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Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

MANAGING BIPOLAR DEPRESSION IN PRIMARY CARE

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project ECHO

SPEAKER DISCLOSURES

- ✓ No conflicts of interest.

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OBJECTIVES

- At the conclusion of this session, attendees will be able to:
  - Recognize the predominant role of depressive episodes in the morbidity associated with bipolar disorder.
  - Summarize the outcomes of the SPIRIT study
  - Apply an orderly approach to the care of bipolar depression.

INTRODUCTION TO THE ISSUES WITH BIPOLAR DEPRESSION

- By far the most common presentation
- Associated with long-term morbidity
- Treatment may differ from
  - Treatment of mania
  - Maintenance treatment

INCIDENCE HIGH

- 4.3% of general primary care patients and up to 10% of primary care patients with a psychiatric complaint.

Cerimele et al, Gen Hosp Psychiatry. 2014 Jan-Feb;36(1):19-25.

MORBIDITY HIGH

Bipolar depression largely accounts for:

- long-term morbidity,
- impaired functioning
- risk of suicide.

Simon GE, Bauer MS, Ludman EJ, Operskalski BH, Unützer J SOJ Clin Psychiatry. 2007;68(8):1237.

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SPIRIT STUDY TAKEHOMES

Collaborative Care of bipolar disorder and PTSD works in rural FQHC's.

Nothing exotic about treatment approach – the medication interventions were standard and the behavioral interventions straightforward.

Fortney JC et al. Comparison of Teleintegrated Care and Telereferral Care for Treating Complex Psychiatric Disorders in Primary Care: A Pragmatic Randomized Comparative Effectiveness Trial. *JAMA Psychiatry.* 2021;78(11):1189–1199.

DIAGNOSIS

- Priors may or may not be valid (e.g. ER doc)
- Present or past history of mania / hypomania makes the distinction between MDD and bipolar depression.
  - CIDI-3 – ask about “periods lasting several days”
  - In SPIRIT: pos CIDI led to 43% psychiatrist dx of bipolar
- Presence / absence of especially stimulants / cocaine / meth
- See Joe Cerimele’s UW PACC slides from 3/18/21

APPROACHING BIPOLAR DEPRESSION

Lamictal [in less urgent cases] push to 200 mg but not faster than standard titration.

Quetiapine (First line when more severe episode or psychosis)

- Metabolic risk
- Administer once daily at bedtime. Day 1: 50 mg Day 2: 100 mg Day 3: 200 mg Day 4: 300 mg

Lurasidone 20-60 mg hs with food

- Much less weight gain than quetiapine
- I have used higher doses

Lumateperone (CAPLYTA)

- 42 mg hs
- Maybe less risk TD?

Olanzapine / fluoxetine

- Issues with wt gain, antidepressant

Lithium useful adjunct in longer term –

- 300 mg hs titrate to level and side effects.

Avoiding antidepressant

Continue maintenance treatment

Cariprazine (haven't used it)

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IS POLYPHARMACY WRONG?

- STEP-BD Project found 89% of those successfully treated for bipolar disorder required three medications.
- If not showing any early improvement in 2-3 wks, adjust treatment.
- If initial treatment is antipsychotic, add-on med should be mood stabilizer, not another antipsychotic.

IS LAMICTAL EFFECTIVE FOR BIPOLAR DEPRESSION?

- Surprisingly few studies
- Some recent reinterpretation: didn't move Hamilton but did move MADRS
- WIDELY used due to tolerability

> Adverse skin reactions occur in 8.3% of patients taking lamotrigine, with 0.04% of patients developing SJS/TEN.

Bloom R, Amber KT. Identifying the incidence of rash, Stevens-Johnson syndrome and toxic epidermal necrolysis in patients taking lamotrigine: a systematic review of 122 randomized controlled trials. An Bras Dermatol. 2017 Jan-Feb;92(1):139-141

WHY NOT JUST USE LATUDA?

- Regardless of diagnosis, **tardive dyskinesia and other tardive movement disorders are not rare** and anyone exposed to treatment with dopamine blockers is at risk.
- The cumulative incidence is about 4% to 5% annually; the prevalence rate is 20% to 30%.
- The SGAs retain some risk. No currently available antipsychotic is risk-free.
- No evidence for preventive efficacy.

ALL ATYPICALS NOT CREATED EQUAL

Table 7-1 Serotonin/dopamine blockers for bipolar spectrum

	Evidence of efficacy in mixed features	FDA-approved for bipolar depression	FDA-approved for bipolar mania	FDA-approved for bipolar maintenance	FDA-approved for major depressive disorder
Aripiprazole			Yes	Yes	Yes (adjunct)
Asenapine	Yes, MMX		Yes	Yes	
Brexpiprazole					Yes (adjunct)
Cariprazine	Yes, MMX, DMX	Yes	Yes		
Lurasidone	Yes, DMX*	Yes			
Olanzapine	Yes, MMX	Yes (with fluoxetine)	Yes	Yes	Yes (with fluoxetine)
Quetiapine	Yes, MMX	Yes	Yes	Yes	Yes (adjunct)
Risperidone			Yes	Yes	
Ziprasidone	Yes, MMX		Yes	Yes	

MMX, mania with mixed features; DMX, depression with mixed features.
*unipolar and bipolar depression.

Stahl, S. (2021). *Stahl's Essential Psychopharmacology: Neuroscientific Basis and Practical Applications* (5th ed.). Cambridge: Cambridge University Press. doi:10.1017/9781108975292

ANTIDEPRESSANTS IN BIPOLAR DEPRESSION

Very commonly encountered.

Probably unwise – though “effective for some” with long track record.

Really avoid antidepressant monotherapy, or long-term use.

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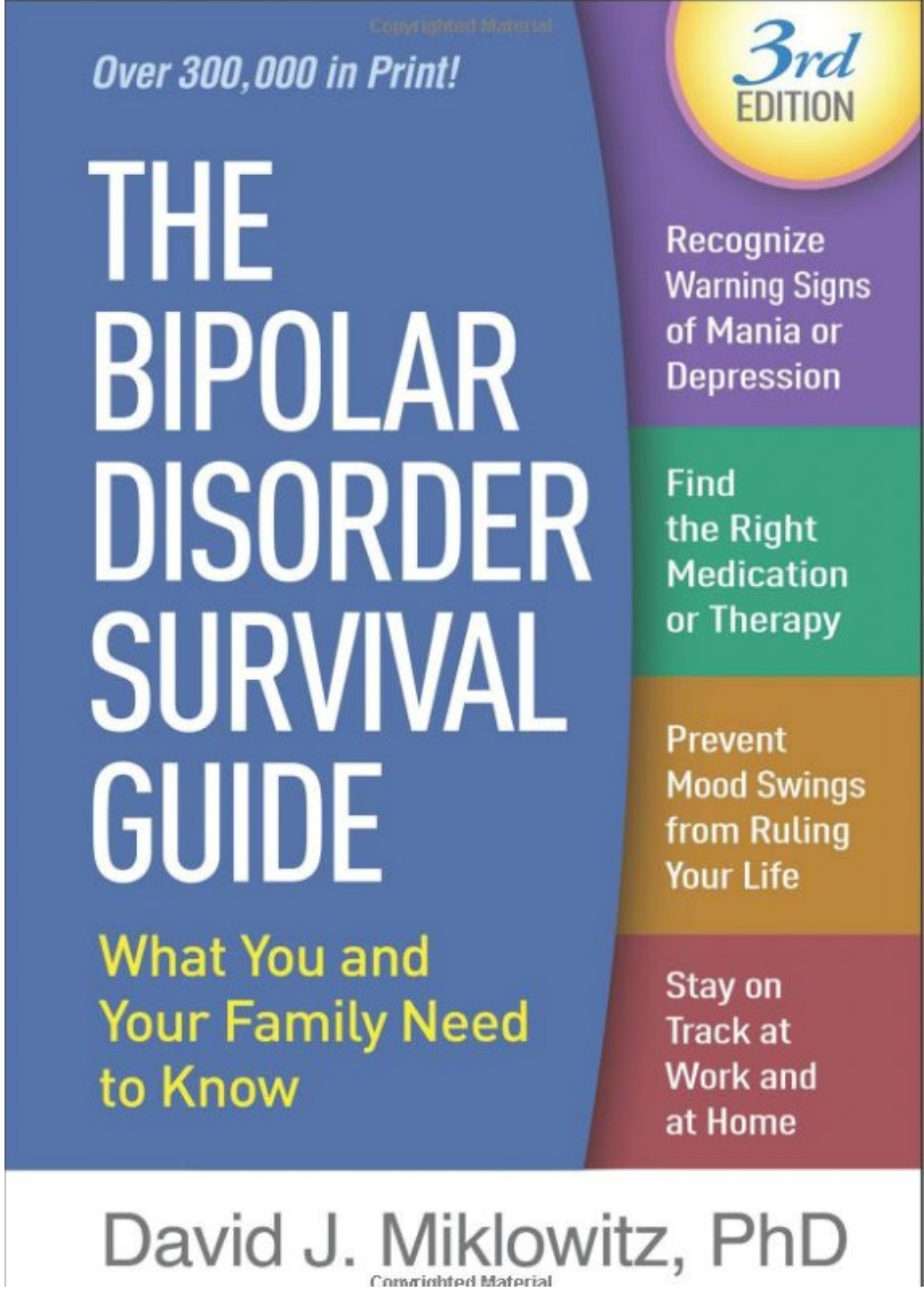
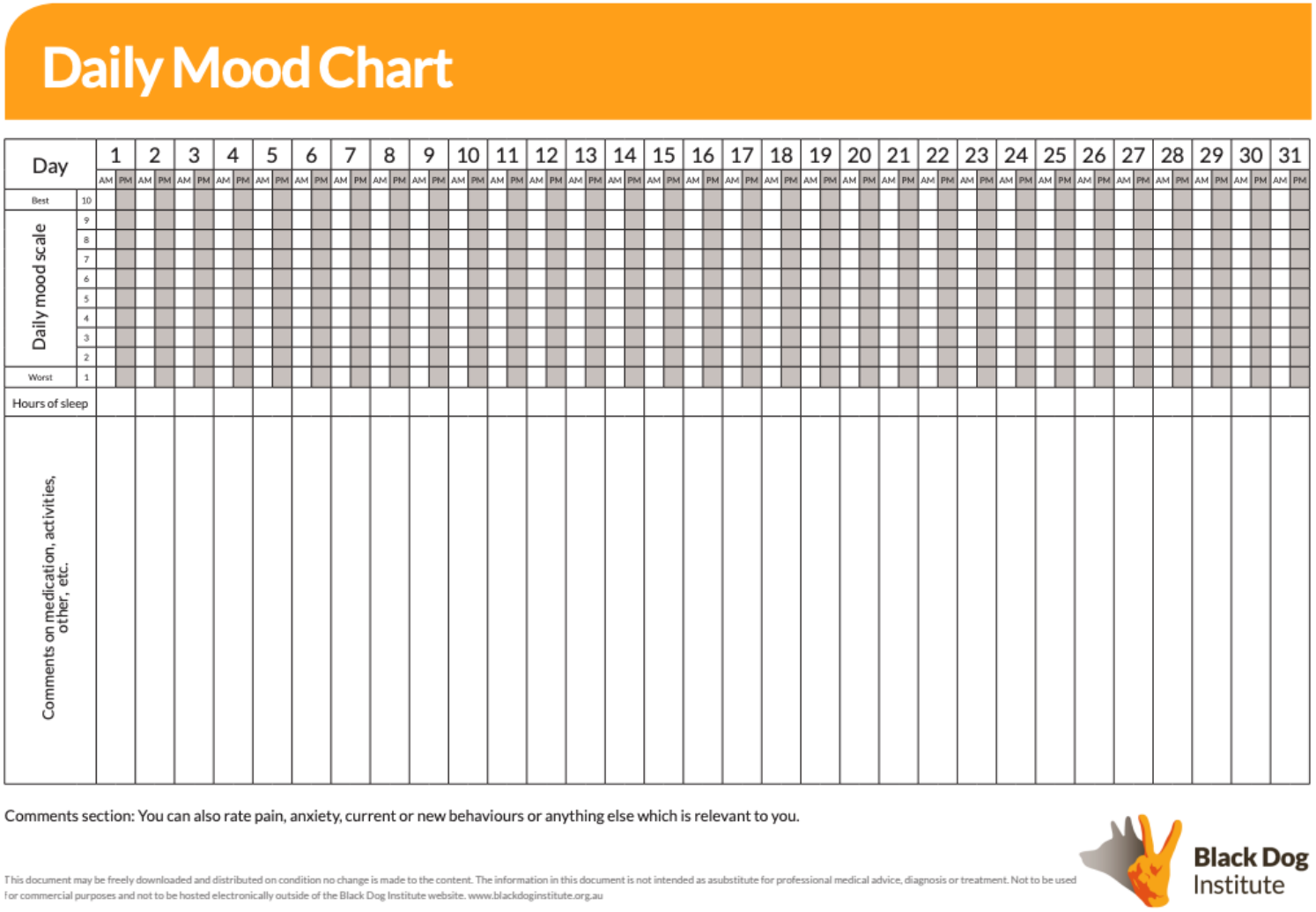
PSYCHOSOCIAL INTERVENTIONS

- Psychotherapy
- Psychoeducation



MOOD CHARTING



Daily Mood Chart

Day	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
	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM	AM PM
Best 10																															
Daily mood scale 9																															
8																															
7																															
6																															
5																															
4																															
3																															
2																															
Worst 1																															
Hours of sleep																															
Comments on medication, activities, other, etc.																															

Comments section: You can also rate pain, anxiety, current or new behaviours or anything else which is relevant to you.

Black Dog Institute

https://www.blackdoginstitute.org.au/wp-content/uploads/2020/04/19-dailymoodchart.pdf

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MANAGEMENT OF SUICIDALITY

- CSSR-S
- Safety plans

Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

1. Name Phone
2. Name_____ Phone_____
3. Name Phone

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

The one thing that is most important to me and worth living for is:

_____

QUESTIONS / CASES?

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