anxiety or an anger management problem.

Bipolar Spectrum Disorder (Bipolar Not Otherwise Specified (BD-NOS) including Cyclothymia (recurrent hypomania with sub-threshold depression). Less severe and shorter mood swings - hypomania < 4 days - but diagnostic criteria and treatment options less well defined.

Epidemiology

Severe BPD (BD-I, BD-II) affects ~ 2-3% of the population (17,18) (BD-I 1%, BD-II 1-2%) but bipolar spectrum disorders and cyclothymia may be more prevalent (19). It has been found that between 5-10% of primary care patients with a working diagnosis of unipolar depression may have bipolar disorder (6) and this rises to 16% - 47% in secondary care and specialist settings (2). Thus, for an average UK GP list size of ~ 1600, at least 16 patients will have BD-I, at least 32 will have BD-II and a significant proportion of those with unipolar depression or treatment-resistant depression may also have an unrecognised bipolar spectrum disorder.

Onset

Bipolar disorder may initially present with either a depressive or a hypomanic/manic episode and the peak age of onset lies in the teens or early twenties. In some, it may be later, but 90% of individuals experience their first episode before the age of 50. Onset of symptoms in old age has been reported but this should raise suspicion of an underlying organic cause.

Time course, 'cycling' and staging

Bipolar disorder is a lifelong condition but the severity and frequency of symptoms vary considerably. Many individuals manage the disorder successfully with the help of primary and secondary care services and some patients are highly creative and productive but most suffer long-term difficulties with depressive symptoms and intermittent manic and/or hypomanic relapses. Mania and hypomania tend to begin abruptly. They are often triggered by stressful life events and sometimes by daylight changes in spring and autumn. Mania usually lasts between 2 weeks and 4-5 months. Bipolar depression tends to last longer, often 6 months, but may be much shorter. 'Mixed episodes', where mania/hypomania and depression occur at the same time are common (20) but under-recognised. In mixed episodes, the predominant mood may vary during the day with depression in the mornings and hypo/mania at night.

The term 'Cycling' refers to the frequency of mood changes. It is somewhat arbitrary but useful for assessing severity and treatment response. 'Rapid cycling' refers to 4 or more episodes of mania or depression in 1 year. The terms 'Ultra rapid' and 'ultradian' cycling are sometimes used interchangeably with the term 'mixed episodes'. In recent years a tentative staging model based on symptom severity, illness course and treatment response has been suggested (21).

BPD causes suffering and reduced life expectancy

Whilst some individuals may be highly productive (typically when hypomanic), many suffer recurrent depression/anxiety, mood swings and cognitive problems. They may experience difficulties with relationships, employment, financial stability and reputation. Around 40-50% of individuals with BPD will have a previous or current alcohol +/- substance misuse problem (22). Associated physical comorbidity includes obesity, metabolic syndrome, Type 2 diabetes, IHD, COPD, asthma, migraine, back pain, HIV and Hepatitis B/C (16,18,23). The risk of suicide is >20x the general population (12,13). Mixed symptoms (depression + mania/hypomania) are common and increase the risk of suicide. (20,24).

2. Most depression/anxiety is treated in primary care. Some of these patients may have unrecognised bipolar disorder (especially BD-II) - antidepressants may not work here and might even cause harm (9,10,25).

BPD, especially bipolar II, is under-recognized under-treated or inappropriately treated in both primary and secondary care (2,6,7,26,27). Average delay to diagnosis is ~ 10 years (27). Delayed diagnosis means ongoing suffering and increased suicide risk (4,11,12).

'Atypical Depression' symptoms are commoner in Bipolar depression (28,29)
'Lead-like' limb heaviness with marked fatigue, severe guilt, psychomotor retardation, excessive eating / sleeping, labile mood or mixed episode, psychosis

The probability of BPD is increased if (2,5,6,28,29):

There is a history of BPD in a first degree relative, age at onset <30 yrs., recurrent depression, 'atypical depression', antidepressant failure (e.g. 3 or more antidepressants have been tried but did not work) or wear-off, mania/hypomania with antidepressants, post-natal depression, history of a suicide attempt, psychosis, alcohol/substance misuse and borderline personality disorder (Figure 4),

Treatment of BPD differs from unipolar depression

Bipolar-specific psychoeducation (understanding mood triggers and the importance of sleep, diet, exercise and daily routines) and holistic social support are crucial to building resilience. Depending on the subtype and severity, medication, typically with 'mood stabilisers', is often required.
Medication strategies are complex (23,30–32) and include lithium, antiepileptic drugs (e.g. valproate, lamotrigine) antipsychotics (e.g. quetiepine) and short-term benzodiazepines. Medication options, combinations, doses and duration of treatment may need to be varied according to the mood state and whether the context is acute or prophylactic maintenance. There is debate about the exact role of antidepressants in BPD but, in contrast to unipolar depression, antidepressants are often ineffective and in some individuals may precipitate hypomania, mania and suicidality (9,10,24). In situations where a trial of antidepressants is deemed necessary, a 'mood stabiliser' should usually be taken at the same time.

3. Putting this into practice in Primary Care (figures 1-5)

NB: Not all individuals who have mood swings have BPD - be wary about medicalising normal mood reactions, personality traits and temperaments. Where necessary, review the patient to assess further. Mood swings are not a diagnostic term and may occur in many situations e.g. adolescence, menstrual cycle changes, the menopause, anxiety disorders, ADHD, in organic brain syndromes (e.g. fetal alcohol syndrome, multiple sclerosis, Parkinson's disease, frontal lobe tumours, dementia) personality disorders and following a head injury.

However, consider BPD in the following situations, which may overlap

• Suicidal ideation or a previous suicide attempt.

- Psychosis.
- Irritability - difficult consultations, anger management issues, relationship and employment problems.
- Anxiety/depression - esp. recurrent depression, lack of response to or agitation with antidepressants, 'atypical depression', post-natal depression, seasonal mood changes e.g. SAD in winter, 'reverse' SAD in summer, irritability or unusually energised in spring/summer/autumn.
- Significant mood swings.
- Unexplained fatigue.
- Insomnia - especially going for days with little sleep or middle insomnia with agitation and racing thoughts.
- Eating disorders.
- ADHD.
- Alcohol/substance misuse.
- Borderline Personality Disorder.

In these situations consider the following BPD screening questions:

- 'Is there a family history of Bipolar Disorder?'
- 'Do you ever feel 'hyper' or irritable or have thoughts that you can't slow down?
- Do you ever experience changes in mood and energy that seem more extreme than other people and has anyone ever mentioned this to you?'

For positive responses, refer to a Psychiatrist for further assessment (where referral pathways allow, ideally with expertise in mood disorders)

Urgency of referral depends on risk assessment. For milder symptoms, a period of observation and information gathering in primary care may be appropriate. A formal mood questionnaire (see below) may help identify hypo/manic symptoms and thereby gauge the probability of BPD but these questionnaires are not diagnostic.

Mood questionnaires

A self-rating mood questionnaire can identify previous hypomania provided the patient has enough insight to recognise this. Information from a third party (with consent) may increase accuracy. However, these tools are not diagnostic and do not replace detailed psychiatric evaluation. Those below are in common use and GPs may wish to familiarise themselves with one of them, being mindful that most were developed for secondary care settings where there are more resources for detailed evaluation. Mood questionnaires take about 10 minutes and can be completed in the consultation or at home with someone who knows the patient well and brought to a follow-up consultation. The probability of bipolar disorder increases with the number of manic symptoms (specific details for each tool); reliability rests on sensitivity (% of true bipolar cases correctly identified as bipolar) and specificity (% of unipolar depression cases correctly identified as unipolar). Mood questionnaires include the following.

MDQ Mood Disorders Questionnaire score >7/13 (33–35).

Widely used benchmark. BPD probable if score > 7/13 + 'yes' + 'moderate or serious' problem. Sensitivity 58%. Specificity 93% in primary care. MDQ has good sensitivity in insightful patients with bipolar I disorder, but may be less useful in patients with impaired insight or milder bipolar spectrum.

BSDS Bipolar Spectrum Diagnostic Scale score >13/25 (36).
BPD probable if score >13/25 Sensitivity 0.76 (Bipolar I and II/NOS) specificity 0.85

HCL32 Hypomania Check List - 32 score >14/32 (37)
BPD probable if score >14/32 Sensitivity 80% specificity 51%. Does not
Distinguish between bipolar I and bipolar II. Identifies "active/elated" hypomania and "risk-taking/ irritable" hypomania.

MSQ Mood Swings Questionnaire Score >22/27 (38) (39)
BPD probable if score >22/27 sensitivity 81.7 specificity 77.9%

Mood diaries may add further valuable information. Several versions are available on-line and there are also many mood-monitoring apps for smartphones.

Bipolar UK http://www.Bipolaruk.org.uk/leaflet-could-mood-swings-mean-Bipolar.html

BEAM http://www.psychiatry24x7.com/bgdisplay.jhtml?itemname=mooddiary

Oxford True Colours http://oxtext.psych.ox.ac.uk/true-colours

4. Differential diagnosis: what else could this be?

Borderline Personality Disorder

Borderline personality disorder (40) is a complex entity that is sometimes confused with BPD. It is common for a patient to be misdiagnosed with BPD when they actually have borderline personality disorder and vice-versa. Some patients may be diagnosed with both and it has been suggested that borderline personality disorder may be part of the bipolar spectrum (41). Advances in neuroscience, imaging and genetics may clarify this issue. Key clinical differences (42) are that patients with borderline personality disorder have rapidly unstable emotions and impulsivity, no family history of bipolar disorder, and do not have severe depression or hypomania. Patients with bipolar disorder usually require medication whereas patients with borderline personality disorder respond poorly to medication but may be helped by behavioural therapy.

ADHD

Impulse control disorder

The symptoms of ADHD have some similarity to the distractibility experienced in hypomania and mania. Some patients have ADHD as well as bipolar disorder (43)

Schizophrenia & Schizoaffective Disorder

Psychosis may be present in severe mania and also in schizophrenia. However, hallucinations, delusions and thought disorder are usually only present in schizophrenia or schizoaffective disorder. In first episode psychosis, a formal underlying diagnosis may be deferred until subsequent developments clarify the situation.

Organic pathology

The following organic conditions can manifest with psychiatric symptoms that overlap with bipolar disorder. Hyperthyroidism (mania), hypothyroidism (depression), Cushings disease (mania), Addisons disease (depression, fatigue), anaemia, renal failure, delerium (e.g. meningo-encephalitis) metabolic (e.g. hyponatraemia, hypercalcaemia, liver dysfunction, Folate, B12 deficiency), frontal lobe lesions, dementia, cerebral lupus, multiple sclerosis, HIV. Rarely: phaeochromocytoma or porphyria.

Iatrogenic

Many drugs affect mood.
Mania/hypomania: corticosteroids, L-dopa, stimulants (e.g. methylphenidate, cocaine, amphetamines)
Depression: corticosteroids, beta-blockers, calcium channel blockers alpha-blockers and statins.
Consider a trial off relevant medication if possible.

Chronic Fatigue Syndrome, Sleep disorders

Primary insomnias; Sleep apnoea causing fatigue and behavioural changes.

5. What investigations are helpful in Primary Care?

Baseline: Thyroid function, FBC, U&E, LFTs, Calcium, Glucose, Urate (hyperuricaemia linked with metabolic syndrome and possibly implicated in BD), B12, Folate and Vitamin D. If BPD confirmed additional blood tests (lipids, prolactin HbA1c) may be required for monitoring.

Additional tests where appropriate: Urine drug screen, cerebral imaging if neurology or older patient (likely to be suggested by psychiatry), sleep study (sleep apnoea), ESR, CRP autoantibody screen (lupus), urine phaechromocytoma screen, urine/stool porphyria screen.

6. A Bipolar diagnosis should be made with care

Where resources and referral pathways allow, refer to a psychiatrist with expertise in mood disorders for detailed assessment and further management advice. Given that bipolar disorder may be difficult to diagnose, a discussion with the psychiatrist and/or a referral for a second opinion should be considered if an initial psychiatric assessment proves inconclusive or if the patient does not respond to treatment. If BPD is confirmed, GPs play a key ongoing role, alongside secondary care colleagues, in holistic support, coordinating care, prescribing and monitoring.

7. Be mindful of iatrogenic harm

Antidepressants or systemic corticosteroids (e.g. for asthma or COPD) may precipitate serious mood episodes in patients with BPD. Where relevant, screen for BPD before prescribing. Medications for BPD (e.g. lithium, valproate, antipsychotics) may cause significant adverse effects, warranting careful risk/benefit assessment and vigilant monitoring.

8. Increasing awareness and diagnosis of bipolar disorder has significant resource implications for primary and secondary care and for the third sector

There is a need to raise awareness of bipolar disorder in primary care. GPs will need increased expertise in mental health and psychopharmacology. Longer consultation times will be needed. Prescribing budgets and monitoring resources will also need to be better resourced. GPs will need prompt access to responsive and expert secondary care services and especially wider provision of psychological support including bipolar-specific psycho-education. From a health economics perspective, BPD carries major costs (32,33), which are likely to rise further. GPs will need to work closely together and with both secondary care colleagues and the third sector to meet the challenges of these important issues.

9. Early diagnosis, careful treatment and good psychosocial support can help individuals with BPD feel better and significantly improve their quality of life.

Figure 1
Diagnostic criteria in brief for the busy GP *after DSM-IV-TR*

Mania – a distinct period of abnormally elevated (e.g. euphoric or expansive) or irritable mood lasting ≥7 days with 3 or more (4 if the mood is only irritable) of:-

- inflated self-esteem or grandiosity
- decreased need for sleep (e.g. feels rested after only 3 hours)
- more talkative than usual or pressured speech – difficult to interrupt
- flight of ideas or a feeling of racing thoughts
- distractibility - lack of attention and drawn to unimportant stimuli
- increased goal-directed activation or agitation
- pursuit of 'heedless pleasure' or risk-taking behaviour, due to impaired judgement, resulting in serious consequences (e.g. excessive spending, unwise business ventures or inappropriate sexual behaviour)

Energy levels are usually significantly increased. Symptoms need to be severe enough to significantly impair functioning (work, social, relationships) or require hospitalization (to prevent harm to self or others). Psychosis (loss of insight, delusions, hallucinations) may occur.

The symptoms do not meet criteria for a mixed episode and are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

Hypomania – symptoms are similar to but less severe than mania and do not significantly impair function. No delusions or hallucinations - Psychosis does not occur. For a diagnosis of Bipolar II, hypomania should last ≥4 days. Shorter duration hypomania = Bipolar Not Otherwise Specified, Bipolar Spectrum Disorders.

Mixed states – simultaneous hypomania or mania with depression symptoms. Symptoms include dysphoria, irritability, anxiety, agitation, suspicion and hostility.

Depression (5) or more of the following symptoms for at least 2 weeks. One of the symptoms must be depressed mood or loss of interest.

- Depressed mood most of the day
- Markedly diminished interest or pleasure in all oralmost all activities (anhedonia)
- Significant weight loss or gain (e.g. >5% change body weight in a month)or increase or decrease in appetite
- Insomnia or hypersomnia
- Psychomotor agitation or Psychomotor retardation
- Fatigue or loss of energy
- Feelings of worthlessness or inappropriate guilt
- Diminished concentration or indecisiveness
- Recurrent thoughts of death, recurrent suicidal thoughts or a specific suicide plan or a suicide attempt.

Symptoms cause significant functional impairment. Psychosis (delusions, hallucinations) may occur. Symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g. hypothyroidism).

Bipolar Depression

'Atypical' depression symptoms more likely *but not always present*:

'Lead-like' limb heaviness

Marked fatigue, severe guilt

Psychomotor retardation

Excessive eating +/- weight gain

Excessive sleeping (esp. during the day)

Labile Mood or mixed episode - manic features during episode - rapid on/off depression

Psychosis

Mixed States are common

Depression and hypomania/ mania are not necessarily opposites. Simultaneous symptoms occur in many patients but may not be recognised. Increased suicide risk

Mania/Hypomania

Mania usually obvious: significant behavioural disturbance. Help often sought via a third party as patients usually have impaired insight**Hypomania** Energised - often feels good - uncommon to seek medical advice - patients rarely seen in this state - but may seek help for racing thoughts and insomnia if becoming tired.

Hypomania can be subtle unless patient well known. Irritability / impulsivity are common

Insight may be impaired

Irritability common in hypomania / mania, depression and mixed states
Sensory hypersensitivity (like migraine): noise, light, colour, touch
Interpersonal upsets

APPEARANCE
May appear slowed
Low self-confidence
Poor eye contact
Signs of self-neglect

MOOD
Anxiety, agitation, guilt
Sadness
Paranoid thoughts
Suicidal ideas

MOOD
Unusually optimistic, euphoric, elated
Irritable

APPEARANCE
Hypomania - brighter clothes, self-care, increased self-confidence,
Mania – unusual or gaudy dress or inappropriate e.g. unclothed

BEHAVIOUR

Loses interest in work, hobbies, pleasurable activities

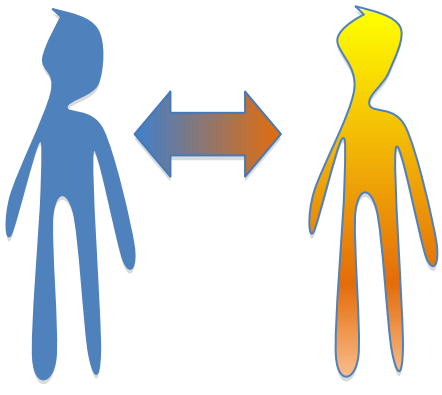
Difficulty with tasks, housework, decisions

Withdrawn from family friends and work

Marked fatigue and listlessness
Limbs heavy 'like lead' (similarities with chronic fatigue syndrome)
-> Functional impairment

Eating more esp. carbohydrates -> weight gain & sluggish

Sleep Diurnal rhythm changes: Sleeping more during the day – but may be more alert in evenings, go to bed late and get up late



BEHAVIOUR

Energised, lots of interests, multitasking, more sociable
Energized ->movement much easier than when depressed - may need to exercise to burn off energy

Decreased sleep

Distractible +/- disorganised

Increased confidence, self esteem, grandiosity (mania)
Over-familiarity, restless, Impatient, irritable, agitated
Hostility/violence (mania)

SPEECH
Louder, faster, difficult to interrupt, puns and jokes, which may be inappropriate, flight of ideas

SPEECH
Slowed, flat tone, difficulty speaking

COGNITION
Slowed thinking
Marked fatigue – no 'starter motor'
Difficulty concentrating, poor memory
Insight may be impaired

COGNITION
Racing thoughts
Fast, crisp thinking, sharpened memory
Increased goal orientated plans and ideas - often unrealistic
Sharpened sensations: colour & sounds brighter and crisper
Dis-inhibition with 'heedless' pleasure and risk-taking- e.g. financial or sexual
Difficulty completing tasks
Insight may be impaired - Psychosis (severe mania) – e.g. grandiose delusions

Figure 2

BIPOLAR DISORDER: SIGNS & SYMPTOMS

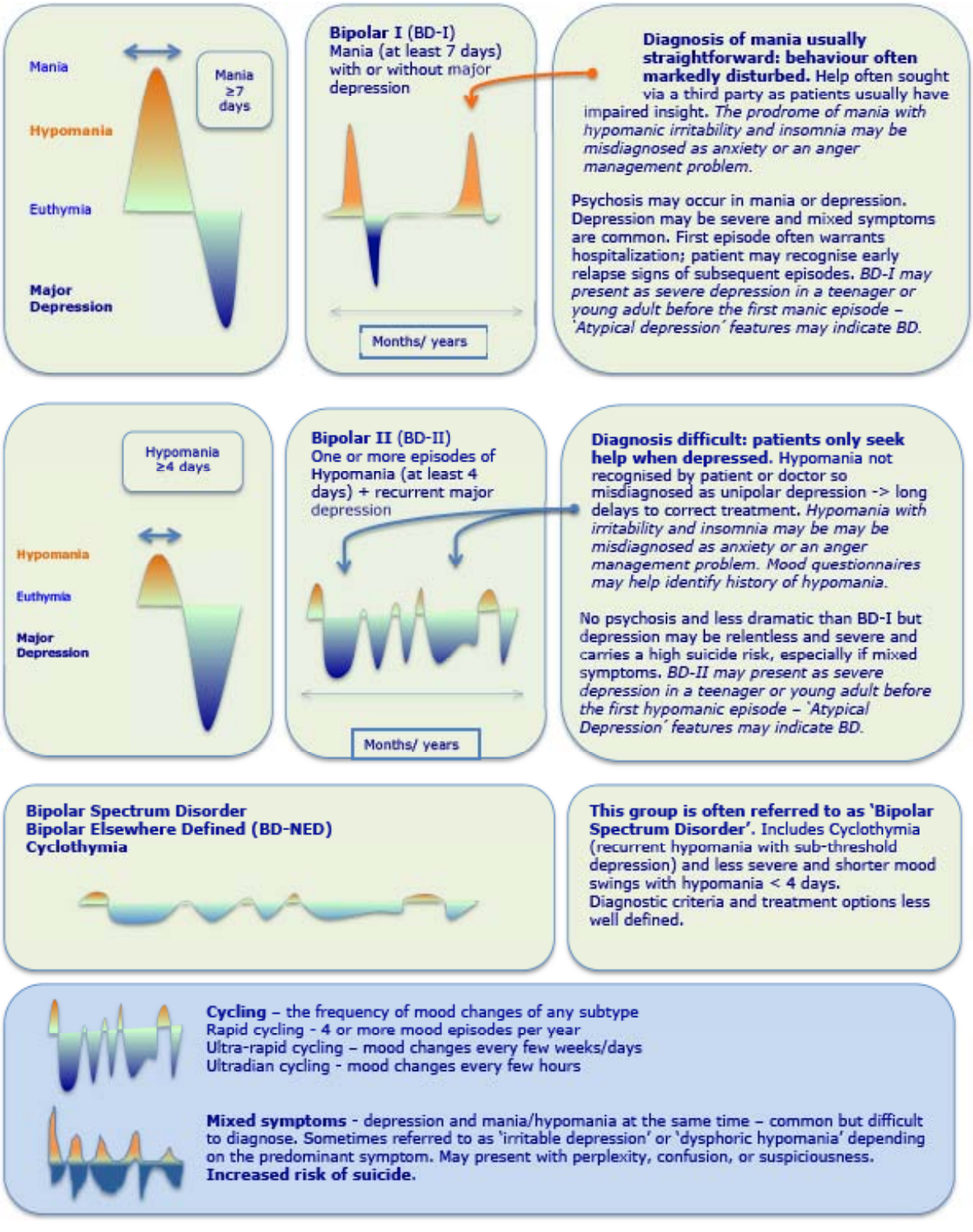


Fig 2. A simplified classification of Bipolar Disorder
Adapted from Bipolar Disorder (Oxford Psychiatry Library) Yatham Malhi OUP Oxford; 1 edition (2011) page 10 with permission

	Bipolar Depression	Unipolar Depression
Family history of bipolar disorder or psychosis	++++	+
Antidepressant associated mania or hypomania	++++	--
Psychotic depression <age 35	++++	--
Suicide attempt	+++	+
Alcohol/Substance abuse	+++	++
Borderline Personality Disorder	+++	+
Significant seasonal mood changes	+++	+
Onset of depression before age 25	+++	+
Postpartum onset of depression	+++	+
Mood reaction with systemic corticosteroids	+++	+
'Atypical' features of depression - 'Lead-like' limb heaviness Marked fatigue, severe guilt Psychomotor retardation Excessive eating / sleeping Labile Mood or mixed episode - manic features during episode	+++	+
Rapid on/off pattern of symptoms	++	--
Frequent recurrence of depressive episodes	++	+
Antidepressant wear-off	++	--
Brief episodes of depression (<3 months)	++	--
ADHD	++	+
Eating Disorders	++	+

Figure4. CLINICAL DIFFERENCES BETWEEN BIPOLAR AND UNIPOLAR DEPRESSION.

Based on Angst (2,3) , Mitchell (28,29) and adapted from Smith (5,44)

Fig 5. RECOGNISING BIPOLAR DISORDER – A DECISION AID FOR PRIMARY CARE

Bipolar I Mania (≥7 days) with or without major depression – often severe – diagnosis usually straightforward – but prodrome may be misdiagnosed as anxiety or an anger management problem.
Bipolar II Hypomania (≥4 days) + recurrent major depression – often severe - high suicide risk.
Diagnosis difficult: patients only seek help when depressed ->Hypomania not recognised by patient or doctor -> misdiagnosed as unipolar depression ->long delays to correct treatment. *Hypomania with irritability and insomnia may be misdiagnosed as anxiety or an anger management problem.*
Bipolar Spectrum (BPD-Not Otherwise Specified including Cyclothymia) – diagnostic criteria less well-defined - milder mood swings with hypomania < 4 days and subthreshold depression.

Primary Care context:
Anxiety, depression, mood swings, fatigue, insomnia
Anger, irritability, or difficult consultations
Relationship or employment difficulties
Alcohol/substance misuse
Self-harm/Suicide attempt

Rule out organic/iatrogenic causes and avoid medicalising normal stress reactions or temperaments – but could this be unrecognised Bipolar Disorder?

If resources allow assess over longer (or several) consultations
Screen for hypomania/mania:

1. 'Is there a family history of Bipolar Disorder?'
2. 'Do you ever feel 'hyper' or irritable or have thoughts that you can't slow down?
3. 'Do you ever experience changes in mood and energy that seem more extreme than other people and has anyone ever mentioned this to you?
4. Are there any features that make bipolar disorder more likely?

No → BPD unlikely but reassess if symptoms change

Yes to any

★	Bipolar Depression	Unipolar Depression
Family history of bipolar disorder or psychosis	++++	+
Antidepressant associated mania or hypomania	++++	--
Psychotic depression <age 35	++++	--
Suicide attempt	+++	+
Alcohol/Substance abuse	+++	++
Borderline Personality Disorder	+++	+
Significant seasonal mood changes	+++	+
Onset of depression before age 25	+++	+
Postpartum onset of depression	+++	+
Mood reaction with systemic corticosteroids	+++	+
'Atypical' features of depression - 'Lead-like' limb heaviness Marked fatigue, severe guilt Psychomotor retardation Excessive eating / sleeping Labile Mood or mixed episode - manic features during episode	+++	+
Rapid on/off pattern of symptoms	++	--
Frequent recurrence of depressive episodes	++	+
Antidepressant wear-off	++	--
Brief episodes of depression (<3 months)	++	--
ADHD	++	+
Eating Disorders	++	+

- **Refer for Psychiatric assessment** – a Bipolar diagnosis should usually be made by a Psychiatrist. Severity of symptoms and risk to self or others determines urgency of referral.
- **Avoid antidepressants (in Bipolar Disorder may worsen symptoms or increase suicide risk)** until seen by / discussed with Psychiatrist. Short term promethazine or benzodiazepine safer interim option if insomnia or agitated
- Consider a Mood Questionnaire and suggest a mood chart - include with referral letter or patient to take to appointment
- Consider watchful waiting if symptoms not marked and no functional impairment; refer if concerns persist
- If Psychiatrist's assessment inconclusive/patient does not improve discuss with Psychiatrist / consider referral for second opinion

Mood questionnaires (5-10 minutes) may help identify previous hypomanic symptoms - if patient has insight. Probability of BPD increases with the number of positive responses - but NOT diagnostic – see individuals tools and interpret with caution.
MDQ Mood Disorders Questionnaire
score >7/13
BSDS Bipolar Spectrum Diagnostic Scale
score >13/25
HCL-32 Hypomania Check List - 32 R
score >14/32
MSQ Mood Swings Questionnaire **Score >22/27**
Suggest patient records a daily mood chart

Selected Resources

Online for professionals

Bipolar Education Programme Cymru (BEP-C) 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 primary care practitioners: http://www.beatingBipolar.org/primary_care_practitioners/

Black Dog Institute Sydney, Australia http://www.blackdoginstitute.org.au/healthprofessionals/bipolardisorder/whentosuspectbipolardisorder.cfm

British Association for Psychopharmacology Evidence-based guidelines for treating Bipolar Disorder: http://www.bap.org.uk/pdfs/Bipolar_guidelines.pdf

British Psychological Society Understanding Bipolar Disorder
http://www.psychminded.co.uk/news/news2010/October10/Understanding-bipolar-disorder.pdf

NICE http://guidance.nice.org.uk/CG38 in the process of being updated for 2014

www.psycheducation.org US website with detailed information on all aspects of Bipolar Disorder

Suicide Mitigation in Primary Care
http://www.rcgp.org.uk/pdf/RCGP%20RCPsych%20Suicide%20Mitigation%20in%20Primary%20Care%20factsheet%20June%202012.pdf

Clinical guide: assessment of suicide risk in people with depression; University of Oxford Judi Meadows Memorial Fund
http://cebmh.warne.ox.ac.uk/csr/Clinical_guide_assessing_suicide_risk.pdf

Books for Professionals

Bipolar Disorder: Your Questions Answered Hunt Churchill Livingstone (18 Jan 2005)

Bipolar Disorder (Oxford Psychiatry Library) Yatham,Malhi OUP Oxford; 1 ed (6 Jan 2011)

Bipolar II Disorder Modelling Measuring and Managing Parker Cambridge 2nd Ed (Apr 2012)

Manic-Depressive Illness: Bipolar Disorders and Recurrent Depression
Goodwin and Redfield Jamison, Oxford University Press, USA; 2 edition (March 22, 2007)

The Maudsley Prescribing Guidelines in Psychiatry Taylor et al Wiley-Blackwell; 11th Ed (2 Mar 2012)

Books for patients, family and those close to them

An Unquiet Mind: A memoir of moods and madness Redfield Jamison Picador (5 Aug 2011)

Bipolar Disorder - The Ultimate Guide Owen,SaundersOneworld Publications (1 July 2008)

Lithium for Bipolar Disorder: A Guide for Patients (Bipolar Information Series) Stafford My Mind Books (1 Jun 2011)

Mood Mapping: Plot your way to emotional health and happiness Miller Rodale (7 Jan 2011)

Overcoming Mood Swings Scott Robinson (25 Mar 2010)

Why Am I Still Depressed? Recognizing and Managing the Ups and Downs of Bipolar II and Soft Bipolar Disorder Phelps McGraw-Hill (1 April 2006)

Online for patients

Bipolar Education Programme Cymru (BEP-C) 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/

Bipolar UK 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.

Depression Alliance http://www.depressionalliance.org
Leading UK charity for people affected by depression

Equilibrium http://www.bipolar-foundation.org
An independent, international, non-governmental organisation dedicated to improving life for people with bipolar disorders

Mind http://www.mind.org.uk/help/diagnoses_and_conditions/bipolar_disorder_manic_depression
A charity providing advice and support to empower anyone experiencing a mental health problem. Mind campaigns to improve services, raise awareness and promote understanding.

Royal College of Psychiatrists 'Help is at Hand' leaflet on Bipolar Disorder:
http://www.rcpsych.ac.uk/mentalhealthinfo/problems/BipolarDisorder/BipolarDisorder.aspx_

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