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Psychiatry and Addictions Case Conference

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WHICH BIPOLAR MEDS TO USE IN PRIMARY CARE?

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project ECHO

GENERAL DISCLOSURES

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SPEAKER DISCLOSURES

- ✓ Any conflicts of interest?

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LEARNING OBJECTIVES

1. Explain range of clinical goals for medication in bipolar disorder.
2. Clarify scope of clinical situations manageable in primary care.
3. Describe best practices for medication management of bipolar disorder in different clinical situations.

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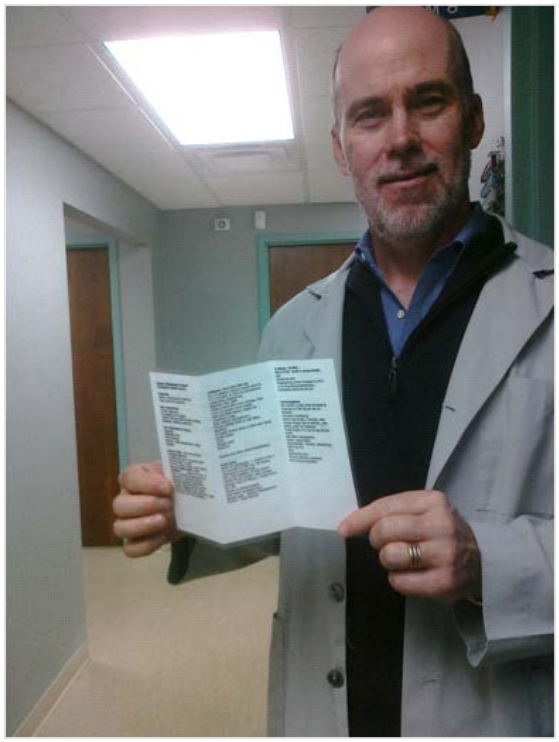
I'M TREATING BIPOLAR DISORDER IN A PRIMARY CARE SETTING. WHY?

- Patients without access to other care.
- Patients who decline other care.
- Relatively stable or follow up patients.
- Patients identified in course of depression screening.



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CASE EXAMPLES FIRST

- 37 yo man, prior dx bipolar. Agreed to return to treatment at wife's urging after a year off meds. Afraid to go back to CMHC – "last time they locked me up." Did well on valproate in past. Affectively stable now.
- 23 yo woman, no prior psych history. Screens positive on PHQ-9: 19. Passive suicidal ideation, "high risk" on CIDI-3: history of intermittent mood changes, impulsiveness, grandiosity. Next psychiatry appt in town is in 3 months.

ARRAY OF CLINICAL SITUATIONS

- Mania, acute.
- Mixed State, acute.
- Bipolar Depression, acute.
- Long-Term Stabilization.

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MANIA

This is usually a psychiatric emergency or close to it.

Often hospital or ER referral is indicated:

- If safety an issue.
- If persistent, damaging or not responding to treatment.

Meds:

Atypicals:

- Seroquel 200 mg hs to start
- Zyprexa 10-20 mg to start
- Latuda 40 mg to start.
  - Remember, they may still be on these months later, so think about side effects, especially weight gain and metabolic syndrome.

Lithium:

- Not immediately effective, but not a bad idea to get on board in the beginning.
- Start with 300-600 mg once daily.

BIPOLAR DEPRESSION

Often quite severe, identified via screening.

Lamotrigine – controversial – in wide use though not shown to be effective for acute bipolar depression. Risk of Stevens-Johnson – slow titration: 25 mg x 2wks, then 50 mg. Slower in presence of valproate. Mostly in milder cases.

Quetiapine – very effective, wt gain risk: Day 1 50 mg , Day 2 100 mg, Day 3 200 mg, Day 4 300 mg.

Lurasidone – Start 20 mg daily, increase by 20 mg to clinical response about weekly. Max 120 mg.

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MIXED STATES

Include both depressive and manic symptoms, often highly irritable.

Management much like mania, though first line are specific atypicals effective for depression: Quetiapine, lurasidone.

LONG-TERM STABILIZATION

Maybe most important of all: the longer a patient is stable, the more likely to remain so.

Lithium is still the gold standard, reducing suicide risk in the long haul. 300 mg to start, check level in 5 days, titrate to response or side effects, target level 0.7.

Valproate [500 mg titrate to response and side effects, usually ~1500 mg hs] and Atypicals are robustly effective for preventing recurrence, especially in mixed or rapid-cycling patients.

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TREATMENT MONITORING

- Lithium:
  - Levels
    - when titrating.
    - Level when unstable or side effects.
    - Or q 6 months
  - TSH
    - At initiation and annually.
  - Lytes / BUN / Creat / Calcium –
    - At initiation & annually
  - EKG
    - Over 50 or presence of heart disease.

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TREATMENT MONITORING

- Valproate
  - Levels
    - when titrating. 50-125.
    - Level when unstable or side effects.
    - Or q 6 months
  - Weight, complete blood count, menstrual history, liver function tests
    - every 3 mo for the first year and then annually

TREATMENT MONITORING

Atypical antipsychotics

- Weight
  - monthly for 3 mo and then every 3 mo
- Blood pressure, fasting blood glucose, lipid profile
  - every 3 mo and then annually
- Monitor for abnormal movements
- Electrocardiogram, prolactin as clinically indicated

THE 4TH LINE: OTHER ANTICONVULSANTS

Commonly used, evidence base uncertain:

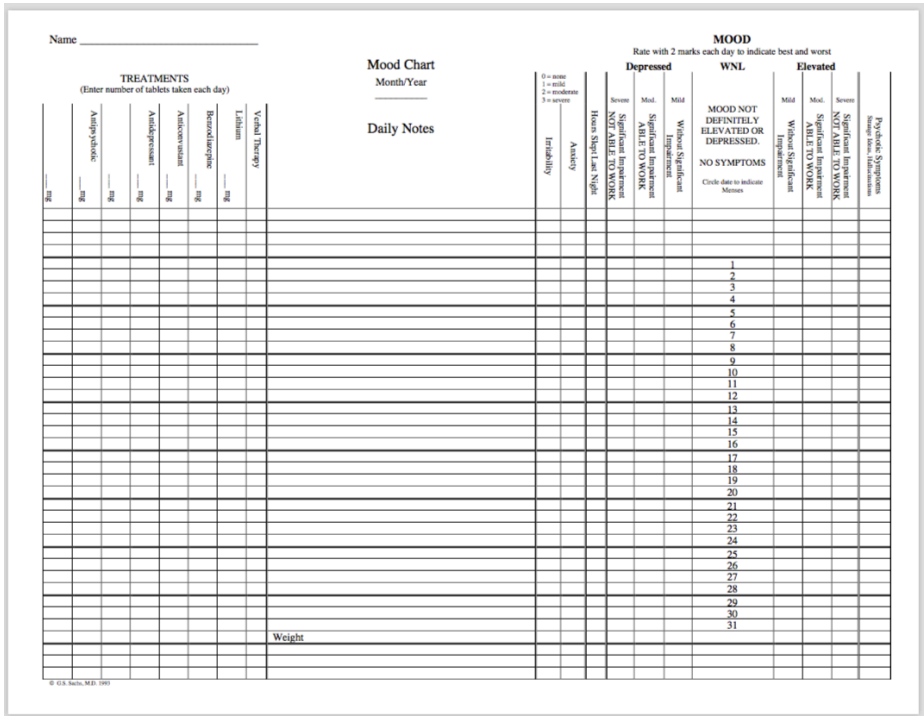
Lamotrigine: for depression, though FDA indication for increasing time to recurrence. Stevens-Johnson syndrome.

Carbamazepine: in use for many years, many drug interactions.

Oxcarbazine: Widely used for mania and prevention, almost no evidence. High risk of hyponatremia.

RHYTHMS

- Sleep
- Eating
- Work
- **Plan these things.**
- Encourage mood tracking.
- Light may have a role, especially in winter.



Name _____

Mood Chart
Month/Year
_____
Daily Notes

TREATMENTS
(Enter number of tablets taken each day)

____ mg	Antipsychotic ____ mg	____ mg	Antidepressant ____ mg	Anticonvulsant ____ mg	Benzodiazepine ____ mg	Lithium ____ mg	Verbal Therapy

MOOD
Rate with 2 marks each day to indicate best and worst

0 = none 1 = mild 2 = moderate 3 = severe			Depressed			WNL	Elevated			
Irritability	Anxiety	Hours Slept Last Night	Severe Significant Impairment NOT ABLE TO WORK	Mod. Significant Impairment ABLE TO WORK	Mild Without Significant Impairment	MOOD NOT DEFINITELY ELEVATED OR DEPRESSED. NO SYMPTOMS Circle date to indicate Menses	Mild Without Significant Impairment	Mod. Significant Impairment ABLE TO WORK	Severe Significant Impairment NOT ABLE TO WORK	Psychotic Symptoms Hallucinations

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

Weight

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SPECIFIC CLINICAL SITUATIONS

- Acute illness – atypicals. Meds for sleep can be very helpful in terminating imminent mania.

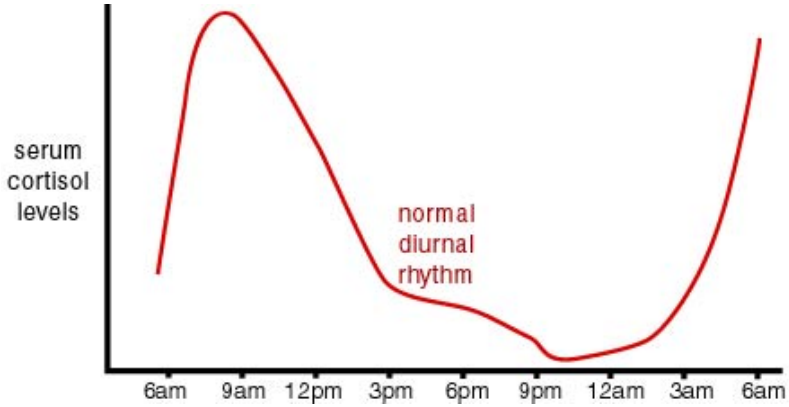
- No money – lithium cheap but labs may not be. Probably whatever atypical is in the cabinet will work **in the short term,** if you are putting out a fire.

- Not likely to adhere to complicated regimen [injectable antipsychotics? No lithium.]

- Role of polypharmacy [it is par for the course.]

THUMBNAIL SUMMARY

- Lithium almost always worthwhile, if you can monitor it, but not always by itself.
- Atypicals useful in any situation, but side effects can be problematic.
- There is no treatment that doesn't require some labs.
- Think about rhythms.



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