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Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

TREATING BIPOLAR DISORDER IN PRIMARY CARE SETTINGS - SHOULD I START A MOOD STABILIZER?

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SPEAKER DISCLOSURES

- ✓ No conflicts of interest.

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OBJECTIVES

- At the conclusion of this session, attendees:
  - Will understand need for high-quality care of bipolar disorder in the primary care setting.
  - Will be able to describe collaborative care models for mental disorders in the primary care setting.
  - Will be oriented to the task of creating a workflow for the treatment of bipolar disorder in the primary care setting.

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INTRODUCTION TO THE ISSUES WITH BIPOLAR DISORDER

- Incidence high.
- Likelihood of referral to specialty care low.
- Overall morbidity high.
- What would ideal program look like?
- How to implement in various settings?

INCIDENCE HIGH

- 4.3% of general primary care patients and up to 10% of primary care patients with a psychiatric complaint. [Cerimele et al]

REFERRAL AWAY UNLIKELY

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REFERRAL AWAY UNLIKELY

- MHIP 26% referred
- Regional MHC – 20% referred, about 20% of these successful – and this to our own CMHC!

ILLNESS SEVERE & COSTLY

- MHIP: bipolar pts high symptom severity.
- Total mean+/-SD costs for patients in the bipolar disorder group ($3,416+/-$6,862) were significantly higher than those in any of the comparison groups (Simon et al 1998)
- Medically complicated: higher prevalence of Diabetes, Hepatitis C, Lower back pain and pulmonary disease in VA bipolar cohort.
- Refractory: some collaborative programs cannot show improvement in depression or mania ratings.

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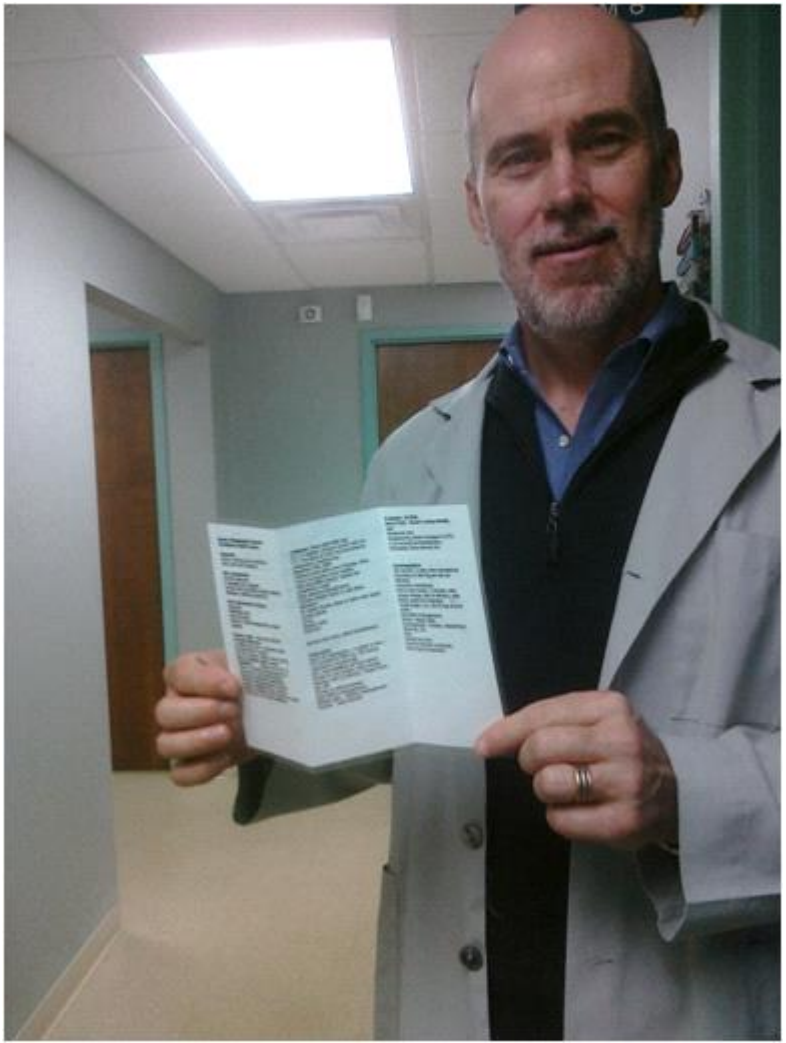
IMPLEMENTATION REQUIRES A PLAN

"They have no military, sire—no one's ever made it past their receptionist."

ONE EXAMPLE – REGIONAL MENTAL HEALTH

- IMPACT-style collaborative care program – 4 primary care sites. **Invited in by the FQHC partner.**
- Bipolar patients unable or unwilling to be seen in CMHC.
- Use of roadmap for PCP's.
- Double-entry registry.
- 920 patients diagnosed with Bipolar I, Bipolar II or Mood Disorder NOS.
- Dx PHQ-9 / MDQ/ CIDI plus clinical interview, psychiatric consultation.
- All med management through consultant psychiatrist.
- Approximately 20% referral **attempted** to CMHC.
- Used as alternative site for CMHC overflow.

BIPOLAR ROADMAP



Bipolar Management Protocol
NorthShore Health Centers

Diagnosis
History, including prior treatment.
MDQ, then CIDI if positive.

BHC consultation
Confirm diagnosis.
Is specialty care needed?
Consult with psychiatrist before making diagnosis, initiating treatment.

Give Information Packet:
Diagnosis
Medication Info
Mood Charting
Rhythm / self-management / sleep hygiene

Choose meds - see med protocol
Arrange aftercare
2 weeks with new or changed meds
No more than 3 months
Call for no show. Follow mood charts.
How to decide which mood stabilizer: Lithium first line. If manic - Lamictal not appropriate If psychotic sx, will need atypical. Seroquel, Lamictal if depressed. Monitor drug interactions & other medical conditions [e.g., kidney disease & lithium.] Not unusual to need more than one mood stabilizer.

Lithium: Start 600-900 mg
In 1-2 weeks: Lithium Level—aim for 0.7, increase at 300 mg increments
Laboratory monitoring:
Baseline TSH, BMP
Lithium level with each change, then every 6 months when stable.
TSH and BMP yearly—watch for creatinine creep
Side effects management
Tremor (lower dose or add Beta-Blocker)
GI upset (lower dose or take with food)
Loose stools
Acne
Weight gain
Polyuria

Serious but rare: renal insufficiency

Valproate
Start 20 mg/kg/day = weight in lbs x 10 rounded to 500 mg. HS dosing
Laboratory monitoring:
cbc, cmp baseline, at one month
Levels at one month, with dosage change, lack of efficacy. Target level: 50-120
Titrate to effectiveness.
Side effect management:
Weight gain - dietary management
Tremor - beta-blocker
Gi distress - hs dose
Risk of PCOS - avoid in young women, rash
Serious but rare:
Hepatotoxicity [minor increase in LFT's is not unusual],encephalopathy, Pancreatitis, bone marrow d/o

Carbamazepine:
200 mg BID x 2 wks, then increase by increments of 200 mg per day as tolerated.
Laboratory monitoring:
level at one month, 3 months, with dosage change, lack of efficacy, side effects, watch for induction
Target levels 4-12, cbc & cmp at one month
Side effect management:
Ataxia - reduce dose
Hyponatremia - monitor, discontinue below Na 125.
Rash
Serious but rare:
Stevens-Johnson syndrome
Bone marrow disorders

Lamictal
Titrate per instructions: 25 mg daily x 2 wks, then 50 mg daily x 2 wk, then 100 mg daily. If on Depakote, 25 mg every other day x 2 wks, then 50 mg.
May not need more than 25-50 mg.

If on Tegretol, 50 mg daily x 2 wks, then 100 mg daily
Labs - not recommended
Side effect management:
Stevens-Johnson syndrome
Rash - warn patient to call about any rash, and come in for a look
Trlleptal
Start 300 mg BID, titrate to tolerability and effectiveness, probably 300 mg per 1-2 wks.
Laboratory monitoring:
CMP, CBC baseline, at one month, 6 months. No levels
Side effect management:
Sedation - hs dose
Ataxia - reduce dose
Hyponatremia - monitor Na, stop below 125.Rash
Serious but rare: Stevens-Johnson syndrome,Bone marrow disorders

Atypical Antipsychotics
Zyprexa - Seroquel - Risperdal - Invega - Abilify – Latuda - Geodon

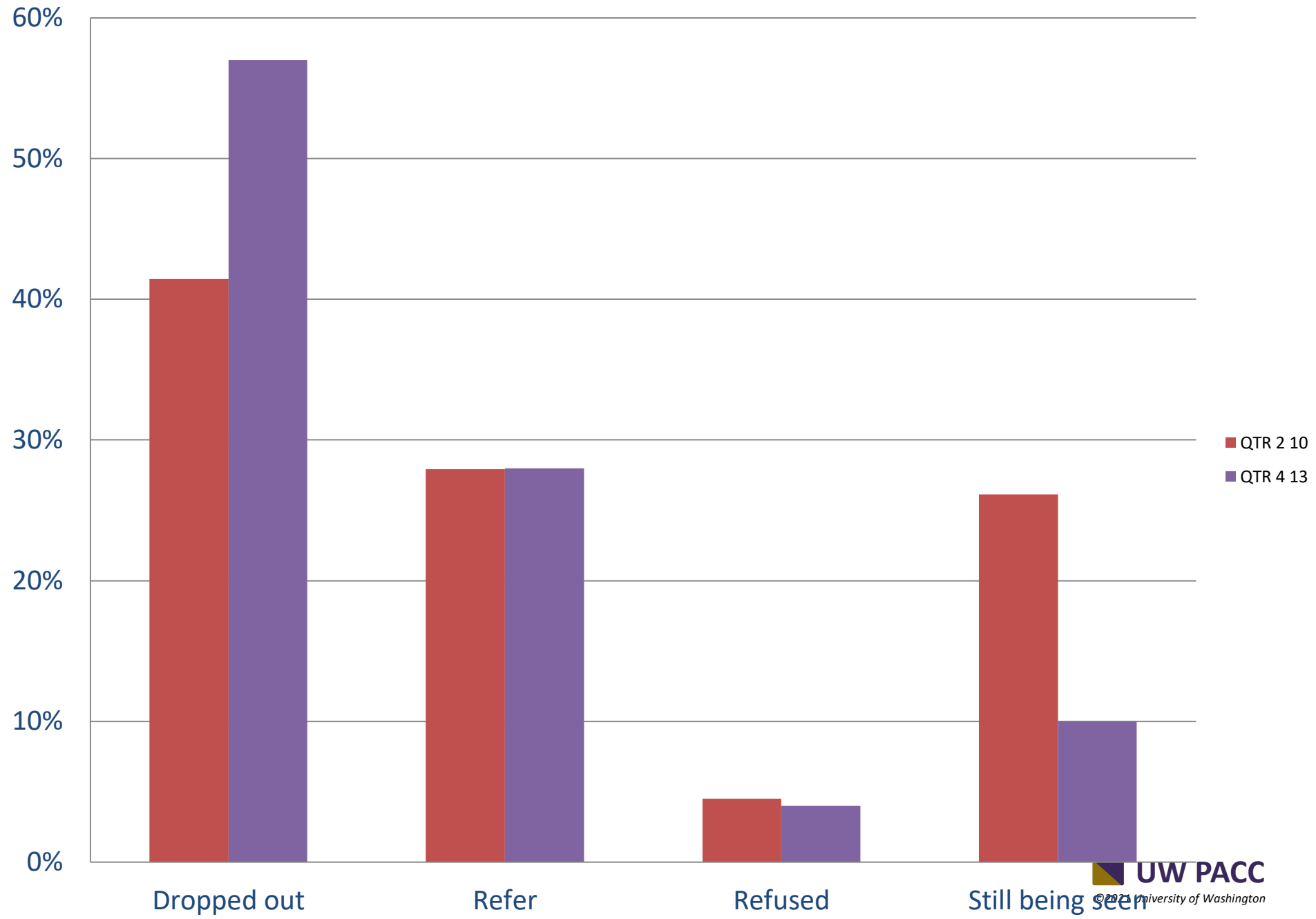
Risk of significant weight gain higher to the left, tardive dyskinesia higher to right.

Side effect mgmt: Risk of wt gain, DM, dyslipidemia, tardive dyskinesia.
Monitor for abnormal movements every 6 months.
Initial Dosing: Zyprexa 10, Seroquel 200, Latuda 40, Risperdal 2, Invega 3, Abilify 5, Geodon 80 [do not give less than 80 mg Geodon]

Atypical Laboratory monitoring:		Baseline	4 wks	8 wks	12 wks	Annually
Personal/ Family hx	x				x	
Weight [BMI] x	x	x	x	x		
Waist circumference	x			x	x	
Blood Pressure x			x	x		
Fasting plasma glucose	x			x	x	
Fasting lipid profile	x			x	x	

John S. Kern MD 1.26.09 https://goo.gl/R72WFb

Outcome Bipolar Patients



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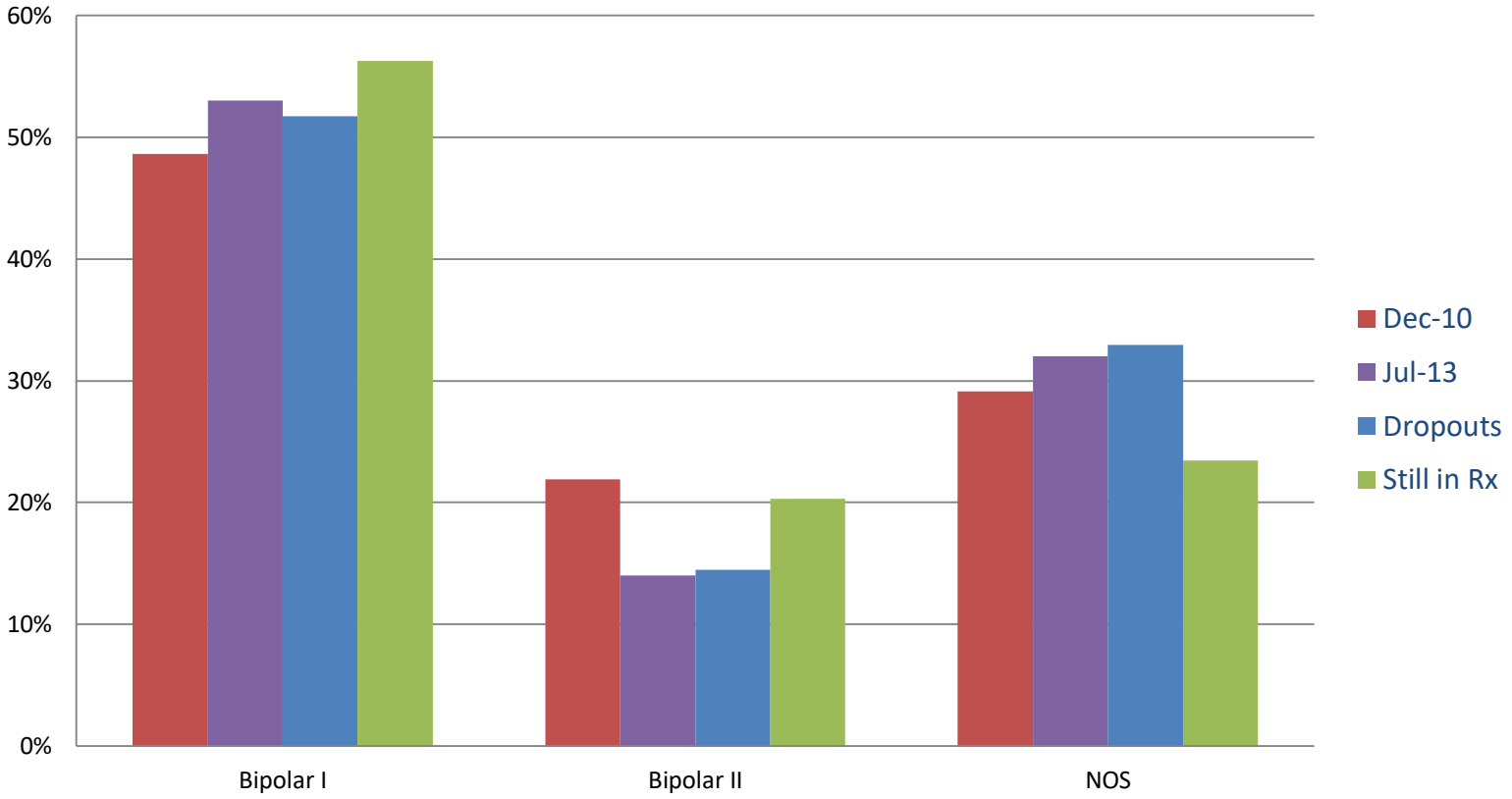
Mood Disorder Dx and retention



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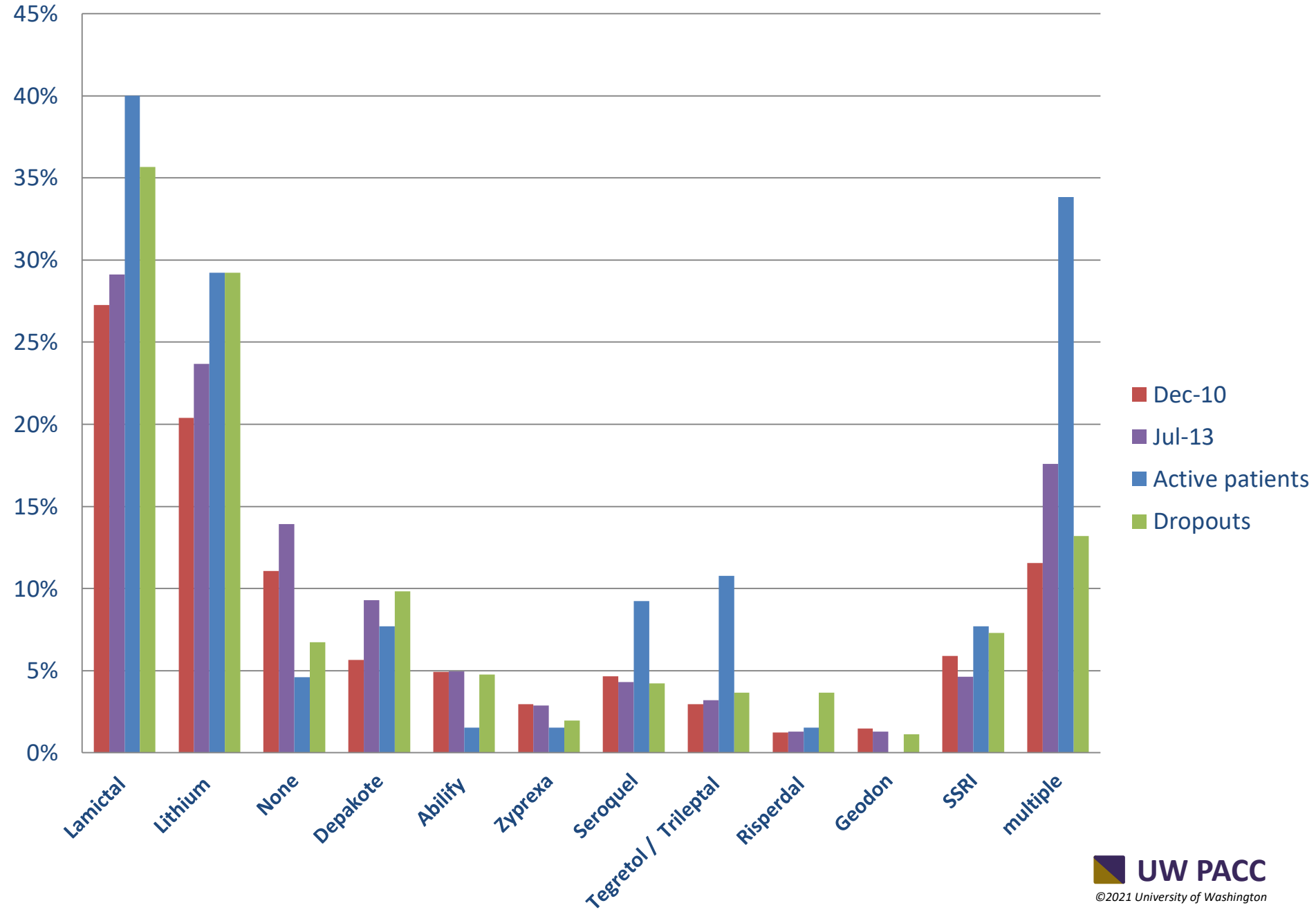
Bipolar meds and retention



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HIGHLIGHTS OF REGIONAL MHC EXPERIENCE

- PCP's haven't decided to do it alone.
- Problems with referrals, funding continue.
- Diagnosis - Mood NOS, or depressed people you don't want to give SSRI.
- Can adequate bipolar mgmt be done - info, monitoring, psychosocial support? So far we have no psychosocial protocol following first appt.
- Can this more intensive work coexist with the short-term immediate-access BHC model?
- Retention.

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.

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APPROACHING BIPOLAR DEPRESSION VS ENHANCING MOOD STABILITY

Improving Depression

- Lamictal [not so useful in mixed states]
- Seroquel
  - Metabolic risk
- Lurasidone
- [Olanzapine / fluoxetine]
  - Antidepressant risk
- Avoiding antidepressant

Mood Stabilizers

- Lithium
  - Still the gold standard.
- Depakote
- Carbamazepine
- [Oxcarbazepine]
- Atypical antipsychotics
  - Effective but metabolic risk and risk of TD.

Expanded use of antipsychotic due to “ease of use” – is this a good idea?

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IS POLYPHARMACY WRONG?

- STEP-BD Project found 89% of those successfully treated for bipolar disorder required three medications.

QUESTIONS / CASES?

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