Bipolar disorder workshop

STAFF

Person Centered Medicine from Bench to Bedside (PHA-6020Y)

Clinical Workshop

By the end of this workshop you should be able to:

- Identify and discuss the potential causes of bipolar disorder
- Evaluate the potential non-pharmaceutical and pharmaceutical interventions for bipolar disorder
- Review patient cases including patients with bipolar disorder and formulate an appropriate pharmaceutical care plan

The information you need to answer the questions are in the lecture and supplementary material on BB.

Please answer task 1 and 2 and we will work through the case studies in the workshop

Task 1: Features of Bipolar Disorder

1) Complete the table below listing the common features of Hypomania/mania and bipolar depression:

Hypomania/Mania	**Bipolar depression**
Abnormal elevated mood	Decreased energy
Easily distracted	Fatigue
Flight of ideas	Poor sleep
Obsessive pre-occupation with some idea, activity or desire	Lethargy
Overactive and intrusive	Doing less
Risk taking	Anhedonia
	Feelings of wanting to self-harm

Task 2: Medication options

2) Use the list of medication below, to complete the table identifying which medication(s) may be suitable to manage the stated symptoms (each medication may be used once, more than once or not at all).

Medication: lamotrigine, lithium, lorazepam, olanzapine, quetiapine, sodium valproate, SSRIs/SNRIs, TCAs, Zopiclone.

Over activity, intrusive bizarre behaviour	Lorazepam (Short term- calm down)
Lack of sleep/up all night	Zopiclone, lorazepam at night or mood stabilising antipsychotic
Aggression	lorazepam
Mood stabilisation and relapse prevention	Lithium, quetiapine
Low mood	SSRI, SNRI, antipsychotic
Acute mania/hypomania	Quetiapine, olanzapine, lorazepam
Bipolar depression and relapse prevention	Lamotrigine, SSRI, SNRI, quetiapine, olanzapine

Case study 1

SW is 35 years old, known to mental health services and has had repeated admissions to hospital.

She has been lodging with a friend who is in despair at her chaotic behaviour and states that she is spending money on irrelevant goods, she is full of self-importance and is very intrusive into everything that is going on in the house.

She has been admitted to hospital with elevated mood, pressure of speech and increasingly chaotic behaviour.

She is dressed in brightly coloured clothes and wears heavy make-up. She describes a ‘cycling’ of mood from periods of low to high and she is ‘flirtatious’ with male members of staff.

SW has a poor diet and she is underweight.

She started lithium therapy 2 months ago and is wearing a support bandage on her leg. She stated that she bounced off a trampoline at the weekend and hurt her leg.

She also says she is using alcohol to get her to sleep as the zopiclone doesn’t work anymore. However, she has been trying to reduce her alcohol consumption lately on her GP’s advice.

See further records on next page:

Past Medical History			
Bipolar Affective disorder Insomnia Swollen Ankle			
Drug Allergies		Reaction	
Unknown		Unknown	
Family History			
Mother suffers from bipolar affective disorder			
Social History			
Smoker Alcohol consumption with an audit C score of 12 Drug Screen negative			
Weight	49 Kg	Height	1.4 m
Current medication			
Combined oral contraceptive pill Lithium tablets 200mg at breakfast Thiamine tablets 50 mg daily Zopiclone 7.5 mg bedtime Ibuprofen tables 400 mg three times a day			
Recent blood tests			
Lithium level 0.2 mmol/Litre			

1) Why do you believe the patient has been referred to the acute mental health ward and what are her signs and symptoms of illness? (Include your potential differential diagnosis?

Reason for referral (Signs and symptoms of illness):
Previous bipolar diagnosis
Signs of hypomanic episode:

- Elevated mood
- Over familiar/disinhibition/risk taking
- pressure of speech/increased talkativeness
- Speeding spree
- Grandiose
- Poor sleep
- Intrusive
- Poor diet
- Under weight
- Bright appearance

Differential diagnosis:
Schizophrenia/unipolar depression/alcohol misuse?

2) What are the most likely indication(s) for the current prescribed medication?

Medication	**Indication**
Combined oral contraceptive pill	Contraceptive (Is this enough if she is sexual disinhibited)
Lithium tablets 200mg at breakfast	Acute mania/hypomanic episodes, prophylaxis f bipolar mood disorder
Thiamine tablets 50 mg daily	Prevention of Wernicke's encephalopathy in regular drinkers
Zopiclone 7.5 mg bedtime	Insomnia
Ibuprofen tables 400 mg three times a day	Anti-inflammatory for her leg trampoline injury

3) Please complete the recommended action and ongoing review and monitoring columns for this partially completed care plan (Part 1)

Care intervention	Recommended Action	Ongoing review and monitoring parameters (including frequency)
Clarification of patients' drug history	• Confirm with GP notes • Check if patient can confirm medication and allergy status • Check if any medications have been brought into hospital • Check contraceptive cover and if had a pregnancy test	Check patients drug chat against history and confirm no unintentional omissions

Lithium (Level, optimisation, dosing)	• Persevere and optimise treatment as the lithium dose if too low. It should be taken at night to minimise renal damage and ensue accurate blood levels
	• Suggest increase lithium to 400mg night then adjust levels according to lithium levels, plasma levels measured after 5-7 days after dose change
	  • TDM, minimum effective level 0.4-0.8 but can go higher for mania 0.8-1.0
	  • Blood samples should be taken 10-12 hours post dose
	  • Dose should be taken at bedtime
		• Plasma levels monitored every 3 months with:
		  • BMI
		  • U & Es
		  • Calcium
		  • eGFR
		  • TFTs
		• Poor diet may be restricting fluid which can increase toxicity. Kep hydrated
		• Monitor for signs of toxicity
		  • Nausea, diarrhoea, blurred vision, polyurea, light headiness, fine resting tremor, muscle weakness and drowsiness
		Side effects: thyroid disturbances, weight gain, fine tremor, GIT disturbances, renal disorders – permanent renal damage

Mania control	• Potentially stop lithium (low dose and level, delay onset for mania 5-7 days) • Start mood stabilising antipsychotic such as quetiapine: 300 mg day 1, 600 mg day 2, 800 mg thereafter, while lithium has chance ot work • Lorazepam may be used as 'calming agent' 1mg qds prn (beware tolerance and restrict to 2-4 weeks • Haloperidol sometimes used (beware EPSE)	Quetiapine monitoring parameters: Baseline: Oral glucose tolerance test or FPG HbA1c Then every 12 months Lipid profile at start and 3 monthly ECG Weight & height – be aware of weight gain

4) Please complete the recommended action and ongoing review and monitoring columns for this partially completed care plan (Part 2)

Care intervention	Recommended Action	Ongoing review and monitoring parameters (including frequency)
Ibuprofen	Interaction with lithium (major interaction and litigation) 2 options: • Determine is SW taking intermittently, if so ibuprofen time limited • Could SW make do with Paracetamol 1g QDS (to avoid interaction)	• Monitor pain relief of injured ankle • If continue with ibuprofen, monitor lithium more regularly until ibuprofen discontinued
Alcohol	• SW self-medicating with alcohol • Alcohol may be driving her symptoms 9ee dot explain this, not beneficial an once acute illness over may not feel urge. • Audit C of 12 indicates brief intervention needed • 14 units per week • Harm o fuse (depressant and poly substance) • Signpost to AA, relapse prevention groups • Alcohol diary • Alcohol affects mood, if mood managed may not be needed • Slow reduction (not sudden stop) • Nalmefene may be beneficial (1-2 hours before drinking)	Monitor regularly (use FRAMES) **F**eedback – use and risk of harm **R**esponsibility – choice **A**dvice – increase self belief/confidence **M**enu – offer strategies, **E**mpathy – non-judgemental **S**elf-efficacy – instal optimise about goal
Thiamine	• Only small amount absorbed so take 2-3 times a day • Reinforce used to prevent Wenicke's encephalopathy • Good diet key: • Poor eating, vomit, alcohol can damage stomach lining – hence poor absorption • Wernicke's (uncontrollable eye movement, poor coordination, confusion and memory loss) • Ocular disturbances • Changes in mental stat • Unsteady gait • Can lead to Korsakoff's psychosis (irreversible) 100m TDS thiamine	Review thiamine if SW reduces alcohol

	Consider IM/IV pabrinex if heavy drinking	
Contraceptive	• Effective contraception required while taking Lithium, C/I first trimester • Discuss alternatives – e.g. Implants • State risks of pregnancy whilst taking lithium	Ensure adequate contraception continued

5) Please complete the recommended action and ongoing review and monitoring columns for this partially completed care plan (Part 3)

Care intervention	Recommended Action	Ongoing review and monitoring parameters (including frequency)
Weight	Significant weight gain with lithium and quetiapine If problematic, consider aripiprazole 5-10mg increase to 15-30mg (better metabolic profile). Quetiapine more robust for bipolar disorder • Weight monitoring • 20% of patient on lithium put on weight, therefore diet and exercise key	Beware of agitation with aripiprazole

Insomnia	• Lack of sleep affecting mood and driving symptoms
	• May have become tolerant to zopiclone (stop and switch to promethazine 25-50mg at night)
	• Alternatively, if quetiapine prescribed then that may be a suitable replacement
	• Sleep hygiene:
	  • Avoid excessive caffeine, alcohol and nicotine
	  • Do not stay in bed for prolonged periods if not asleep
	  • Avoid daytime naps
	  • A warm bath or gentle exercise may help
	  • Mak bed and bedroom comfortable
	  • Regular routine
	  • Diet high in carbohydrates (nu not a big meal within 2 hours)
	  • Avoid backlit screens 2 hour prior to bed (inhibit blue light)
		Monitor sleep pattern, hypnotics only used for 2-4 weeks

Non-pharmacological advice	• DVLA notified (acute illness – patients responsibility) • Help SW identify triggers for illness-mania • CBT and family therapy may be helpful • Psychosocial interventions may help Efficacy, side effects, adherence, alternative therapies, increase staying well and reduce relapse	• Social support • Monitor engagement with psychologist • Signpost alcohol support • Discuss trigger factors • Financial support • Employment support

	Check with nursing staff expected discharge and resolve any adherence issues, inform community support worker of any issues	• Engagement with community mental health tams • Sign post smoking cessation • Signpost MIND • Monitor response to treatment and tolerability and adherence every 3-6 months