A SELECTION OF TEN CURRENT READINGS ON TOPICS RELATED TO BIPOLAR DISORDER AND DEPRESSION –

some available as free full-text and some requiring payment

Selection of readings made by A/Prof Goh Lee Gan

READING 1 – Guide to primay care physician managing depression

Bostwick JM. A generalist's guide to treating patients with depression with an emphasis on using side effects to tailor antidepressant therapy. Mayo Clin Proc. 2010 Jun;85(6):538-50. Epub 2010 Apr 29. Review. PubMed PMID: 20431115; PubMed Central PMCID: PMC2878258.

URL: http://www.mayoclinicproceedings/content/85/6/538.full.pdf+html (payment required)

Department of Psychiatry and Psychology, Mayo Clinic, Rochester, MN 55905, USA. bostwick.john@mayo.edu

ABSTRACT

This review provides a guide to the primary care physician for diagnosing and managing depression. To identify relevant articles, a PubMed search (ending date parameter, October 15, 2009) was conducted using the keywords depression, antidepressants, side effects, adverse effects, weight gain, sexual dysfunction, and sleep disturbance, and the reference lists of relevant articles were hand searched. This review explores the challenges in diagnosing depression that will and will not respond to antidepressants (ADs) and describes the value of 2-question screening instruments followed by in-depth questioning for positive screening results. It underscores the implications of veiled somatic presentations in which underlying depression is missed, leading to fruitless and expensive medical work-ups. Following this survey of the difficulties in diagnosing depression, the 4 options generalists have for treating a patient with depression are discussed: watchful waiting, antidepressant therapy, psychotherapy, and psychiatric referral. This review proposes that physicians, once they decide to prescribe, use AD side effects to advantage by selecting medications to minimize negative and maximize positive possibilities, thereby improving adherence. It focuses on the 3 most troubling adverse effects-sleep disturbance, sexual dysfunction, and weight gain. It provides AD-prescribing principles to assist primary care physicians in successfully managing depression and appropriately referring patients to a psychiatrist. Antidepressant therapy is not a panacea for treating patients with depression. An approach blending enlightened observation, medications, and psychotherapy often helps depressed patients recover to their former baselines. PMCID: PMC2878258 PMID: 20431115 [PubMed - indexed for MEDLINE]

READING 2 – Increasing recognition of mood disorders and risk for suicide

Lake CR, Baumer J. Academic psychiatry's responsibility for increasing the recognition of mood disorders and risk for suicide in primary care. Curr Opin Psychiatry. 2010 Mar;23(2):157-66. Review. PubMed PMID: 19926995.

URL: http://ovidsp.tx.ovid.com.libproxy1/sp-3.4.2a/ovidweb.cgi (payment required)

Department of Psychiatry and Behavioral Sciences, University of Kansas School of Medicine, Kansas City, Kansas, USA. clake@kumc.edu

ABSTRACT

PURPOSE OF REVIEW: The authors seek solutions to better meet the healthcare needs of depressed patients in primary care by improving the recognition of depression, other mood disorders and of a risk for suicide.

RECENT FINDINGS: For 25 years academic psychiatry and primary care have known that only 10-50% of depressed patients are adequately treated, primarily because of the failure to recognize depression. There are substantial negative consequences including suicide. Suicide occurs during depression so the recognition of depression is the critical first step to preventing suicide. Recently noted is that one barrier to recognition is the traditional, comprehensive, psychiatric interview taught in academic departments of psychiatry that is impractical in primary care settings because it takes too much time. Some brief, initial psychiatric techniques have been developed but these typically have been introduced in primary care training programs and not by departments of psychiatry.
SUMMARY: A verbal four-question, 90 s screen for depression may be acceptable for routine use in primary care because it typically requires only seconds to a few minutes. Introduction of such a screening instrument to medical students on psychiatry and primary care clerkships could increase the recognition of depression and reduce death by suicide. PMID: 19926995 [PubMed - indexed for MEDLINE]

READING 3 – Unrecognised bipolar disorder in primary care patients with depression

Smith DJ, Griffiths E, Kelly M, Hood K, Craddock N, Simpson SA. Unrecognised bipolar disorder in primary care patients with depression. Br J Psychiatry. 2011 Jul;199:49-56. Epub 2011 Feb 3. PubMed PMID: 21292927.

URL: http://bjp.rcpsych.org/content/199/1/49.long (payment required)

Department of Psychological Medicine and Neurology, Cardiff University School of Medicine, University Hospital of Wales, Cardiff, UK. smithdj3@cardiff.ac.uk

ABSTRACT
BACKGROUND: Bipolar disorder is complex and can be difficult to diagnose. It is often misdiagnosed as recurrent major depressive disorder.
AIMS: We had three main aims. To estimate the proportion of primary care patients with a working diagnosis of unipolar depression who satisfy DSM-IV criteria for bipolar disorder. To test two screening instruments for bipolar disorder (the Hypomania Checklist (HCL-32) and Bipolar Spectrum Diagnostic Scale (BSDS)) within a primary care sample. To assess whether individuals with major depressive disorder with subthreshold manic symptoms differ from those individuals with major depressive disorder but with no or little history of manic symptoms in terms of clinical course, psychosocial functioning and quality of life..
METHOD: Two-phase screening study in primary care.
RESULTS: Three estimates of the prevalence of undiagnosed bipolar disorder were obtained: 21.6%, 9.6% and 3.3%. The HCL-32 and BSDS questionnaires had quite low positive predictive values (50.0 and 30.1% respectively). Participants with major depressive disorder and with a history of subthreshold manic symptoms differed from those participants with no or little history of manic symptoms on several clinical features and on measures of both psychosocial functioning and quality of life.
CONCLUSIONS: Between 3.3 and 21.6% of primary care patients with unipolar depression may have an undiagnosed bipolar disorder. The HCL-32 and BSDS screening questionnaires may be more useful for detecting broader definitions of bipolar disorder than DSM-IV-defined bipolar disorder. Subdiagnostic features of bipolar disorder are relatively common in primary care patients with unipolar depression and are associated with a more morbid course of illness. Future classifications of recurrent depression should include dimensional measures of bipolar symptoms. PMID: 21292927 [PubMed - indexed for MEDLINE]

READING 4 – Tools to improve differential diagnosis of bipolar disorder in primary care

Manning JS. Tools to improve differential diagnosis of bipolar disorder in primary care. Prim Care Companion J Clin Psychiatry. 2010;12(Suppl 1):17-22.
PubMed PMID: 20628502; PubMed Central PMCID: PMC2902192.

URL: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2902192/?tool=pubmed (free full text)

Department of Family Medicine, University of North Carolina, Chapel Hill, and the Moses Cone Family Practice Residency and private practice, Greensboro, North Carolina.

ABSTRACT
Among patients seen in a primary care setting for depressive and/or anxiety symptoms, 20% to 30% are estimated to have bipolar disorder. Although relatively common in primary care settings, bipolar disorder is still underrecognized, primarily due to misdiagnosis as unipolar depression. Patients often seek treatment when they are depressed but uncommonly present with mania or hypomania, the specific markers of bipolar spectrum disorders. An awareness of the prevalence, characteristics, and predictors of bipolar disorder can help the primary care physician to properly differentiate between bipolar depression and unipolar depression. Completing a differential diagnosis of bipolar disorder requires obtaining a comprehensive patient history that investigates symptom phenomenology and associated features, family history, longitudinal course of illness, and prior treatment response. In addition to the clinical interview, the Mood Disorder Questionnaire and the World Health Organization Composite International Diagnostic Interview 3.0 can be useful tools for evaluating patients for bipolar disorder. Screening patients at risk for bipolar disorder will help to avoid the use of unproductive or possibly even harmful treatments. PMCID: PMC2902192 PMID: 20628502 [PubMed]

READING 5 – Early onset bipolar spectrum disorders

Danner S, Fristad MA, Arnold LE, Youngstrom EA, Birmaher B, Horwitz SM, Demeter C, Findling RL, Kowatch RA; LAMS Group. Early-onset bipolar spectrum disorders: diagnostic issues. Clin Child Fam Psychol Rev. 2009 Sep;12(3):271-93. Review. PubMed PMID: 19466543.

URL: http://www.springerlink.com/content/p8357372h5w628x2/fulltext.pdf (payment required)

Ohio State University, Columbus, OH, USA.

ABSTRACT
Since the mid 1990s, early-onset bipolar spectrum disorders (BPSDs) have received increased attention in both the popular press and scholarly press. Rates of diagnosis of BPSD in children and adolescents have increased in inpatient, outpatient, and primary care settings. BPSDs remain difficult to diagnose, particularly in youth. The current diagnostic system makes few modifications to accommodate children and adolescents. Researchers in this area have developed specific BPSD definitions that affect the generalizability of their findings to all youth with BPSD. Despite knowledge gains from the research, BPSDs are still difficult to diagnose because clinicians must: (1) consider the impact of the child's developmental level on symptom presentation (e.g., normative behavior prevalence, environmental limitations on youth behavior, pubertal status, irritability, symptom duration); (2) weigh associated impairment and course of illness (e.g., neurocognitive functioning, failing to meet full DSM criteria, future impairment); and (3) make decisions about appropriate assessment (differentiating BPSD from medical illnesses, medications, drug use, or other psychiatric diagnoses that might better account for symptoms; comorbid disorders; informant characteristics and assessment measures to use). Research findings concerning these challenges and relevant recommendations are offered. Areas for further research to guide clinicians' assessment of children with early-onset BPSD are highlighted. PMID: 19466543 [PubMed - indexed for MEDLINE]

READING 6 – Impact of educational programme on management of bipolar disorder

Rouillon F, Gasquet I, Garay RP, Lancrenon S. Impact of an educational program on the management of bipolar disorder in primary care. Bipolar Disord. 2011 May;13(3):318-22. doi: 10.1111/j.1399-5618.2011.00916.x. PubMed PMID: 21676135.

URL: http://onlinelibrary.wiley.com/doi/10.1111/j.1399-5618.2011.00916.x/abstract (payment required)

CMME, Centre Hospitalier Sainte-Anne, Paris INSERM, Paris.

ABSTRACT

OBJECTIVE: Government agencies and industry have recently undertaken educational programs for the management of bipolar disorder in primary care, but their medical impact is not well known. Therefore, we conducted a survey among general practitioners to evaluate the impact of the Bipolact Educational Program on the diagnosis and treatment of bipolar disorder.

METHODS: A total of 45 general practitioners attending the Bipolact Educational Program (trained group) were compared with a control group of 50 untrained general practitioners on their ability to: (i) diagnose bipolar I and II disorders and (ii) treat bipolar disorder patients appropriately.

RESULTS: Trained physicians, but not untrained physicians, showed a significant improvement ($p < 0.0001$, chi-square test) in the ability to identify patients as having bipolar I (from 10.4% to 28.8%) and bipolar II disorder (from 20.1% to 45.8%). This trend resulted in a strong decrease in nonidentified bipolar disorder patients (from 64.6% to 19.5%). Trained physicians, but not the untrained group, greatly increased the number of prescriptions for mood stabilizers for bipolar disorder patients, from 25.6% to 43.2% ($p = 0.0013$, chi-square test). Finally, trained physicians reduced the number of antidepressant prescriptions for bipolar disorder patients (the control group also reduced the number of antidepressant prescriptions, suggesting some bias in the survey).

CONCLUSION: A well-designed education package on diagnosis and management of bipolar disorder greatly increased the likelihood of physicians correctly assigning a subtype, namely bipolar I or bipolar II disorder, to patients already perceived as having some form of bipolar illness, and to prescribing mood stabilizers instead of antidepressants to these patients. PMID: 21676135 [PubMed - in process]

READING 7 – Family-focused treatment for caregivers of patients with bipolar disorder

Perlick DA, Miklowitz DJ, Lopez N, Chou J, Kalvin C, Adzhiashvili V, Aronson A. Family-focused treatment for caregivers of patients with bipolar disorder. Bipolar Disord. 2010 Sep;12(6):627-37. doi: 10.1111/j.1399-5618.2010.00852.x. PubMed PMID: 20868461; PubMed Central PMCID: PMC2947337.

URL: http://onlinelibrary.wiley.com/doi/10.1111/j.1399-5618.2010.00852.x/abstract (free full text)

Department of Psychiatry, Mount Sinai School of Medicine, New York, NY 10029, USA. deborah.perlick@mssm.edu

ABSTRACT

OBJECTIVES: Family members of patients with bipolar disorder experience high rates of subjective and objective burden which place them at risk for adverse physical health and mental health outcomes. We present preliminary efficacy data from a novel variation of Family Focused Treatment [Miklowitz DJ. Bipolar Disorder: A Family-Focused Treatment Approach (2(nd) ed.). New York: The Guilford Press, 2008] that aimed to reduce symptoms of bipolar disorder by working with caregivers to enhance illness management skills and self-care.

METHODS: The primary family caregivers of 46 patients with bipolar I (n = 40) or II (n = 6) disorder, diagnosed by the Structured Clinical Interview for DSM-IV Axis I Disorders, were assigned randomly to receive either: (i) a 12-15-session family-focused, cognitive-behavioral intervention designed to provide the caregiver with skills for managing the relative's illness, attaining self-care goals, and reducing strain, depression, and health risk behavior [Family-Focused Treatment-Health Promoting Intervention (FFT-HPI)]; or (ii) an 8- to 12-session health education (HE) intervention delivered via videotapes. We assessed patients pre- and post-treatment on levels of depression and mania and caregivers on levels of burden, health behavior, and coping.

RESULTS: Randomization to FFT-HPI was associated with significant decreases in caregiver depressive symptoms and health risk behavior. Greater reductions in depressive symptoms among patients were also observed in the FFT-HPI group. Reduction in patients' depression was partially mediated by reductions in caregivers' depression levels. Decreases in caregivers' depression were partially mediated by reductions in caregivers' levels of avoidance coping.

CONCLUSIONS: Families coping with bipolar disorder may benefit from family interventions as a result of changes in the caregivers' ability to manage stress and regulate their moods, even when the patient is not available for treatment. PMCID: PMC2947337 PMID: 20868461 [PubMed - indexed for MEDLINE]

READING 8 – Monitoring outcomes in patients with bipolar disorder

Ketter TA. Strategies for monitoring outcomes in patients with bipolar disorder. Prim Care Companion J Clin Psychiatry. 2010;12(Suppl 1):10-6. PubMed PMID: 20628501; PubMed Central PMCID: PMC2902193.

URL: http://www.ncbi.nlm.nih.gov.libproxy1/pmc/articles/PMC2902193/?tool=pubmed (free full text)

Department of Psychiatry and Behavioral Sciences, and the Bipolar Disorders Clinic, Stanford University School of Medicine, Stanford, California.

ABSTRACT

Practical strategies are available for primary care physicians to monitor psychiatric and medical outcomes as well as treatment adherence in patients with bipolar disorder. Current depressive symptoms can be assessed with tools like the 9-item Patient Health Questionnaire or Beck Depression Inventory. Lifetime presence or absence of manic or hypomanic symptoms can be assessed using the Mood Disorder Questionnaire (MDQ). These measures can be

completed quickly by patients prior to appointments. Sensitivity of such ratings, particularly the MDQ, can be increased by having a significant other also rate the patient. Clinicians should also screen mood disorder patients for psychiatric comorbidities that are common in this population such as anxiety and substance use disorders. While patients with bipolar disorder may commonly be nonadherent with prescribed medication regimens, strategies that can help include having frank discussions with the patient, selecting medication collaboratively, adding psychotherapy with a psychoeducation element, monitoring appointment-keeping, using patient self-reports of medication-taking, enlisting the aid of significant others, and measuring plasma drug levels. Medical monitoring is needed to assess the safety and tolerability of psychotropic medications. All of the approved medications for bipolar disorder have at least 1 boxed warning for serious side effects, but are also associated with other common management-limiting side effects such as sedation, tremor, unsteadiness, restlessness, nausea, vomiting, diarrhea, constipation, weight gain, and metabolic problems. Routine monitoring is particularly needed for obesity, metabolic syndrome, and cardiovascular disorders, which lead to high rates of medical morbidity and mortality in patients with bipolar disorder. Monitoring protocols such as the one recommended by the American Diabetes Association for patients taking second-generation antipsychotics can be used for regular assessment. PMCID: PMC2902193 PMID: 20628501 [PubMed]

READING 9 – Pharmacological treatment of bipolar disorder in primary care

Malhi GS, Adams D, Berk M. The pharmacological treatment of bipolar disorder in primary care. Med J Aust. 2010 Aug 16;193(4 Suppl):S24-30. PubMed PMID: 20712557.

URL: http://www.mja.com.au/public/issues/193_04_160810/mal10159_fm.html (free full text)

CADE Clinic, Department of Psychiatry, Royal North Shore Hospital, and Discipline of Psychiatry, University of Sydney, Sydney, NSW. gin.malhi@sydney.edu.au

ABSTRACT

OBJECTIVE: To provide a practical overview of the pharmacological management of adults with bipolar disorder in primary care and the role of general practitioners in the pharmacotherapy of this complex disorder.

DATA SOURCES: Published guidelines for the treatment of bipolar disorder, plus Cochrane reviews, meta-analyses, review articles and reports from randomized controlled trials that were published up to May 2009.

STUDY SELECTION: Over 500 articles on the treatment of bipolar disorder were reviewed, with an emphasis on meta-analyses and systematic reviews of randomized controlled trials. Where evidence was more limited, open trials and non-controlled data were also reviewed.

DATA EXTRACTION: Key recommendations relevant to GPs were synthesised and rated according to National Health and Medical Research Council levels of evidence.

DATA SYNTHESIS: Lithium, valproate and atypical antipsychotics are first-line treatment options for acute mania, and monotherapy is ideal if it produces an adequate response. For depressive episodes, recommendations are less definitive and the use of antidepressants is controversial. Most patients require maintenance treatment, during which pharmacotherapy should be used to prevent relapse, and psychological and social interventions should be considered.

CONCLUSIONS: Bipolar disorder is a lifelong episodic illness that affects 1%-2% of the population, many of whom are principally managed by their GPs. Pharmacological treatment with mood-stabilising agents is the primary form of management, although this is ideally provided in conjunction with psychosocial interventions. PMID: 20712557 [PubMed - indexed for MEDLINE]

READING 10 – Critical appraisal of treatments for bipolar disorder

Nierenberg AA. A critical appraisal of treatments for bipolar disorder. Prim Care Companion J Clin Psychiatry. 2010;12(Suppl 1):23-9. PubMed PMID: 20628503; PubMed Central PMCID: PMC2902191.

URL: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2902191/?tool=pubmed (free full text)

Department of Psychiatry, Harvard Medical School and Massachusetts General Hospital, Boston.

ABSTRACT

Recovery-the absence of all abnormal mood symptoms-is the goal of treatment for bipolar disorder. Unfortunately, a minority of people suffering from bipolar disorder achieve sustained recovery. Improving recovery rates for this population will require clinicians in the primary care setting to be familiar with appropriate treatments for acute bipolar mania and depression and for the maintenance phase. Efficacy and tolerability of pharmacotherapeutic and psychotherapeutic options for all phases of treatment and each type of mood episode are discussed. Primary care physicians are encouraged to avoid prescribing antidepressant monotherapy for any patient with depression and a history of mania or hypomania. PMCID: PMC2902191 PMID: 20628503 [PubMed]