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Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

MY PATIENT IS MANIC (?) AT MY CLINIC WHAT SHOULD I DO?

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UNIVERSITY OF WASHINGTON

OBJECTIVES

- Review criteria for mania and hypomania symptoms
- Identify importance of prodromal symptoms for acute mania
- Discuss ways to prevent escalation of mania and ambulatory treatment of mania

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WHY DO WE CARE ABOUT TREATING MANIA (OR BIPOLAR)?

- ↑ risk for suicide
- ↑ involvement in high risk behaviors
- ↑ rates of trauma-related deaths
- ↑ criminal justice involvement
- ↑ unemployment

Schaffer A, et al, 2015; Stewart AJ, et al, 2012; Fond G, et al, 2019; Christopher P, et al, 2012; Bowdon, CL, 2005

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CASE: NEW MANIA?

21yo M presents to clinic before heading off to school because he thinks he is "manic." He describes irritability, poor sleep, and restlessness. Denies any high-risk behaviors and is currently living at home. No SI/HI/AVH.

Substances: CBD oil, 2-3 drinks alcohol/mo, no drugs

PE: unremarkable

MSE: irritable, rapid speech, tangential, psychomotor agitation

Past History: depression and anxiety

Current Meds: Sertraline 100mg qday

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CASE: NEW MANIA

Questions that might cross your mind...

Is this person really manic?

Does he need to be hospitalized?

What if he refuses to be hospitalized?

What meds should I start?

Who can I call for help?

Current Meds: Sertraline 100mg qday

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WHAT IS THE MOST COMMON MANIC SYMPTOM?

A. Hyperactivity
B. Euphoria
C. Decreased need for sleep
D. Pressured speech
E. Grandiosity

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WHAT IS THE MOST COMMON SET OF MANIC SYMPTOMS?

A. Hyperactivity (90%)
B. Euphoria (63%)
C. Decreased need for sleep (83%)
D. Pressured speech (88%)
E. Grandiosity (73%)

Screening Question:
“Apart from the times when you’re depressed and when your mood is normal, do you have periods when
you’re energized and wired?”

Solomon DA et al, 2010; Parker G, 2021 Carlat Report

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TOP 10 MOST FREQUENT MANIC SYMPTOMS

1. Hyperactivity: 90%
2. Hyperverbal: 89%
3. Rapid, pressured speech: 88%
4. Decreased sleep: 83%
5. Flight of ideas/racing thoughts: 76%
6. Distractibility/poor concentration: 75%
7. Grandiosity: 73%
8. Irritability: 71%
9. Euphoria: 63%
10. Presence or history of psychotic symptoms (hallucinations and delusions): 61%

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MANIC EPISODE-DSM5

- Distinct period of abnormally and persistently elevated, expansive, or irritable **mood** & increased **energy**, lasting **≥ 1 week**, nearly every day

And...

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MANIC EPISODE-DSM5

- 3 or more of the following, 4 if mood is only irritable
  - Inflated self-esteem or grandiosity
  - Decreased need for sleep
  - More talkative than usual or pressure to keep talking
  - Flight of ideas or subjective experience that thoughts are racing
  - Distractibility as reported or observed
  - Increase in goal-directed activity or agitation
  - Excessive involvement in activities that have a high potential for painful consequences

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MANIC EPISODE-DSM5

- Disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to **necessitate hospitalization**, or there are **psychotic** features

- Not attributable to physiological effects of a substance or medical condition
  - If emerges and persists at syndrome level beyond physiological effect of antidepressant treatment (including ECT)→manic episode

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WHICH OF THE FOLLOWING IS ACCURATE?

A. Hypomania is not always observable by others
B. Hypomania needs only 3 or more of the 7 symptoms
C. Hypomania can include psychotic symptoms
D. Hypomania can be severe enough cause marked impairment in social, or occupational functioning, or necessitate inpt stay

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BIPOLAR DISORDER

- Bipolar I
  - 12 month prevalence: 0.6%
  - Age of onset: 18yo
  - 60% of manic episodes occur immediately before depressive episode
  - Mid or late-life onset→consider neuro or substance
- Bipolar II
  - 12 month prevalence: 0.3%
  - Age of onset: mid-20's
  - Number of episodes higher vs Bipolar I
  - 5-15% may transition to Bipolar I

DSM 5

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MANIA COURSE

- May develop sudden over a few days
- Duration: weeks to months
  - Prospective observational study of 246 patients
    - 25% recovered within 4 weeks
    - 50-75% recovered within 7-15 weeks

Solomon DA et al, 2010

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CASE: PRODROMAL MANIA

Questions that might cross your mind…

Do I need to be concerned about this?
Should I just give her what she is requesting?
Are there other meds that would be better?

200mg qday

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CASE: PRODROMAL MANIA

<u>What would you do next?</u>

A. Prescribe Zolpidem 10mg qhs prn
B. Increase dose of Haloperidol to 2mg QHS
C. Switch her to Olanzapine 2.5mg qhs
D. Send her to the ED
E. Start her on melatonin
F. Other

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WHAT ARE SOME MANIA PRODROMAL SYMPTOMS?

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PRODROMAL MANIA SYMPTOMS

Symptom	Number of Patients (N=60)
Hostility	54 (90%)
Overactivity	52 (87%)
Ideas of grandiosity	48 (80%)
Meddling and arguing	46 (77%)
Reduced sleep	46 (77%)
Does not need much sleep	44 (73%)
Irritability	44 (73%)
Elation	42 (73%)
Pressure of Speech	40 (67%)
Overspending	36 (60%)
Distractibility	34 (57%)
Being uncooperative	32 (53%)
Senses seem to be sharper	30 (50%)

Sahoo MK et al, 2012

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PRODROMAL MANIA SYMPTOMS

- Relative vs Patient Report

# Subjects who reported prodromal symptoms	
Patients	21 (70%)
Relatives	29 (97%)

Duration of prodromal period	
Patients	Mean 20 days
Relatives	Mean 25 days

- Range of 20-29 days
- Other studies: As few as 50% of patient may recognize it

Sahoo MK et al, 2012; Mantere O et al, 2008; Molnar GJ et al, 1988; Smith JA et al, 1992

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ADDRESSING PRODROMAL SYMPTOMS

What could you do to address prodromal symptoms?

- Medication adherence?
- Sleep habits?
- Regular routine?
- Substance use?
- What has helped in the past?

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ADDRESSING PRODROMAL SYMPTOMS

- Will need to tailor intervention to length of prodrome
- Modifying excessive behavior
  - Prioritizing and reducing tasks
- Engage in calming activities
- Taking time to rest
- See a provider
- Stay in routine
- Eat
- Continue to identify and monitor symptoms

Lam D et al, 2005

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MEDICATION ADJUSTMENTS IN PRODROMAL STAGE

- What has worked in the past?
- Increase dose of Antipsychotic
- Start an antipsychotic
  - Sedating: Olanzapine and Quetiapine
  - Risperidone and Abilify are also good option (more EPS issues, but less metabolic issues)

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CASE: PRODROMAL MANIA

-REST OF THE CASE

- Prescribed hydroxyzine for sleep and anxiety. Patient left country to visit family. Hospitalized while on trip for acute mania x 2 weeks. Eventually discharged and returned to US.

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CASE: NEW MANIA?

20yo M presents to clinic before heading off to school because he thinks he is “manic.” He describes irritability, poor sleep, and restlessness. Denies any high-risk behaviors and is currently living at home. No SI/HI/AVH.

Substances: CBD oil < daily, 2-3 drinks alcohol/mo, no drugs

PE: unremarkable

MSE: irritable, rapid speech, tangential, psychomotor agitation

Past History: depression and anxiety

Current Meds: Sertraline 100mg qday x 4 years for panic/anxiety

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CASE: NEW MANIA

What would you do next? (ok to choose multiple)

A. Start Olanzapine 5mg qday
B. Start Lamictal 25mg qday
C. Send him to the ED
D. Start Lithium 300mg bid
E. Stop Sertraline

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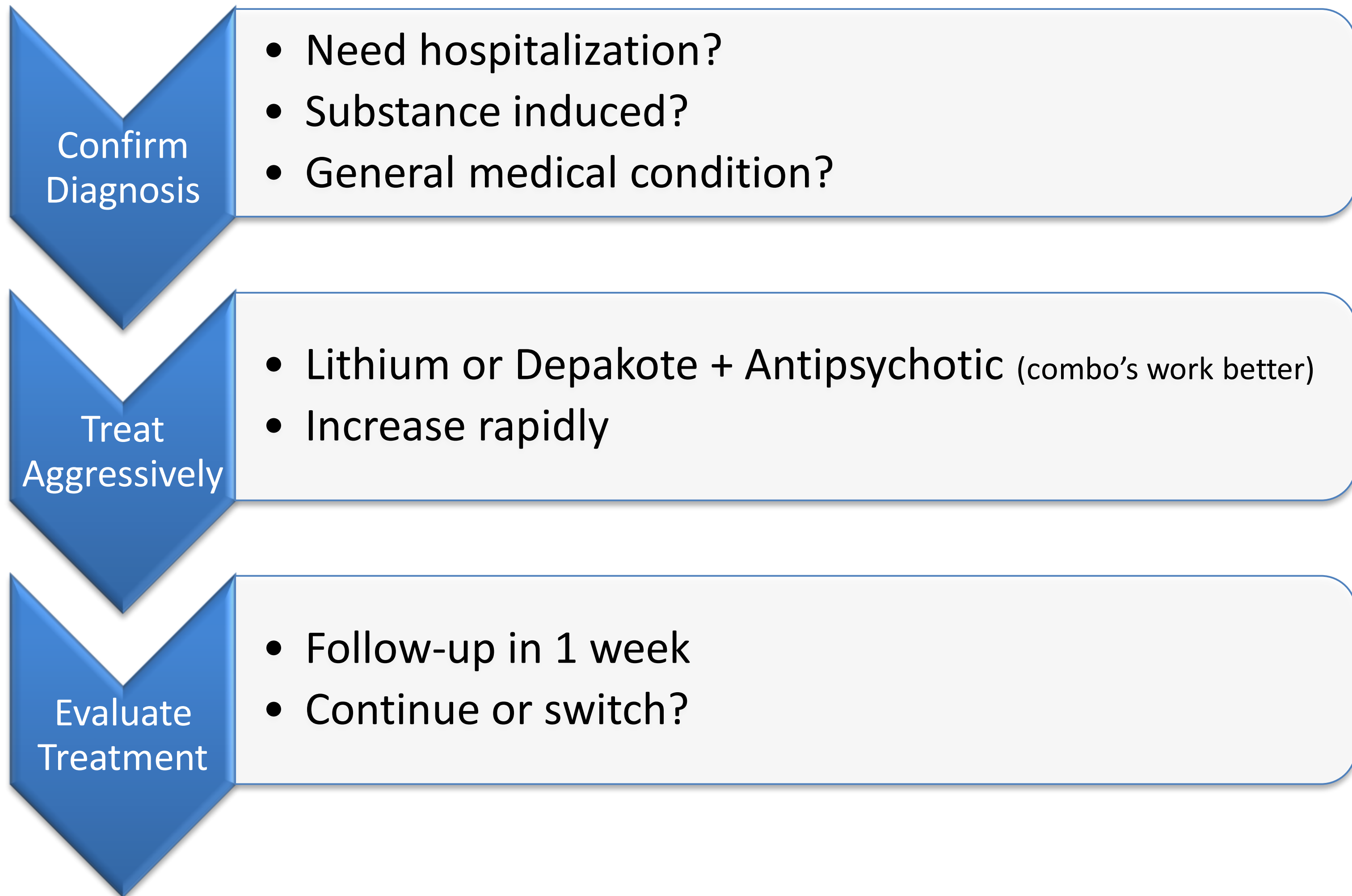
TREATING APPROACH: MANIA (SEVERE)



Ogawa Y et al, 2014

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TREATING APPROACH: HYPOMANIA AND MILD TO MODERATE MANIA

Confirm Diagnosis

- Need hospitalization?
- Substance induced?
- General medical condition?

Treat Aggressively

- Monotherapy with an antipsychotic

Evaluate Treatment

- Follow-up in 1 week
- Continue or switch?
  - How is it working after 2 weeks at target dose?

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WHAT MEDS TO USE: NEW MANIA

Mood Stabilizers	Antipsychotics	Do not use
• Lithium	1. Olanzapine	• Lamotrigine
• Valproate	2. Risperidone	• Gabapentin
	3. Haloperidol	• Topiramate
	4. Quetiapine	• Oxcarbazepine
	5. Aripiprazole	• Lurasidone

How to choose?
Consider the best fit...

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AGGRESSIVE TITRATION: MANIA

Med Starting Dose	Dose Titration	Mania Dose
Lithium 300mg BID	300-600mg inc q1-5 days	1.0-1.2 mEq/L (900-1800mg daily)
Divalproex DR 300mg qam and 450mg qhs	250mg-500mg inc q1-3 days	1200-1500mg/day (50-125mcg/ml)
Quetiapine 150mg qhs	100mg inc q1 day	400-800mg qday
Olanzapine 10mg qhs	5mg qday inc q1 day	30mg qday
Risperidone 1mg bid	1mg qday inc q1 day	4-6mg qday
Aripiprazole 10mg qday	5mg qday inc q7+ days	15-45mg qday
Haloperidol 5mg qday	2.5mg inc q2-3 days	Up to 30mg+ qday

- If no response in 1-3 weeks→switch antipsychotics

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WHAT ABOUT BENZO'S?

-BENZOS AND Z-DRUGS IN BIPOLAR

- Can be helpful for restoring sleep treating agitation during acute period
- Restrict use
  - Up to 20% will become long-term users (> 6 months of use)

Wingard L et al, 2018

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CASE: NEW MANIA

-REST OF THE CASE

1 week from initial visit

Patient started on Lamictal 25mg qday and Quetiapine 25mg qhs, but did not start Quetiapine. Sertraline was continued at 100mg qday. Mania is better but persisting.

Plan: Lamictal increased to 50mg qday and Quetiapine 25mg was started. Sertraline continued at 100mg qday.

3 weeks from initial visit

Still with mild mania, but better.

Plan: Quetiapine increased to 50mg qday, Lamictal increased to 100mg qday, Sertraline reduced to 50mg qday.

4 weeks from initial visit

Hypomania has resolved. Going off to school in 2 weeks (not from mania).

Plan: Lamotrigine increased to 200mg qday, Quetiapine taper planned, Sertraline continued at 50mg qday.

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CASE: RECURRENT MANIA

- 31yo M with Bipolar I who has been hospitalized multiple times involuntarily for mania, last time was a year ago x 1 month. Currently presenting manic-pressured speech, psychomotor agitation, sleeping 2-3 hours a day, arguing more with parents, planning for a shoe deal with a Chinese company, pursuing more relationships online, may have solicited a prostitute.
- ***But*** denies SI/HI, AVH, and continues to live with parents and return home daily. Declines voluntary admission.

Meds: Lurasidone 120mg, Depakote 1000mg, Valium 10mg qid

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CASE: RECURRENT MANIA

What would you do next?

A. Add Quetiapine 100mg qhs
B. Start Trazodone 100mg qhs
C. Increase Diazepam to 20mg qid
D. Switch to Olanzapine 10mg qhs and titrate up
E. Check a Depakote level
F. Other

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ADDRESSING RECURRING MANIC SYMPTOMS

Topics to Start With

- Medication adherence?
- Sleep habits?
- Regular routine?
- Substance use?
- What has helped in the past?

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ADDRESSING RECURRENT MANIA

Medication Strategies

- Restart a 2nd med (if needed)
- Aggressively increase dose of antipsychotic (if possible)
- If no improvement in 1-2 weeks at max tolerable dose switch antipsychotics (more sedating?)
  - Could also switch the mood stabilizer
- Add a benzodiazepine
  - Clonazepam start 1-3mg 2-3x's/day, target 4mg
  - Lorazepam start 2-4mg 2-4x's/day, target 6mg

Curtin F et al, 2004

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CASE: RECURRENT MANIA

- You chose to check a Depakote level and add 100mg of Quetiapine as he reported this addition has helped in the past. He has required significant levels of sedatives while inpt in the past.

- Case: Depakote level was low, Quetiapine addition modestly helpful. Mother reports he is very busy but not getting things done. Buying lots of stuff online. Irritable. Feet have cracking callouses due to the amount of walking he is doing.

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CASE: RECURRENT MANIA

What would you do next?

A. Increase Depakote dose
B. Increase Quetiapine to 300mg qhs
C. Increase Diazepam to 20mg qid
D. Switch to Olanzapine 10mg qhs and titrate up
E. Refer for involuntary admission
F. Other

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CASE: RECURRENT MANIA

- It is now 6 weeks later, and you doubled his dose of Depakote and switched him over to Olanzapine 25mg qhs. He is still taking Valium 10mg qid. He is starting to slow down. From this point it will take him another month before he sleeping around 8 hours a night.

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TAKE AWAYS ON AMBULATORY MANIA MANAGEMENT?

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TAKE AWAYS ON AMBULATORY MANIA MANAGEMENT?

- Adherence?
  - levels
- Take into account past history
  - What has worked and at what dose?
- Can you work with existing meds
  - Important to get to lowest effective dose during remission
- May need to switch to more sedating medications
- Be aggressive in treating

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OTHER CONSIDERATIONS

- Close follow-up
- It may take several weeks
- Psychiatric Consultation
- Involve integrated behavioral health

Maintenance Treatment

- Continue stabilizing regimen for maintenance once stable x several months
- Consider monotherapy once stable

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QUESTIONS?

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