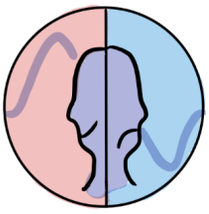

Bipolar Disorders

References
- Diagnostic & Statistical Manual of Mental Disorders: Fifth Ed (DSM-5)
- RANZCP Clinical Practice Guidelines for Mood Disorders
- 2020 RANZCP Clinical Practice Guidelines for the Treatment of Mood Disorders

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	Bipolar Type I	Bipolar Type II
Main Features	At least 1 episode of **mania** **+/-** Depressive episode Psychotic features possible	At least 1 episode of **hypomania** **+** 1 major **depressive** episode **+** No episodes of mania
Definition	**Mania** is a period of: • Persistently elevated, expansive or irritable mood • Abnormal & persistent increase in goal-directed activity or energy	**Hypomania** is a period of: • Elevated, expansive or irritable mood • + goal directed activity
Epidemiology	0.6-1% lifetime prevalence Average age of diagnosis is in late 20s Affects both genders equally	0.4% lifetime prevalence (Lower than BP1D) Average age of onset is early 30s More common in females than males
Risk Factors	FHx bipolar or schizophrenia disorder, more common in high income countries	
Aetiology	Multifactorial origin: genetic, increased parental age Triggers: child trauma, psychosocial distress	
Criteria	**A minimum of 3 of the following symptoms:** • Distractibility • Insomnia - decreased need for sleep. Awake and energised with just a few hours of sleep • Grandiosity - inflated self esteem • Flight of ideas - racing thoughts • Activity increased - increased goal-oriented activity (social, work) • Speech - pressure of speech, increased talkativeness • Thoughtlessness - risk taking behaviours. Examples include spending beyond means, gambling, sexuall/social disinhibition, alcohol/substance Not attributable to substances, medications or another psychiatric / medical condition	
Duration	Symptoms of mania last at least 1 week, for most days of the week	Symptoms of hypomania lasting at least 4 consecutive days AND symptoms of major depressive disorder lasting at least 2 weeks
Level of dysfunction	Causes significant dysfunction	Uncommon to cause significant dysfunction

Work up

Examination
- BMI, vitals
- Signs of self harm
- Rule out organic conditions:
  - Endocrine disorders (e.g. goitre, hyper/hypo-thyroid features, Cushingoid features, PCOS)
  - Respiratory disorders (e.g. sleep apnoea, restless leg syndrome, lung malignancy)
  - Neurological disorders (e.g. Parkinsonism, motor or sensory deficits)

Investigations
- FBE, UECs, LFTs, TFTs
- ECG
- Urine & blood drug screen
- Inflammatory markers
- bHCG
- STI testing

**Make sure to do a mental state exam (MSE) and a risk assessment

Treatment

Bio-
- Diet + exercise, sleep patterns
- Cessation of smoking + substance use
- *Pharmacotherapy:*
  - Monotherapy mood stabiliser
  - Lithium (gold standard – unless renal/thyroid risks)
  - Valproate
- If depressive-dominant: lamotrigine +/- lithium or valproate.
- Do not give antidepressants as monotherapy!
- If psychotic features: consider adjuvant antipsychotics
- May need maintenance ECT
- Review 12-monthly

Pyscho-
- Cognitive behavioural therapy (CBT)
- Family-Focused Therapy (FFT)

Social-
- Psychoeducation (e.g. support groups, www.bipolaraustralia.org.au)
- Social supports (e.g. family, self-help organisations, community groups)
- Allied health support e.g. social workers