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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Managing Mixed Bipolar Episodes

HOW TO TREAT RESISTANT BIPOLAR PATIENTS

The DSM-IV defines mixed bipolar episodes as being relatively rare, but for those of us in clinical practice, this definition may be too conservative to be of much use. What is a mixed bipolar episode and how best can we treat these patients?

Welcome to the Clinician's Roundtable. I am Dr. Leslie Lundt, your host and with me today is Dr. Robert Post. Dr. Post is Professor of Psychiatry at George Washington University and Penn State College of Medicine and he heads the Bipolar Collaborative Network. For 37 years, he worked at the NIMH, studying and treating treatment-resistant unipolar and bipolar patients. He has won more than a dozen national and international awards for his research. Dr. Post has just published a new book "Treatment of Bipolar Illness: A Casebook for Clinicians And Patients."

DR. LESLIE LUNDT:

Welcome to ReachMD, Dr. Post.

DR. ROBERT POST:

Well, thank you very much. I am very happy to be here.

DR. LESLIE LUNDT:

Dr. Post, what is a mixed bipolar episode and I think that most of our audience may be never learned about this in their training?

DR. ROBERT POST:

Yeah, it's actually fairly common as opposed to what the DSM suggests and basically it's one of two different things. It's either an uncomfortable or disraught or anxious, irritable mania where instead of the classic euphoric presentation where patients are happy and bubbling over, they actually don't like how they feel. They are overdriven and I have seen patients, who are clearly manic, delusional, in seclusion rooms but actually having panic attacks simultaneously with their mania. So, it can be quite uncomfortable and it turns out that some two-thirds of women's hypomania is actually uncomfortable and dysphoric than 40% of mens. So, it's actually quite common and is

fairly important because lithium is less effective in those with dysphoric mania. The other component of mixed bipolar episodes is that they can also be very rapidly fluctuating between mania and depression, some times multiple times within a day, what we call ultra-rapid cycling or ultradian cycling, meaning many switches within the day and that also is relatively difficult to treat as well.

DR. LESLIE LUNDT:

So, thinking about maybe a primary care practitioner in the audience listening, how might they be able to pick up these patients in their office?

DR. ROBERT POST:

Again, I think the issue is focusing in on patients having increased energy and decreased need for sleep as to great screening questions because even an uncomfortable, dysphoric, manic patient will answer positively to those questions. So, it's the energy and feeling even with marked sleep loss that they are just ready to go that those 2 components will pick up both the euphoric patients and the dysphoric patients.

DR. LESLIE LUNDT:

Yeah, that makes sense and certainly a unipolar depressed patient might complain of decreased sleep of course, but they would notice the effect. They would feel fatigued and sluggish and less productive, right?

DR. ROBERT POST:

Exactly, exactly.

DR. LESLIE LUNDT:

So, it sounds like the DSM-IV definition isn't terribly useful in our practices?

DR. ROBERT POST:

Well, it does focus in on this component of the illness, which really tells us that the treatment should be different, that lithium often needs assistance by another mood stabilizer or an atypical and in general, the antidepressants are not excellent drugs for mixed state. So, that is another further reason for avoiding the first use of the antidepressant augmentation and in general now we are deferring the use of the antidepressants to much later in the sequence or trying to avoid them altogether in someone with mixed states.

DR. LESLIE LUNDT:

If you are new to our channel, you are listening to The Clinician's Roundtable on ReachMD, the Channel for Medical Professionals. I am Dr. Leslie Lundt, your host and with me today is Dr. Robert Post. We are discussing mixed bipolar episodes.

DR. LESLIE LUNDT:

Dr. Post, when I was in training, we called these patients agitated depression. Is that different from dysphoric mania? I am having a hard time figuring out what an agitated depression really is now.

DR. ROBERT POST:

Yeah, well, in an agitated depression, the patient is classically depressed, low, sad, hopeless, goal driven, and at the same time, they may have a lot of hand wringing and psychomotor activation as part of that depression, but as you pointed out, the key element here is that they are not energized and they don't have a decreased need for sleep. They may be insomniac, but they wish they could be sleeping as opposed to a dysphoric manic patient, who even on a few hours of sleep is ready to go.

DR. LESLIE LUNDT:

Okay, so that's really the kind of fatigue and energy is the key component here. Is it so hard to figure out what's anxiety, what's mania? If you add another component of may be some attention deficit in there, it gets very confusing for those of us out there in the trenches.

DR. ROBERT POST:

Yeah and to make it even more confusing, the Italians have now looked at something that they call mixed depression and that's a classically depressed patient, who has a little bit of speeded up component. They are not really hypomanic, but they may have racing thoughts or feel a little speeded up and those patients also are much more likely to switch into mania on antidepressants. So, I think, the major message is that if there is a mixed state, either a mixed mania or a mixed depression in the context of bipolar illness that avoiding those antidepressants is probably a very good place to start.

DR. LESLIE LUNDT:

Thinking about the mood stabilizers, then can you give us a quick rundown on the mood stabilizers that would be appropriate in these patients?

DR. ROBERT POST:

Yeah, again lithium often needs some extra help with the other ones and lamotrigine or Lamictal, carbamazepine or Tegretol, or valproate or Depakote, those are the other anticonvulsant mood stabilizers. Each of those seems to be helpful in the anxious components and some of the dysphoric components of the illness; and now we are increasingly seeing that the atypical antipsychotics also have very good antidepressant, anti-anxiety effects and for example, quetiapine or Seroquel is actually now FDA approved as monotherapy for the bipolar depression so that those are very good adjunctive approaches to the patients with mixed mania.

DR. LESLIE LUNDT:

Should these patients be treated by a psychiatrist? Should we need to encourage our primary care colleagues to refer them?

DR. ROBERT POST:

Perhaps, I think it relates to the comfort level of the treating physician if they are really on top of it and comfortable with dealing with these other agents that actually can be helpful for them either to be involved somewhat or primarily involved because so many of these medications have side effects and so many medical illnesses are co-occurring with depression. For example, patients are twice as likely to have a heart attack and die of it if they are depressed than if they are not. All sorts of illnesses, medical illnesses are much more common and/or difficult to treat in the context of depression. So, having a primary care doc either closely involved or if they are comfortable actually treating the illness is I think a good idea.

DR. LESLIE LUNDT:

If I look at the list of mood stabilizers, including lithium, there are some pretty nasty possible side effects and some fairly intense monitoring that needs to be done – if we think of Tegretol of course we have to worry about getting CBCs and looking for aplastic anemia; Depakote, the risk of pancreatitis, polycystic ovaries, liver disease. None of them are clean without significant problems that I can see.

DR. ROBERT POST:

Yeah, I think that's the case and I think that's why patient education is a critical variable in here, to have the patient well informed and part of the treatment team and looking at not only for a completeness of clinical response, but some of the side effects, which can often be avoided altogether or if they occur be rapidly dealt with. So, I think that's really a very important element here and that goes along with the life charting to not only chart mood and sleep carefully, but also side effects and try to deal with them very quickly.

DR. LESLIE LUNDT:

Can you give us some suggestions about dealing with the atypical antipsychotics, lot of worry about the weight gain and possible lipid and metabolic consequences of using drugs in this category?

DR. ROBERT POST:

Yeah, this is a definite problem and one of the approaches that I have taken is actually to try to use some of the more difficult to titrate drugs first that has a better profile for less weight gain and less metabolic problems that is aripiprazole (Abilify) or ziprasidone (Geodon). Those are pretty weight neutral in adults compared to moderate weight gain with quetiapine or Seroquel or risperidone. Olanzapine (Zyprexa) and Clozapine are sort of the worst offenders. So that if one is going to use an atypical is trying to use some of the better tolerated ones in preference for ones that can be more problematic.

DR. LESLIE LUNDT:

Any suggestions on dosing? I know many of us have had a hard time with aripiprazole and ziprasidone just trying to figure out how the dose is.

DR. ROBERT POST:

Yeah, I think I had that problem in the beginning where I tried pretty hefty doses right from the get-go and patients did not like me whatsoever; and I think the thing to do is to actually start with baby doses, start everybody with 1 or 2 mg of aripiprazole and then titrate slowly according to side effects tolerability and particularly now that aripiprazole is approved as an adjunct for unipolar depression, starting it low in those patients is quite important. The story with the ziprasidone or Geodon is a little bit more complicated and it actually may be that higher doses achieve fairly rapidly, may be less activating as one brings in some of the other mechanisms of action of the drug at slightly higher doses, but both of those drugs require a little care in the approach to the patient as opposed to some of the other ones that are much easier to deal with.

DR. LESLIE LUNDT:

Well, it's certainly a confusing and difficult topic, but thank you for enlightening us today.

DR. ROBERT POST:

Thank you.

DR. LESLIE LUNDT:

We have been speaking with Dr. Robert Post, the author of “Treatment of Bipolar Illness: A Casebook for Clinicians And Patients.” We have been talking about managing mixed bipolar states.

I am Dr. Leslie Lundt. You have been listening to the Clinician’s Roundtable on ReachMD XM157, the Channel for Medical Professionals. Thank you for listening.