TREATMENT OF RAPID-CYCLING BIPOLAR DISORDER

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CONFLICT OF INTEREST

• Ms. Marcus has no conflicts of interest.
• There are no discussions of off-label medications in this presentation

OBJECTIVES

• Differentiate between symptoms manifested by individuals with Bipolar I, Bipolar II, and Mixed Bipolar disorder, as compared to Rapid-Cycling Bipolar Disorder with case study
• Describe the medications most often used for patients with Bipolar Disorder

OBJECTIVES

• Identify two nursing interventions that are most helpful when providing psycho-education for patients and their families to better understand and manage symptoms of Rapid Cycling Bipolar Disorder. Discussed using case study

BIPOLAR DISORDER, OVERVIEW

• Affects approximately 1% (2-2.5 million) in the USA, ages 18 and older
• First manic episode- 18-20 years old
• Earlier age of onset – worse outcomes, including rapid cycling in adulthood
• Individuals with Bipolar Disorder account for one quarter of all suicidal deaths reported in the general population.

BIPOLAR DISORDER

• Bipolar I affects men and women equally
• Bipolar II more common in women
• Women are more likely to have mixed mania and manic switches during treatment with an antidepressant
• Rapid cycling: four or more episodes per year
• Frequent cycling: two to three episodes a year
BIPOLAR I
- One or more manic episode alternating with a major depressive episode
- Manic episode – Persistent elevated, expansive or irritable mood
- Sleep disturbances
- Increase distracted, restless
- Impulsive behavior
- Exaggerated self-esteem

BIPOLAR I
- Manic episodes begin suddenly – lasting a few days to a few months
- Abrupt mood shifts – rapid changes from euphoria to anger or depression
- Individuals with depressive symptoms tend to be less responsive to conventional therapy

BIPOLAR II
- Major depressive episode and one hypomanic episode
- No history of a manic or mixed episode
- No psychotic features
- Hypomanic episodes usually occur before or after a major depressive episode
- Diagnosis is difficult

RAPID CYCLING
- Four or more manic episodes for at least 2 weeks in a year
- Have partial or full remission for 2 months or switch to the opposite mood (if manic; switches to depressed mood)
- High risk of recurrence and resistance to treatment
- Greater severity of symptoms of mania and depression

ETIOLOGY:GENETIC
- Bipolar disorders – highly inheritable
- Complex mode of inheritance, involving multiple interacting genes
- Dysregulation in gene G protein receptor (GRK3) – dopamine metabolism
ETIOLOGY: GENETIC

- Genetic: Concordance rates in monozygotic twins 67%; dizygotic twins 19%.
- Research is being done on genetic testing for bipolar disorder; including where the genetic disruption may be occurring.
- Genetic association of serotonin system genes is being conducted.

NEUROANATOMIC ISSUES

- Volume reduction in subregion of prefrontal cortex
- Amygdala and striatal enlargement
- Midline cerebellar atrophy
- Enlarged lateral and third ventricle with white matter hyperdensity in 10-30% of individuals with bipolar disorder

NEUROTRANSMITTERS

- Increase in sensitivity of postsynaptic receptors
- Dysregulation in dopamine and serotonin along with deficits in other systems, such as GABA
- Signaling pathway abnormalities and altered neurotransmitters; G proteins translate the signals and relay the signals to the second-messenger systems are increased with bipolar disorder

PSYCHOLOGICAL INFLUENCES

- Response to biological makeup and coping skills
- Faulty beliefs about self and the world around them
- Risks do not have consequences
- Goal striving – euphoria – drive increases regardless of feedback from others and disruption in daily routine

PSYCHOLOGICAL INFLUENCES

- Psychosocial stressors trigger bipolar episodes by disruption of usual social rhythms
- Disruption of circadian systems

MEDICATION MANAGEMENT
CHOOSE THE BEST MEDICATION

- Syndrome targeting (the pattern and stage of the illness)
- Symptom targeting
- Awareness of interactions
- Best drug class
- Mechanisms of drug action

CHOOSE THE BEST MEDICATION

- Symptoms presented
- History and patterns of illness
- Side effect profile
- Personal and family responses to treatment
- Cost
- Ease of administration
- Onset of action
- Drug to drug interaction

USE OF LITHIUM

- LiCo3 is an older mood stabilizer, continues to demonstrate good therapeutic results and is seen as the first line treatment for a mood stabilizer

MOOD STABILIZER

- Treatment of choice in manic phase
- LiCo3 and Valproate are the two first line treatment choices
- Second line alternative is Carbamazepine or LiCo3 and valproate

MOOD STABILIZERS

- Rapid cycling:
  - Valproate; first line
  - Carbamazepine; first line
- Second line alternative:
  - LiCo3 and valproate
  - LiCo3
  - LiCo3 and carbamazepine
MOOD STABILIZERS

- Mixed episode or dysphoric mood:
  - Valproate; first line
  - LiCo3 or Carbamazepine
  - Gabapentin
  - Lamotrigine
  - Topiramate
- Second line alternative:
  - LiCo3 and valproate

ADJUNCTIVE MEDICATIONS

- Manic with psychosis:
  - Therapeutic goal:
  - Control psychosis
  - Induce sleep and sedation

ADJUNCTIVE MEDICATIONS

- First line: and a high or medium potency antipsychotic to the mood stabilizer
  - Benzodiazepine may be added to the antipsychotic and mood stabilizer
  - Low potency antipsychotic

ADJUNCTIVE MEDICATIONS

- Severe mania without psychosis
  - Add a benzodiazepine to the mood stabilizer
  - Add a high or medium potency antipsychotic to the mood stabilizer and benzodiazepine.

ADJUNCTIVE MEDICATIONS

- Hypomaniac:
  - Add a benzodiazepine to the mood stabilizer
  - Add a high or medium potency antipsychotic
    - This is rarely needed, but is sometimes helpful.

TREATING THE ACUTE PHASE

- Major depression with psychotic features:
  - ECT
  - Mood stabilizer and antidepressant with an antipsychotic
TREATING THE ACUTE PHASE

- Severe major depression, no psychosis:
  - Mood stabilizer and antidepressant
  - Do not use antidepressants as an monotherapy to prevent mania/hypomanic episodes
  - Phototherapy when depression occurs in late fall or winter

- Milder major depressive episode:
  - Mood stabilizer and an antidepressant
  - Mood stabilizer alone

ADJUNCTIVE MEDICATIONS

- Insomnia:
  - Add benzodiazepine
  - Second line
    – Add trazodone
    – May use a sedating antidepressant

- Psychotic symptoms in the depression:
  - Add a high or medium potency conventional antipsychotic in addition to the mood stabilizer and antidepressant regimen

IMPORTANT ITEMS TO NOTE

- When starting a patient on an antidepressant for severe depressive episode; note mood changes to determine if the mood has switched into a mania or hypomania
- If the patient demonstrates manic or hypomanic symptoms, discontinue the antidepressant

- Check thyroid function studies
- Individuals with rapid cycling bipolar disorder frequently have hypothalamic-pituitary-thyroid axis abnormalities
- Cytomel 25 to 75 mcg per day (T3)
- Levothroid 50 to 200 mcg per day (T4)
WHEN TO ADMIT A PATIENT TO THE INPATIENT UNIT

- High risk for suicide
- A high risk for violence
- Severe psychosis
- Deterioration in self care

ALTERNATIVES FOR HOSPITALIZATION

- Use intensive outpatient program when the patient needs medication check for 3-5 days a week

ALTERNATIVES FOR HOSPITALIZATION

- Outpatient treatment is needed when there is medication management and psychotherapy

PSYCHOTHERAPY

- Most effective psychotherapeutic techniques:
  - Depression: Interpersonal or cognitive/behavioral

PSYCHOTHERAPY

Manic and depression:

Meet with family and review stressors that lead up to the latest episode

EDUCATION OF THE PATIENT

- Symptoms of the illness
- Maintain a journal of the symptoms
- Teach about the biological nature of illness
EDUCATION OF THE PATIENT

- Discuss medications
- Purpose
- Side effects
- Consistency of adhering to the regimen
- Discuss when medication adjustments are needed
- Discuss work and social schedules

EDUCATION OF THE PATIENT

- Discuss role of family and friends; work and social stressors
- Determine warning signs of relapse
- Maintain good sleep hygiene

EDUCATION OF THE PATIENT

- Eat a healthy diet and exercise
- Use caffeine and alcohol moderately
- Discuss meaning of illness and issues surrounding the illness (impact on work, marriage, children, peers)

EDUCATION OF THE PATIENT

- Evaluate the patient’s mood
- Ability to sleep
- Eating patterns
- Energy level

INTERVENTIONS

- Evaluate the patient’s ability to relate to others by behaving in a manner that would not cause later shame

HARM-REDUCTION TECHNIQUES FOR MANIA

- Entrust a friend or family member his/her credit cards to prevent excessive spending.
- Give his/her keys to an appointed friend or family member to prevent traffic accidents or violations.
- Remove alcohol, drugs and firearms from the home
- Relieve the patient of child care responsibilities
FAMILY NEEDS

- The family members need support to recognize symptoms and encourage the patient to seek treatment.

USEFUL WEB SITES

- www.nimh.nih.gov/publicat/bipolar.cfm
- www.psychtracker.com
- www.moodtracker.com

BIBLIOGRAPHY


