ESSENTIALS OF BIPOLAR DISORDER – DIAGNOSIS FOR THE GENERAL PRACTITIONER

Introduction

Bipolar disorder is a common, severe and persistent mental illness that affects about 1% of the population. For patients suffering with bipolar, it usually implies a lifelong struggle and challenge. For this reason, it is essential to make the correct diagnosis of the disorder as this leads to appropriate and effective treatment.

Bipolar disorder used to be called ‘manic-depressive illness’ in old terminology, but with the evolution of and new insights into the illness, the name was changed to ‘bipolar disorder’. Essentially the term describes extreme mood swings, which can range from severe, prolonged depression on the one pole to an excessively elevated or irritable mood (mania) on the other. Most people experience both highs and lows to various degrees and in various patterns over time, usually with periods of normal mood in between. Other variations include a ‘mixed’ picture, where both highs and lows are experienced at the same time.

KEY MESSAGES

• Bipolar disorder is characterised by extreme mood swings. A useful tool in the assessment of a possible bipolar condition is the Mood Disorder Questionnaire (available at http://www.dbsalliance.org/pdfs/MDQ.pdf)

• Potential causes of mood swings, such as medications and other neurological conditions, need to be excluded before making the diagnosis of bipolar disorder

• General practitioners are well placed to support patients with this condition. Referral criteria have been usefully defined in the UK NICE guidelines and are appropriate for the South African setting

Signs and symptoms

Both the ICD-10¹ and the DSM-5² give detailed criteria for the diagnosis of bipolar disorder and its various phases. Important indicators that a patient might have bipolar disorder are: symptoms and signs of mania and hypomania, which can include the following types of behaviour that are out of character for the individual as a whole:¹

• Feeling energised and ‘wired’
• Excessively seeking stimulation
• Overly driven in pursuit of goals
• Needing less sleep
• Irritable if stopped from carrying out ideas

• Disinhibited and flirtatious
• Offensive or insensitive to the needs of others
• Spending money in an unusual manner or inappropriately
• Indiscreet and disregarding social boundaries
• Having poor self-regulation
• Making excessively creative and grandiose plans
• Having difficulty discussing issues rationally or maturely
• Reporting enhanced sensory experiences

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¹ International Statistical Classification of Diseases and Related Health Problems, 10th Revision
² Diagnostic and Statistical Manual of Mental Disorders, 5th Edition
The criteria of the DSM-5 require that symptoms of mania should last at least one week (four consecutive days for hypomania) and be present most of the day nearly every day before a diagnosis is made.

Major depressive episodes are characterised by the following symptoms and should be present during the same two-week period (at least one of the symptoms being either a depressed mood or a mood characterised by a loss of pleasure or interest):2

- Depressed mood

Assessment

Due to the complexity of bipolar disorder, a full psychiatric assessment should be done on each patient, regardless of whether he/she is undergoing a manic, hypomaniac, depressed or mixed episode. This is especially important when the possibility of bipolar disorder is suspected. By convention, a history (longitudinal) with mental status examination is done with a particular focus on the current clinical status of the patient.

As an adjunct to the clinical interview, some standardised tools have been developed to obtain the necessary information about the symptoms, symptom severity and effects on daily functioning required to diagnose bipolar disorder. The most notable are the Structured Clinical Interview for DSM-IV/V (SCID) and the Schedule for Affective Disorders and Schizophrenia (SADS). These are unfortunately lengthy to use and require some prior training for the physician. A commonly used short screening tool is the Mood Disorder Questionnaire (MDQ). The MDQ has only 13 items, is completed by the patient and is reported to have had high sensitivity for identifying bipolar disorder in a community sample.

Once a diagnosis has been made, the severity of the episode should be established. The severity of a manic episode can be measured using the Young Mania Rating Scale (YMRS), which is the most widely advocated tool. The assessment of hypomania remains more difficult. However, the Hypomanic Personality Scale (HPS) has been developed to help with the identification of these subtle symptoms. Standard scales may be used to measure depression, e.g. Beck Depression Inventory, Zung Depression Self-Rating Scale and the Montgomery-Asberg Depression Rating Scale (MADRS), to mention a few.

For general practitioners (GPs), the continuous monitoring of symptoms and functioning is pivotal for people suffering from chronic, recurrent conditions like bipolar disorder. It is recommended that the same standardised questionnaire used initially be further utilised to monitor treatment response at follow-up visits, after each change in treatment, and to periodically assess the patient’s response to treatment until full remission/recovery is achieved.

Diagnosis of bipolar disorder

Examination of patients with suspected bipolar affective disorder includes evaluation using the standard Mental Status Examination (MSE) with special focus on the following areas:4, 5

- Appearance
- Affect/mood
- Thought content
- Perception

- Markedly diminished pleasure or interest in nearly all activities
- Significant weight loss or gain or significant loss or increase in appetite
- Hypersomnia or insomnia
- Psychomotor retardation or agitation
- Loss of energy or fatigue
- Feelings of worthlessness or excessive guilt
- Decreased concentration ability or marked indecisiveness
- Preoccupation with death or suicide; patient has a plan or has attempted suicide

Areas to be assessed during the clinical status evaluation should focus on the following:6

- Suicide/self-destruction
- Homicide/violence/aggression
- Judgment/insight
- Cognition
- Physical health
• Medical comorbidity (Comorbid medical problems that can contribute to mood dysregulation)
• Psychiatric comorbidity (It is important to assess for and treat all psychiatric comorbid conditions)
• Psychosocial stressors (Current stressors can contribute to mood problems and adherence to treatment)
• Current medications (Assess the frequency and dosages of all prescribed and over-the-counter medications the patient is taking)
• Past medications (Check for previous historical response to mood stabilisers; note reasons for discontinuation, including side-effect problems and non-response)
• Medication compliance (Evaluate whether the patient has been compliant in the past with medication treatment)
• Suicide risk (Evaluate risk factors for suicide, including family history, previous attempts and co-occurring substance use)
• Substance use (Substance abuse can contribute to or precipitate a relapse; it can also be a reason for medication non-response)

Differential diagnoses

Many other psychiatric, neurological and medical disorders and pharmacological agents can produce symptoms of depression, hypomania or mania. It is important to consider these potential causes.

When to refer bipolar disorder patients to specialist care

The 2006 NICE guidelines for bipolar disorder give clear criteria for referral of bipolar patients to a specialist psychiatrist. They divide their referral criteria into two broad categories (see Table 1): Firstly, in a newly diagnosed patient or a patient with suspected bipolar disorder, and secondly, patients with existing bipolar disorder.

GPs are in the ideal position to coordinate the care of patients with bipolar disorder. Care in general practice will usually include ongoing management of both a patient’s mental and physical conditions. Further, the GP is best placed to understand the patient’s social circumstances and monitor progress. The GP may also coordinate care of the patient among various members of the ‘mental health team’ (e.g. psychiatrist and psychologist).
Table 1: Criteria for referral of bipolar patients to a specialist psychiatrist (NICE 2006)*

A. If new or suspected bipolar disorder:

- refer urgently patients with mania or severe depression who are a danger to themselves or other people
- refer for assessment and development of a care plan, patients with either:
  - periods of overactive, disinhibited behaviour lasting at least four days, with or without periods of depression, or
  - three or more depressive episodes and a history of overactive, disinhibited behaviour
- ask about hypomanic symptoms when assessing a patient with depression and overactive, disinhibited behaviour

B. Patients with existing bipolar disorder:

- consider referring a new patient with existing bipolar disorder who registers with the practice
- refer urgently a patient with bipolar disorder managed solely in primary care if there is:
  - an acute exacerbation of symptoms – particularly mania or severe depression
  - an increase in the degree (or change in the nature) of risk to self or others
- consider review in secondary care, or increased contact in primary care, for a patient managed solely in primary care, if:
  - functioning declines significantly or response to treatment is poor
  - treatment adherence is a problem – you suspect alcohol and/or drug misuse
  - the patient is considering stopping prophylactic medication.

References

6. USA Department of Veterans Affairs/Department of Defence: Clinical Practice Guideline for Management of Bipolar Disorder in Adults (Version 2.0 – 2009).
7. NICE (July 2006). Bipolar Disorder. www.nice.org.uk