Cheshire and Wirral Partnership NHS
NHS Foundation Trust

Bipolar Disorder at work

Dr Micheline Tremblay & Fiona Cooper

Care • Well-being • Partnership

Aims and Objectives

- Recognising key symptoms of Bipolar Disorder.
- To identify why bipolar affects people in the workplace
  - Symptoms
  - Comorbidity
  - Pharmacotherapy
- To discuss ways of supporting someone in the workplace

Non Bipolar Person

High Energy

Feel anxious

Feel good with lots of energy

Negative mood

Positive mood

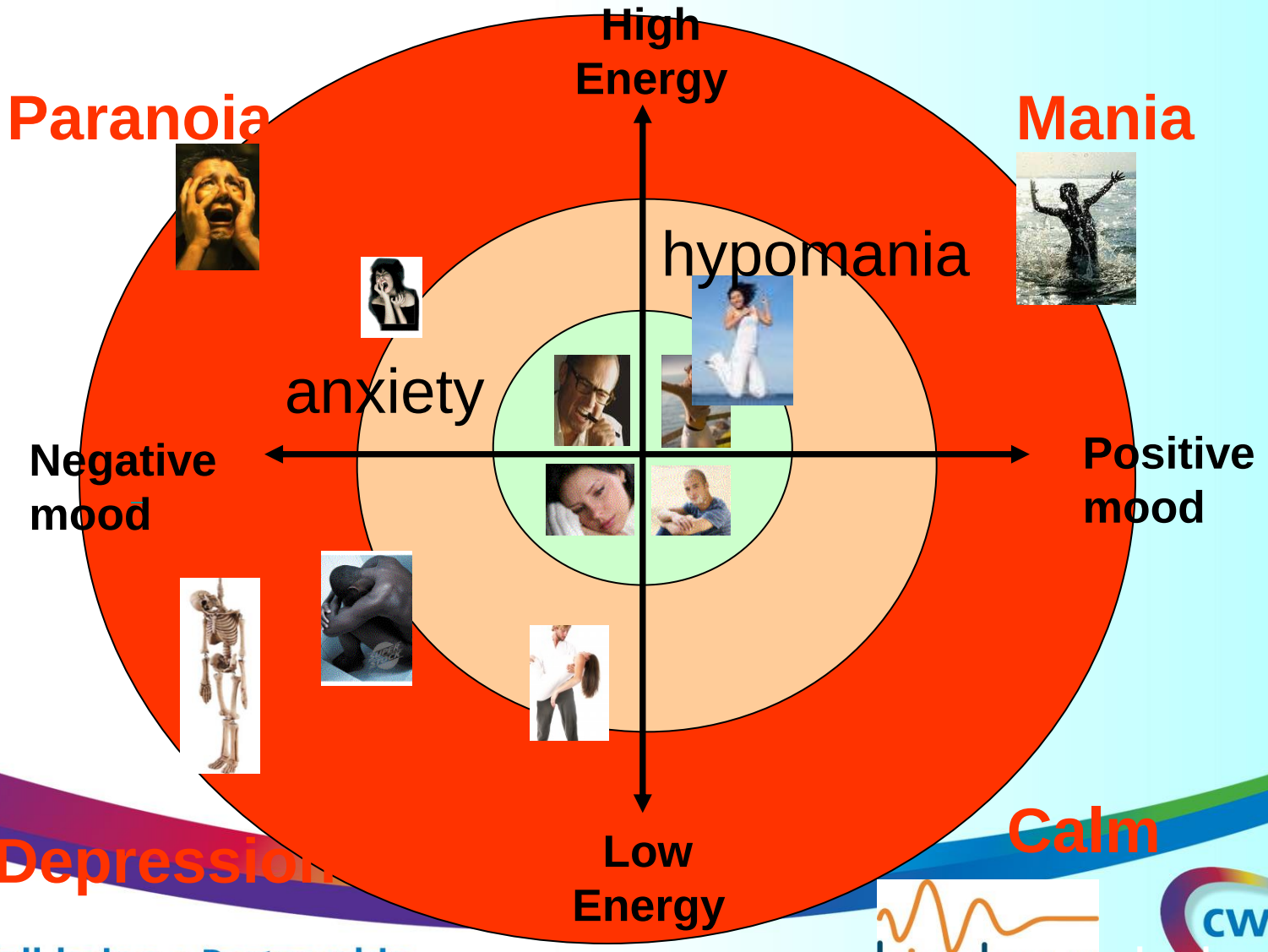
Feel low

Feel content and relaxed

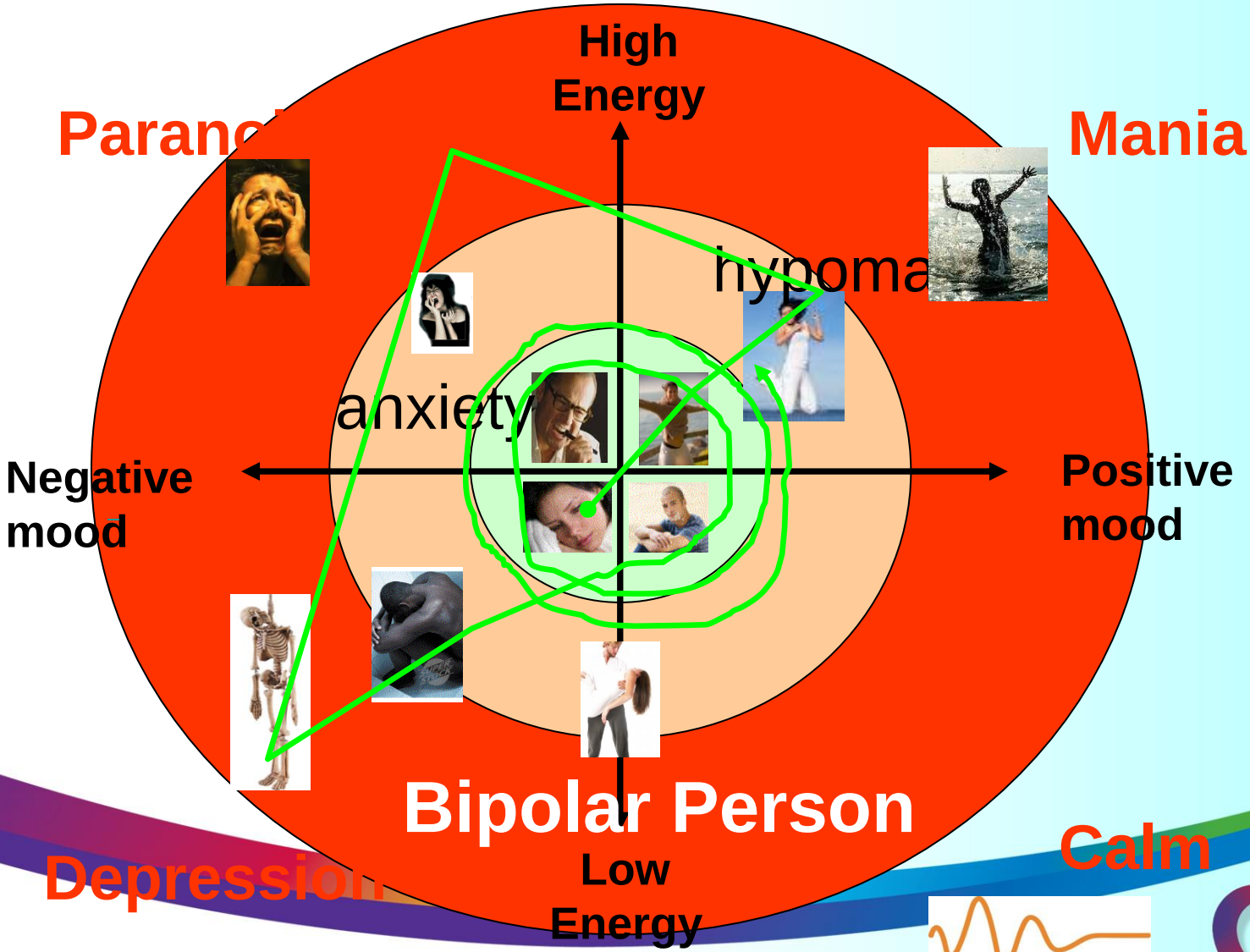
Low Energy

Non Bipolar Person

Bipolar Person



Nicola's Journey



Mood Scale

Mania	10	Total loss of judgement, exorbitant spending, religious delusions and hallucinations.
	9	Lost touch with reality, incoherent, no sleep, paranoid and vindictive, reckless behaviour.
Hypomania	8	Inflated self-esteem, rapid thoughts and speech, counter-productive simultaneous tasks.
	7	Very productive, everything to excess (phone calls, writing, smoking, tea), charming and talkative.
Balanced Mood	6	Self-esteem good, optimistic, sociable and articulate, good decisions and get work done.
	5	Mood in balance, no symptoms of depression or mania. Life is going well and the outlook is good.
	4	Slight withdrawal from social situations, concentration less than usual, slight agitation.
Mild to Moderate Depression	3	Feelings of panic and anxiety, concentration difficult and memory poor, some comfort in routine.
	2	Slow thinking, no appetite, need to be alone, sleep excessive or difficult, everything a struggle.
Severe Depression	1	Feelings of hopelessness and guilt, thoughts of suicide, little movement, impossible to do anything.
	0	Endless suicidal thoughts, no way out, no movement, everything is bleak and it will always be like this.

Triggers

Death of a family member

Divorce

Imprisonment

Separation

Personal injury or illness

Retirement

Marriage

Birth of a child

Moving house

Falling in love

Oustanding personal achievement

Change in job

Going on holiday

Christmas

Pregnancy

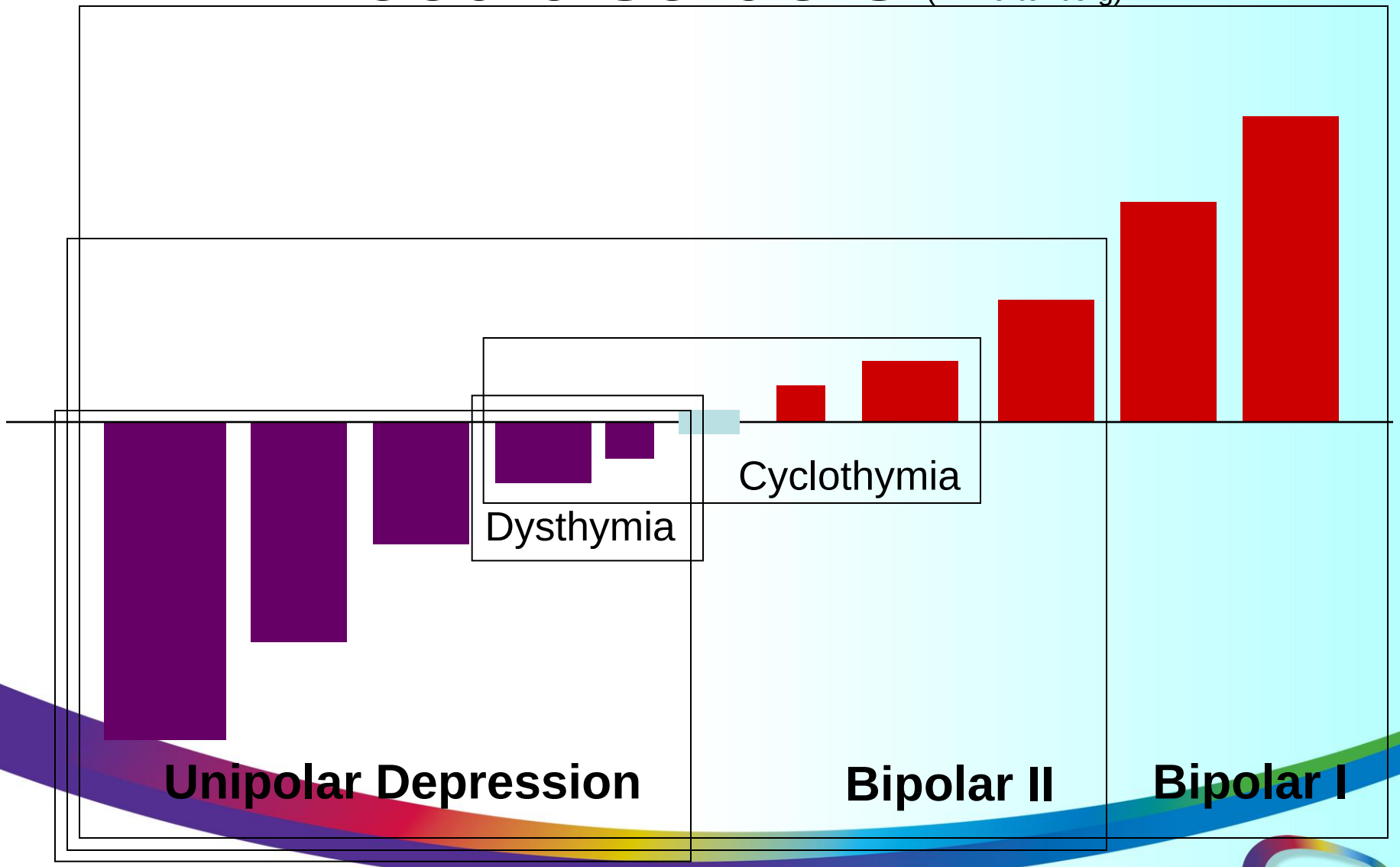
Minor violation of the law

Dismissal from work

Financial difficulties

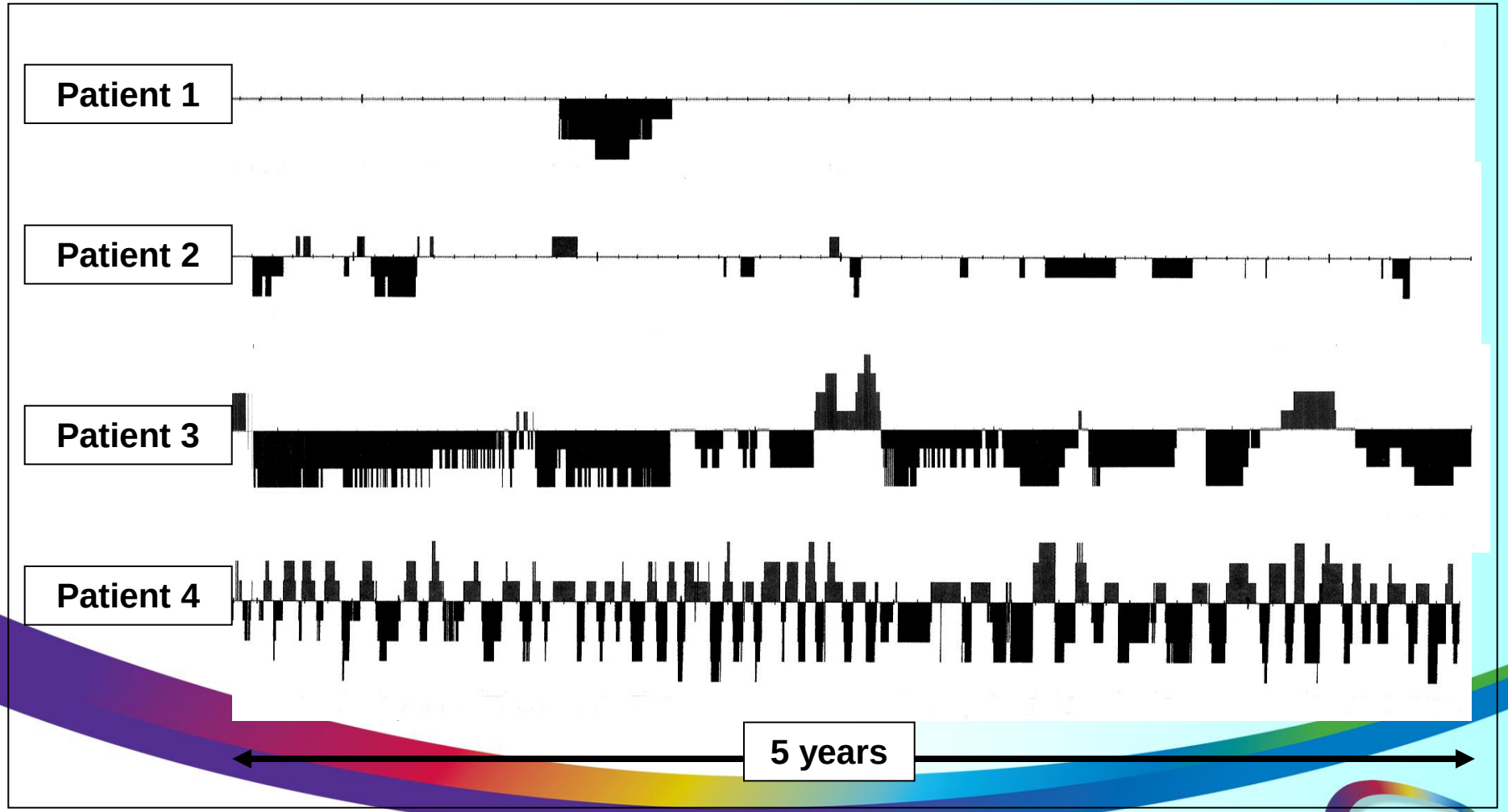
Change in leisure activities

Mood disorders (Pr Kortenberg)



Bipolar disorder has a heterogenous longitudinal course

…irregularity is the rule, regular cycling the exception (Pr Kortenberg)



Epidemiology: NICE

- Annual incidence 7 per 100,000
- Estimated lifetime prevalence – bipolar I
  4–16 per 1000
- Peak onset between 15 and 19 years of age
- Suicide
  bipolar I – 17% attempt suicide
  bipolar disorder – 0.4% die annually by suicide

Epidemiology Demographics

- **Male = Female**
  - More Depressive/Mixed/Rapid disorders in females
  - More manic episodes in males
- **Peak age of onset 15-19 years; before 30**
  - **Mean age onset; 21**
  - **90 % of patients develop the disorder before 50 years of age**
- **Increased incidence in black and ethnic minority**
- **Increased incidence in upper class**

Problems of Misdiagnosis

- Efficacious treatment with mood stabilisers and appropriate counselling specific to bipolar disorder is delayed as a result of misdiagnosis[1]
- When appropriate treatment for bipolar disorder is initiated for patients who have had several episodes of illness, treatment may be less effective[2]
- Inappropriate treatment with antidepressants can lead to an elevated risk of hypomania, mania, and cycling

Bipolar Depression

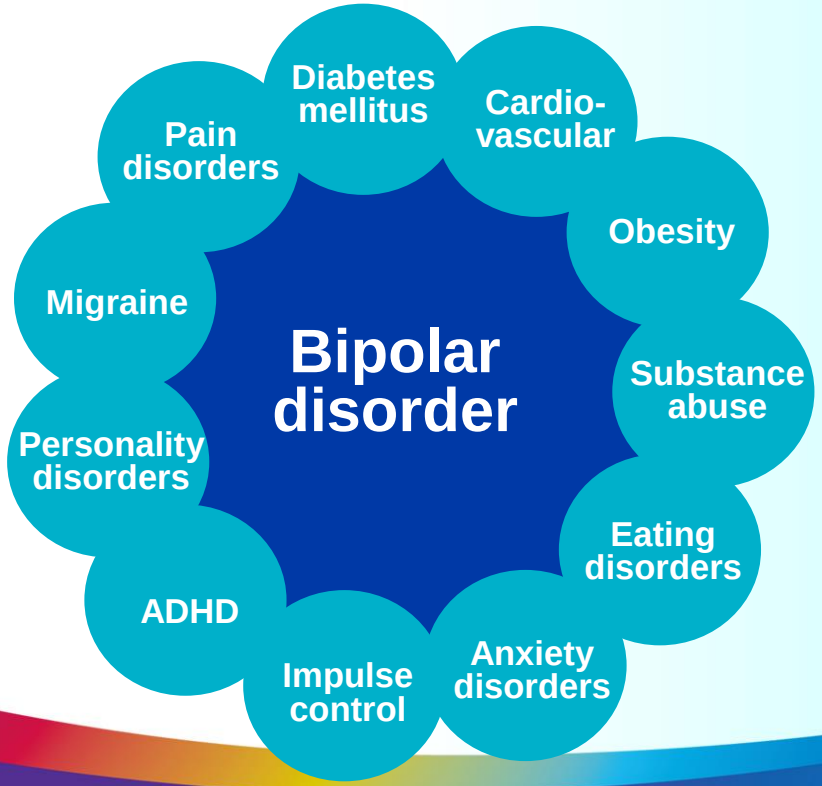
- Potentially misdiagnosed as unipolar
- Epidemiology
  - Early onset
  - Psychotic symptoms
  - Post partum
  - Treatment resistant unipolar
  - Hx of AD induced hypomania/mania
  - Change in the type of depressive symptoms over time
  - Seasonal pattern
    - Mitchell, J Clin Psych, 2001

Other conditions could share similar characteristics

- Cyclothymia
- Personality Disorder
- Adult Attention Deficit Disorder
- Schizophrenia or Schizoaffective Disorder
- Substance misuse
- Organic brain syndrome
- Metabolic Disorders
- Iatrogenic

Frequent Co-morbid Conditions in Bipolar I Disorder

Disease and treatment are complicated by frequent psychiatric and physical comorbidities



ADHD=Attention deficit hyperactivity disorder

McIntyre, et al. Hum Psychopharmacol 2004;19(6):369-386

Course and Prognosis

- The onset is 21yrs in hospital studies and 17 yrs in community surveys. Late onset rare and may be precipitated by organicity.
- Average lenght mania; 6 months.
- 90% will have further episodes.
- Over 25 years average of 10 further episodes.
- Intervals gradually shorter.
- Pnx rather poor, worse rapid cycling.

For most patients bipolar disorder is chronic and recurrent

- The risk of recurrence in the 12 months after a mood episode is especially high in patients with BPD compared with other psychiatric disorders[1]
  - 50% in 1 year
  - 75% at 4 years
  - Afterwards 10% per year

1. National Institute of Health and Clinical Excellence. CG38, 2006.

Proportion of YLDs, YLLs, and DALYs explained by the ten leading causes of total burden in 2010

DALYs=disability-adjusted life-years. YLDs=years lived with disability. YLLs=years of life lost.

	Proportion of total DALYs (95% UI)	Proportion of total YLDs (95% UI)	Proportion of total YLLs (95% UI)
Cardiovascular and circulatory diseases	11·9% (11·0–12·6)	2·8% (2·4–3·4)	15·9% (15·0–16·8)
Common infectious diseases; eg diarrhoea	8·1% (7·3–9·0)	1·2% (1·0–1·5)	11·2% (10·2–12·4)
Neonatal disorders	7·6% (7·0–8·2)	0·6% (0·5–0·7)	10·7% (10·0–11·4)
Cancer	7·4% (6·2–8·6)	22·9% (18·6–27·2)	0·5% (0·4–0·7)
Mental and substance use disorders	7·4% (6·2–8·6)	22·9% (18·6–27·2)	0·5% (0·4–0·7)
Musculoskeletal disorders	6·8% (5·4–8·2)	21·3% (17·7–24·9)	0·2% (0·2–0·3)
HIV/AIDS and tuberculosis	5·3% (4·8–5·7)	1·4% (1·0–1·9)	7·0% (6·4–7·5)
Other non-communicable diseases	5·1% (4·1–6·6)	11·1% (8·2–15·2)	2·4% (2·0–2·8)
Diabetes, urogenital, blood, and endocrine diseases	4·9% (4·4–5·5)	7·3% (6·1–8·7)	3·8% (3·4–4·3)
Unintentional injuries other than transport injuries	4·8% (4·4–5·3)	3·4% (2·5–4·4)	5·5% (4·9–5·9)

TREATMENT

When to start long term treatment? NICE 2006

- BP-1
  - 2 or more episodes
  - after 1 manic episode involving significant risk & adverse consequences
- BP-2
  - significant functional impairment
  - significant risk of suicide
  - frequent episodes

Lithium


7up
Seven-Up
Settles the
Stomach
For Hospital
or home use.
LITHIATED
LEMON SODA
The added citrates neutralize free acid. The sugar is inverted...
burns clean. 7-Up is more than a mixer ...It blends out the harsh
features. Dispels hangovers ...takes the "ouch" out of grouch
Slenderizing
PRINTED IN U. S. A.

Adverse Effects

- Adverse effects at normal plasma level
  - Tremor, weight gain, thirst, polyuria, polydipsia
  - Precipitates or worsens skin problems
- Renal complications
  - Diabetes insipidus (inhibits renal action of ADH)
  - Chronic renal impairment? (reduced GFR)
- Hypothyroidism (5%)
- Toxicity
- Teratogenesis
  - Major congenital anomalies in early pregnancy
  - 4-12 % of births (cf 2-4% in untreated comparison groups)

Summary for Lithium

- Efficacy established in acute mania
  - Poorer response in:
    - mixed affective episodes
    - rapid cyclers
- Effective in maintenance of BPD (mania > depression)
- Appears anti-suicidal in BPD
- Side effects, acute and long term, are problematic
- Newly established national ***Lithium register***

Valprorate

Adverse effects

- Nausea & vomiting
- Tremor
- Weight gain
- Alopecia
- Blood dyscrasias and hepatoxicity (FBC & LFTs)
- Upward titration the norm
- Problematic in women of child bearing potential

- Teratogenic (MCA:10.6% vs 2.8 %:, Artama et al, 2004).
- Effect on cognitive development (Adab et al 2004)

Summary for Valproate

- Effective in acute mania
- Probably effective in maintenance
- Placebo controlled data lacking
- Effectively marketed, in US now more commonly used than lithium
- Valproate semi-sodium licensed for acute mania in UK (Depakote; Sanofi)
- Effects on new born are a major risk

Other anticonvulsivants

Carbamazepine

- Weak anti manic and prophylactic effect
- Drug interactions
  - induces metabolism of various drugs
  - e.g. OCP, antipsychotics, antidepressants, anticoagulants, steroids
- Teratogenic
- Adverse effects
  - nausea and vomiting
  - hepatotoxicity
  - drowsiness and diplopia

Lamotrigine

- Roles
  - antidepressant in bipolar depression?
  - prophylaxis of bipolar depression?
  - some evidence for effect in rapid cycling
  - not licensed in UK for use in BPD
- Side effects
  - rash (including S-J syndrome), cautious dose increase
  - ?teratogenic (cleft defects)

Antipsychotics

British National Formulary

Molecule	Acute Mania	Acute Depression	Prevent Mixed	Prevent Mania	Prevent Depression
Lithium	X	x		X	x
Valproate	X				
Quetiapine IR/ XL	X	X	X	X	X
OLZ	X			X	
Aripiprazole	X			X	
Risperidone	X				

ECT

- Indications
  - Severe symptoms that have not responded to other treatment
  - Life-threatening condition
- Diagnostic indications
  - severe depression
  - prolonged or severe mania
  - catatonia
- Consider potential risks and benefits

General Principles for Management

- Treat the illness, not just the episodes
- Help the patient learn about destabilizing factors and early warning signs
- Therapeutic alliance

Physical Care

- Familiarisation with guidance for each group of psychotropic medication.
- Importance of basic health check
  - Initial; smoking/alcohol status, weight/height, BP, thyroid/LFTs/renal FTs, FBC, lipids, glucose.
  - Options; EEG/CT/MRI if organicity suspected, ECG/X-Ray/Drug screen if hx.

A day at the office…

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- Return to work
- Open discussion
- Help the employee to identify triggers
- Put in place reasonable adjustments
- Tools - mood scales / advance statement

A day at the office…The Receptionist

The triggers:

- The fire alarm goes off
- The constant ring of the telephone
- The lighting in the office
- Unclear tasks

A day at the office…The Firefighter

The triggers:

- Rotating shift patterns
- Disclosure / stigma
- Review meetings

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- Limitations
  - '*Not a substitute for professional knowledge and clinical judgement*'

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Micheline Tremblay

Adult Psychiatry and Honorary Lecturer for the University of Liverpool
Cheshire and Wirral Partnership NHS Foundation Trust

Dr Tremblay is Consultant in Adult General Psychiatry as part of a Community Mental Health Team providing specialist mental health services to the Northwich population in Cheshire.

She completed her specialist training in Quebec, Canada, as well as her Master's Degree in Experimental Sciences.

Over years Dr Tremblay has held various posts within her Trust including Clinical Director, Chair of the ElectroConvulsive Therapy Group and Medical Governor. This exposure to medical management and governance helped shape an interest for the effective management of disorders through the use of Integrated Care Pathways.

Dr Tremblay developed a special interest for Bipolar Disorder being involved in training and education with a variety of groups including psychiatric trainees as Honorary Lecturer for the University of Liverpool, practitioners including pharmacists and GPs, and most importantly users and carers through her work and involvement with Bipolar UK

As a Fellow of NICE, Dr Tremblay wishes to expand this interest in adapting a concept of Integrated Care Pathway in the management of Bipolar Disorder for use with the Patient Electronic Record systems. This tool is designed to provide cutting edge evidence based information at the finger tips of mental health practitioners. A collaboration with NICE will support the infusion of the latest information within the pathway and facilitate its dissemination. She is hoping to promote evidence based practice, training and education with

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