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Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

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

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project ECHO

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✓ No conflicts of interest

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OBJECTIVES

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

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HOW DO YOU KNOW SOMEONE IS MANIC?

- Type answer into chat or say it verbally

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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

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

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

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 does not include grandiosity
D. Hypomania can be severe enough cause marked impairment in social, or occupational functioning, or necessitate inpt stay

WHICH OF THE FOLLOWING IS ACCURATE?

A. Hypomania IS always observable by others
B. Hypomania needs only 3 or more of the 7 symptoms
C. Hypomania DOES include grandiosity
D. Hypomania IS NOT 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
  - Depression more enduring and profound

MANIA COURSE

- May be 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

CASE: SLEEP CHANGES

- 45yo M with h/o Bipolar I presents to your clinic requesting Zolpidem to help her sleep. She reports being under significant stress recently and has been having problems sleeping. She would like to use zolpidem to help get her sleep back on track like she has done in past.

- Medications: Haloperidol 1mg qhs, Lamotrigine 200mg qday

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CASE: SLEEP CHANGES

What would you do next?

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

- Common Symptoms Across Studies
  - Sleep disturbance
  - Overactivity
  - Mood changes
  - Increased self-worth
  - Unusual thought content
  - Disinhibition
- Relapse Signatures
  - Idiosyncratic prodromes (50% in Sahoo paper)

Lam D et al, 2005; Jackson A et al, 2003; Sierra P et al, 2007

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PRODROMAL MANIA SYMPTOMS

- Relatives 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

Sahoo MK et al, 2012

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ADDRESSING PRODROMAL SYMPTOMS

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

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WHAT MEDICATION ADJUSTMENTS COULD YOU MAKE IN THE PRODROMAL STAGE?

A. Add a sleep aid
B. Start/Increase an antipsychotic
C. Increase lamotrigine
D. Add a scheduled benzodiazepine
E. Start Lithium
F. Increase Lithium
G. Other

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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)

BENZOS AND Z-DRUGS IN BIPOLAR

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

Wingard L et al, 2018

MELATONIN AND BIPOLAR?
-PREVENTION STRATEGY

- Exogenous melatonin has demonstrated efficacy in treating primary insomnia, delayed sleep phase disorder, improving sleep parameters and overall sleep quality

- There is scientific rational to use melatonin during remission to help promote stable sleep

- Evidence is needed!

Geoffroy PA et al, 2015

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LONG-ACTING INJECTABLE (LAI) ANTIPSYCHOTICS AND BIPOLAR DISORDER *-PREVENTION STRATEGY*

- Systematic review of 37 studies
- LAI well-tolerated and effective for treatment of mania and prevention
  - ***Risperidone***: several RCTs
  - ***Aripiprazole***: 1 RCT
  - Paliperidone and Olanzapine: No RCTs-1 observational study and 1 case report

Keramatian K et al, 2019

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CASE: SLEEP CHANGES-*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: THE MANIC PATIENT

- 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 self-care is good enough. Declines voluntary admission.

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

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CASE: THE MANIC PATIENT

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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CASE: THE MANIC PATIENT

- 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.

CASE: THE MANIC PATIENT

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: THE MANIC PATIENT

- 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.

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
- Ok to be aggressive

QUESTIONS?

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