Bipolar Disorder

OVERVIEW

Bipolar affective disorder, or manic-depressive illness (MDI), is a common, severe, and persistent mental illness. This condition is a serious lifelong struggle and challenge. Other mental disorders and general medical conditions are more prevalent in patients with bipolar disorders than in patients in the general population. Among the general comorbid conditions, cardiometabolic conditions such as cardiovascular disease, diabetes, and obesity are a common source of morbidity and mortality for persons with bipolar disorder.

The lifelong prevalence of bipolar affective disorder, or manic-depressive illness (MDI), including subsyndromal forms in the United States has been noted to range from 3.7% to 3.9%. However, the prevalence in patients who present with depression is higher in primary care (21-26%) and psychiatric clinic settings (28-49%). Studies also indicate differences in lifetime prevalence estimates for bipolar disorder type I (BPI) (1.0%), bipolar disorder type II (BPII) (1.1%), and subthreshold bipolar disorders (2.4-4.7%). The age of onset of bipolar disorder varies greatly. For both BPI and BPII, the age range is from childhood to 50 years, with a mean age of approximately 21 years. Most cases of bipolar disorder commence when individuals are aged 15-19 years. The second most frequent age range of onset is 20-24 years. Some patients diagnosed with recurrent major depression may indeed have bipolar disorder and go on to develop their first manic episode when older than 50 years. These individuals may have a family history of bipolar disorder. However, for most patients, the onset of mania in people older than 50 years should lead to an investigation for medical or neurologic disorders, such as cerebrovascular disease.

Signs and Symptoms

Bipolar affective disorder is characterized by periods of deep, prolonged, and profound depression that alternate with periods of an excessively elevated or irritable mood known as mania. Manic episodes are feature at least 1 week of profound mood disturbance, characterized by elation, irritability, or expansiveness (referred to as gateway criteria). At least 3 of the following symptoms must also be present:

- Grandiosity
- Diminished need for sleep
- Excessive talking or pressured speech
- Racing thoughts or flight of ideas
- Clear evidence of distractibility
- Increased level of goal-focused activity at home, at work, or sexually
- Excessive pleasurable activities, often with painful consequences

Hypomanic episodes are characterized by an elevated, expansive, or irritable mood of at least 4 consecutive days' duration. At least 3 of the following symptoms are also present:

- Grandiosity or inflated self-esteem
- Diminished need for sleep

- Pressured speech
- Racing thoughts or flight of ideas
- Clear evidence of distractibility
- Increased level of goal-focused activity at home, at work, or sexually
- Engaging in activities with a high potential for painful consequences

Major depressive episodes are characterized as, for the same 2 weeks, the person experiences 5 or more of the following symptoms, with at least 1 of the symptoms being either a depressed mood or characterized by loss of pleasure or interest:

Depressed mood

- 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

Diagnosis

Examination of patients with suspected bipolar affective disorder includes evaluation using the Mental Status Examination as well as assessment of the following:

- Appearance
- Affect/mood
- Thought content
- Perception
- Suicide/self-destruction
- Homicide/violence/aggression
- Judgment/insight
- Cognition
- Physical health

Testing

Although bipolar disorder is diagnosed based on the patient’s history and clinical course, laboratory studies may be necessary to rule out other potential causes of the patient’s signs and symptoms as well as to have baseline results before administering certain medications. Laboratory tests that may be helpful include the following:

- CBC count
- ESR levels
- Fasting glucose levels
- Electrolyte levels
- Protein levels
- Thyroid hormone levels
- Creatinine and blood urea nitrogen levels
- Liver and lipid panel
- Substance and alcohol screening

Depending on the patient’s presentation, other laboratory tests may be indicated, which may include urinary copper levels, antinuclear antibody testing, HIV testing and/or VDRL testing. Electrocardiography is important in elderly patients and before antidepressant therapy. Electroencephalography and/or MRI may be appropriate for selected patients.

Management

The treatment of bipolar affective disorder is directly related to the phase of the episode (ie, depression or mania) and the severity of that phase, and it may involve a combination of psychotherapy and medication. Always evaluate patients with mania, hypomania, or mixed episode, and those with bipolar depression, for suicidality, acute or chronic psychosis, or other unstable or dangerous conditions.

Pharmacotherapy

Medications used to manage patients with bipolar disorder include the following:

- Benzodiazepines (e.g., lorazepam, clonazepam)
- Antimanic agents (e.g., lithium)
- Anticonvulsants (e.g, carbamazepine, valproate sodium, valproic acid, divalproex sodium, lamotrigine, topiramate)
- First-generation antipsychotics (e.g., inhaled loxapine, haloperidol)
- Second-generation antipsychotics (e.g., asenapine, ziprasidone, quetiapine, risperidone, aripiprazole, olanzapine, olanzapine and fluoxetine, clozapine, paliperidone)
- Phenothiazine antipsychotics (e.g., chlorpromazine)
- Dopamine agonists (e.g., pramipexole)

Nonpharmacotherapy

Psychotherapy may help to decrease relapse rates, improve quality of life, and/or increase functioning, or more favorable symptom improvement. Electroconvulsive therapy may be useful in selected patients with bipolar disorder.

PROFESSIONAL ORGANIZATIONS

WellCare adheres to the American Psychiatric Association (2002) *Practice Guideline for the Treatment of Patients with Bipolar Disorder, Second Edition.* WellCare adheres to the 2005 *Guideline Watch* – the document contains an update of the 2002 guideline. The text of both can be found at http://psychiatryonline.org/guidelines

MEMBER EDUCATION

Treatment of patients with bipolar affective disorder, or manic-depressive illness (MDI), involves initial and ongoing patient education. To this end, a strong therapeutic alliance is essential.

Educational efforts must be directed not only toward the patient but also toward their family and support system. Furthermore, evidence continues to mount that these educational efforts not only increase patient compliance and their knowledge of the disease, but also their quality of life.

An explanation of the biology of the disease must be provided. This decreases feelings of guilt and promotes medication compliance. Information should be provided on how to monitor the illness in terms of an appreciation of the early warning signs, reemergence, and symptoms. Recognition of changes can serve as a powerful preventive step.

Education must also encompass the dangers of stressors. Helping the individual identify and work with stressors provides a critical aspect of patient and family awareness. Efforts should be made to educate the patient about relapses within the total context of the disorder.

Individual stories help patients and families. The National Institute of Mental Health (NIMH) has a story of a person with manic-depressive illness that can help the patient see the struggle and challenge from another perspective.[34] Others have written about their family struggles and challenges.

It is important resources for patients and families to gain information on dealing with manic-depressive illness. A thorough list of resources is available here.

MEASURES OF COMPLIANCE

CMS has not published any measures for this topic.

NCQA has published the following measure for this topic:

Follow-Up After Hospitalization for Mental Illness. Members who are hospitalized due to a mental health diagnosis should follow up with a mental health practitioner:

- 7-Day Follow-Up should include an outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 7 days after discharge.
- 30 Day Follow-Up should include an outpatient visit, intensive outpatient visit or partial hospitalization with a mental health practitioner within 30 days after discharge.

Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications. Members 18 to 64 years of age with schizophrenia or bipolar disorder who were dispensed an antipsychotic medication should have an annual diabetes screening.

RELATED CLINICAL PRACTICE GUIDELINES

In addition to the information contained in this document, please reference the following CPGs:

- *Persons with Serious Mental Illness and Medical Co-Morbidities :* HS 1044

REFERENCES

1. Practice guideline for the treatment of patients with bipolar disorder (2nd ed.). American Psychiatric Association Web site. http://psychiatryonline.org/guidelines. Published 2002. Accessed February 3, 2015.

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MEDICAL POLICY COMMITTEE HISTORY AND REVISIONS

Date	History and Revisions by the Medical Policy Committee
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3/7/2013	• Approved by MPC. New guideline.