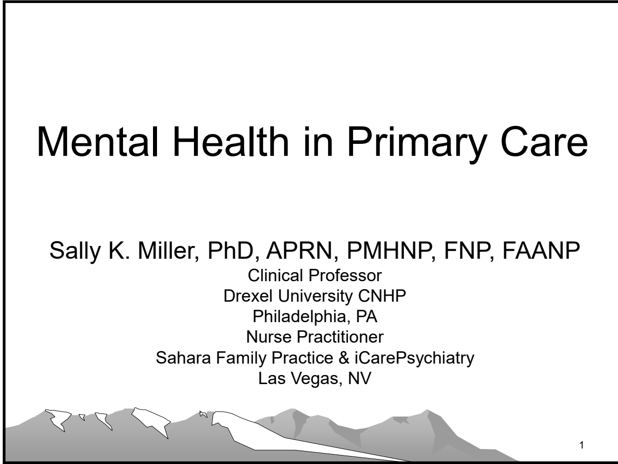
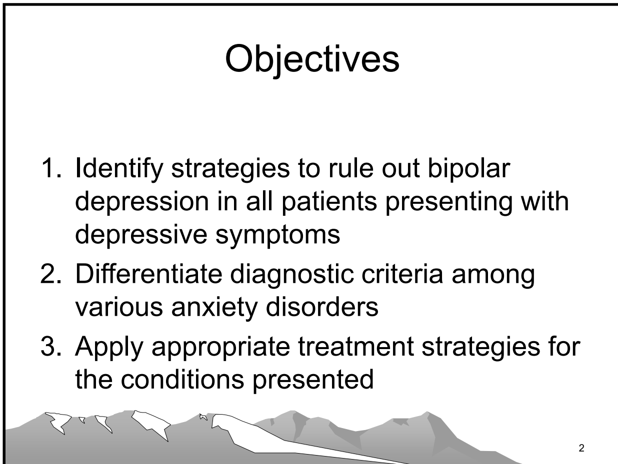
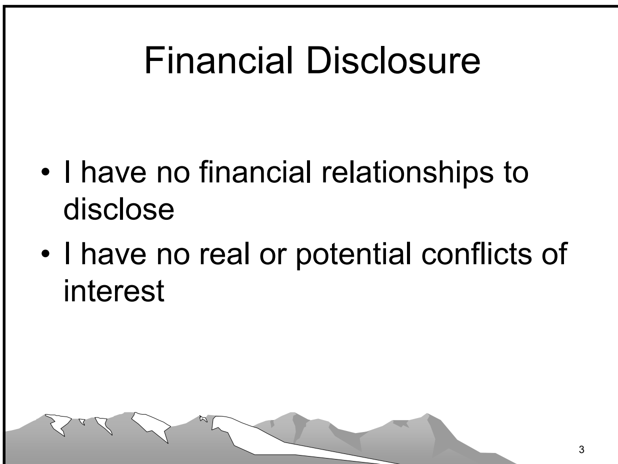


1



2



3

The Biggest Challenge in Bipolar Depression? Recognizing It!

- Managing bipolar depression is not especially difficult
- The two most important issues are:
  - Recognizing bipolar depression
  - Deciding if you are comfortable managing it in primary care

4

4

Making the Diagnosis

- Screening for depression has become a common mandate in primary care
  - Most compelling for those with chronic disease, history of depression, and the elderly
- Conventional screening and diagnostic tools are based upon DSM-V domains to establish diagnosis

5

5

DSM-V Criteria for MDD

(present nearly every day for at least 2 weeks)

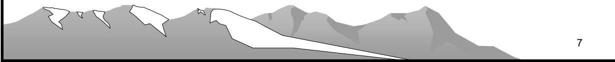
- Depessed mood or irritability*
- Decreased interest or pleasure*
- Change in weight (≥ 5%) or appetite
- Sleep changes
- Psychomotor changes
- Fatigue or energy loss
- Guilt/worthlessness
- Diminished concentration
- Suicidality

6

6

Problem #1 – Recognizing Bipolar Depression

- Traditional screening tools do not identify bipolar depression
- If someone screens positive for depression, you want to evaluate for symptoms of mania or hypomania *before* starting antidepressant medication.



7

7

Case Study

25-year-old Female

8

8

Case Study

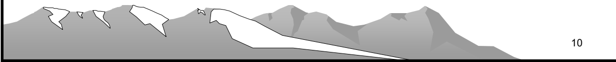
- A 25-year-old female presents for evaluation because she thinks she "needs an antidepressant."
- She finally has health insurance and wants to get help.

9

9

Case Study
(continued)

- She has struggled with depression on and off ever since she was a teenager.
- She was talking to a friend at work who was depressed.
  - Sertraline changed her life.



10

10

Case Study
(continued)

- Relevant history
  - Denies any medical or surgical history
  - Takes no medications
  - Patient tobacco use; alcohol 1–2 × week
  - Experimented with some recreational drugs in her teens and college
  - No family history of psychiatric disorders

11

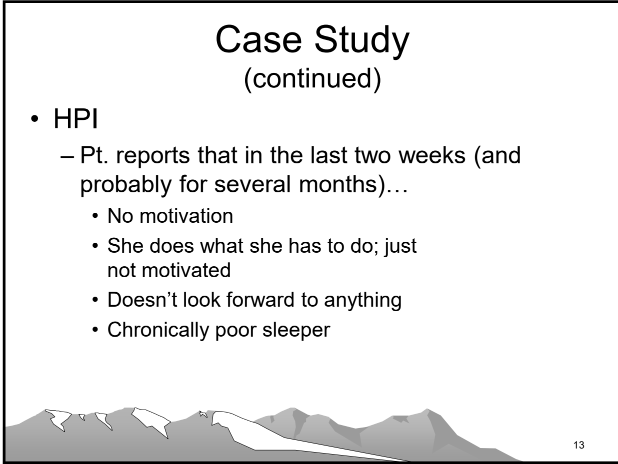
11

Case Study
(continued)

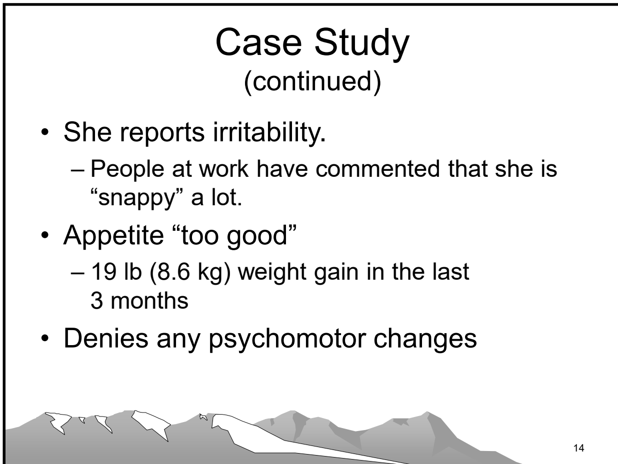
- Complete ROS
  - She feels fatigued a lot.
    - "Just don't want to do anything."
  - Sleep is inconsistent.
  - Appetite is too good; eats constantly, has gained 19 lb (8.6 kg) in the last 3 months
  - Chronically constipated
  - The remainder of ROS is negative.

12

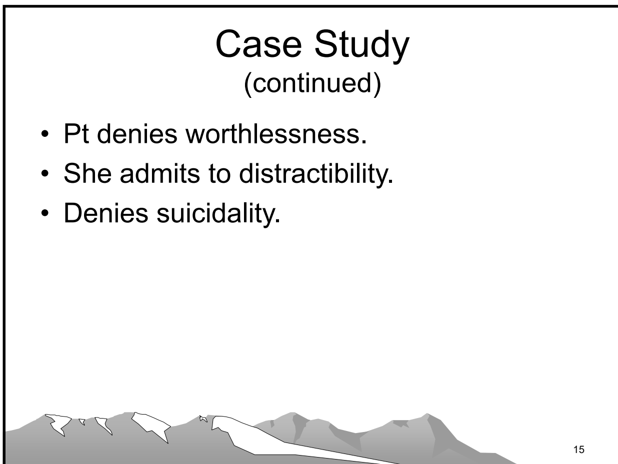
12



13



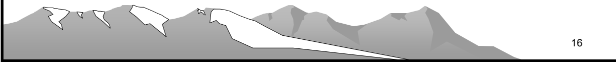
14



15

Analysis of HPI

- Irritability +
- Decreased interest/ pleasure +
- Weight change/ appetite change +
- Sleep disturbances +
- Activity change –
- Fatigue/ energy loss +
- Guilt/ worthlessness –
- Concentration loss +
- Suicidiality –



16

16

Case Study
(continued)

- Physical exam
  - Normal
  - Well groomed
  - Attends to hygiene
  - Good eye contact
  - Coherent thought
  - Normal flow of conversation
  - Voice well modulated

17

17

Case Study
(continued)

- What's your diagnostic impression?
- How do you treat her?
  - SSRI
  - Pick a typical starting dose.
  - Start daily with half a pill for 1–2 weeks then full pill.
  - Follow-up in 4 weeks
  - Consider a therapist referral.

18

18

Why Don't Depressed Patients Respond to Antidepressants?

- Inadequate dose
- Inadequate therapeutic trial
- Wrong diagnosis

19

19

Why Don't Depressed Patients Respond to Antidepressants?

- Wrong diagnosis more likely when:
  - Absolutely no response (no effect, no side effects)
  - Worsening of symptoms
  - Intolerable side effects with no improvement in presenting symptoms

20

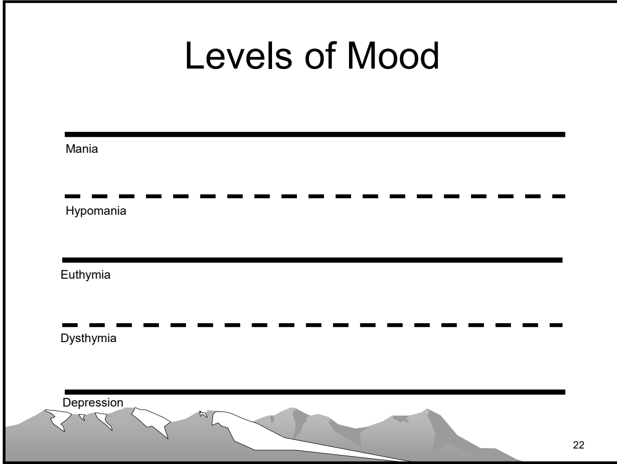
20

Why Don't Depressed Patients Respond to Antidepressants?

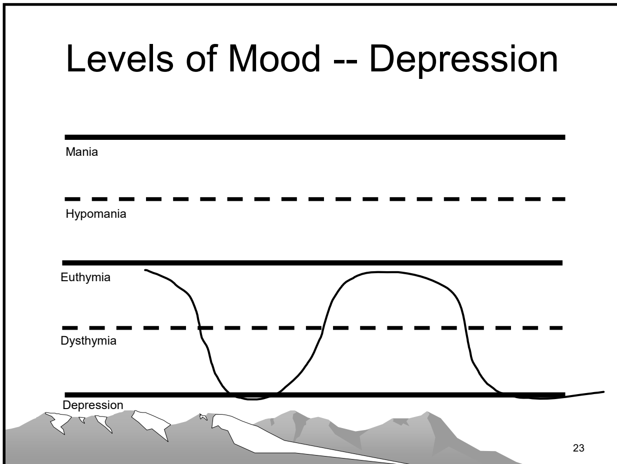
- When one of the indicators of "wrong diagnosis" occurs, we need to reconsider the diagnosis
- Most common misdiagnoses are:
  - Cyclothymia
  - Bipolar disorder

21

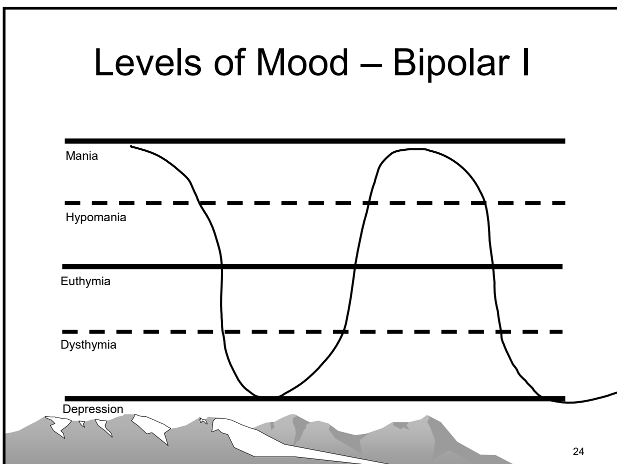
21



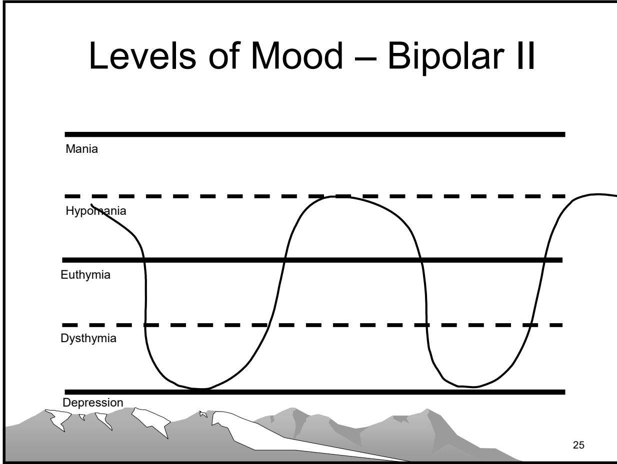
22



23



24



25

Differentiating Mood Disorders

- Major depressive disorder (MDD) is not characterized by manic or hypomanic episodes
- Typically presents as the classic “5 of 9 domains”
- These patients respond best to antidepressants

26

26

Differentiating Mood Disorders

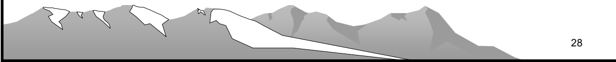
- Bipolar I characterized by classic cycling from depression to mania
- Bipolar II characterized by cycling from depression to hypomania
- Cyclothymia characterized by cycling from dysthymia to hypomania

27

27

Differentiating Mood Disorders

- Any patient who presents with depressive symptoms should be evaluated for a history of cycling
- Patients with BPI, BPII, or cyclothymia may have mania precipitated by an antidepressant



28

28

Differentiating Mood Disorders

- Before starting patients on antidepressants, history should include assessment for symptoms consistent with mania or hypomania

29

29

Differentiating Mood Disorders

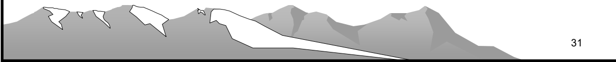
- Symptoms of "up" mood
  - 2 or more sleepless nights
  - Hallucinations
  - Feelings of grandiosity or invincibility
  - Extreme/disproportionate anger
  - History of risk-taking behavior
  - Binge behavior – shopping, gambling, eating, sexuality

30

30

Differentiating Mood Disorders

- Patient history consistent with cyclic mood disorders
  - Family history of BPD
  - Younger age of onset
  - Periods of excess energy/sleeplessness
  - Hyperphagia
- Remember – patients often like their manic/hypomanic times and don't report it



31

31

Our 25-year-old Patient

- She has struggled "on and off" with depression since adolescence
- She has "experimented with drugs in teens and college"
- Periods of sleeplessness
- She is hyperphagic and has gained 19 lbs
- People at work tell her she is "snappish"

32

32

These Are ALL Indictors of BPD

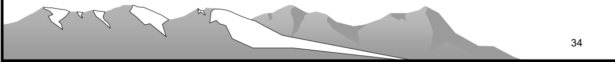
- When patients present with these vague or historical features of BPD, be more aggressive in your symptom assessment to consider BPD
- Patients do not often complain of manic symptoms – you must hunt for them.

33

33

Drug Therapy for Bipolar Depression

- Mood stabilizers
  - Lamotrigine frequently used for the depressive or hypomanic phases
    - Start 25 mg daily – titrate up to 200-300 daily in divided doses, depending upon other rx
    - Generally well tolerated, but consider potential for itch "Lamitchtal" and Steven-Johnson Syndrome.



34

34

Drug Therapy for Bipolar Depression

- Antipsychotics – ***Q***uietly ***L***ift ***O***ut of bipolar depression
  - Quetiapine (Seroquel)
  - Lurasidone (Latuda)
  - Olanzapine (Zyprexa)
- Newer agents
  - Cariprazine (Vraylar)

35

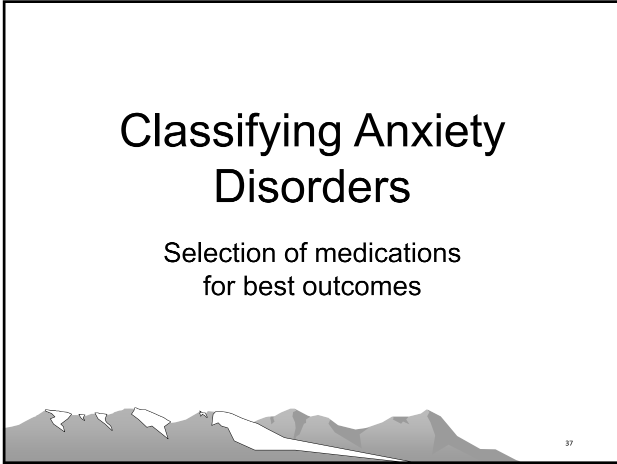
35

Summary and Key Points

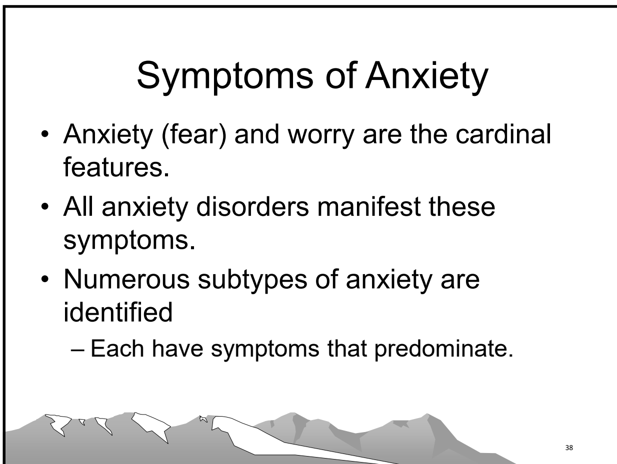
- Before starting an antidepressant, review for those indicators of another mood disorder
- When treating bipolar depression, avoid antidepressants
- Don't forget non-pharmacologic component of care.

36

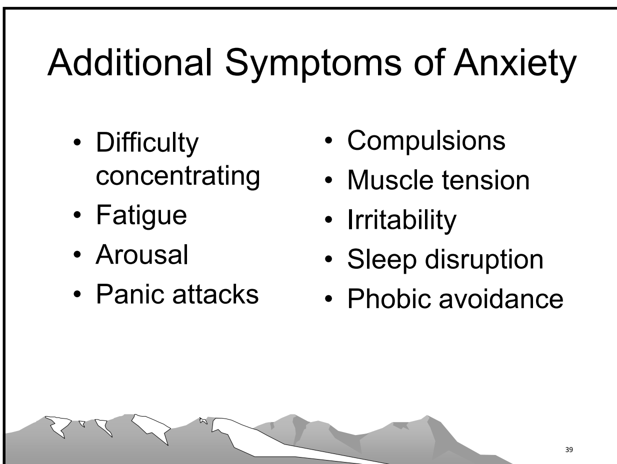
36



37



38



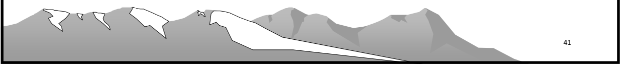
39

Differentiating Among Anxiety Disorders

- The differences among types of anxiety disorders is *not* anatomic location of the malfunction or neurotransmitters involved.
- Differentiating anxiety disorders is based upon:
  – Nature and timing of the malfunction.
  – Duration of symptoms
- Identification of the subtype is key to best treatments

40

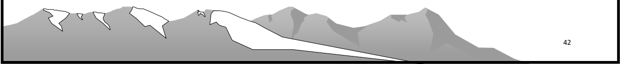
Chronic Anxiety Disorders–GAD



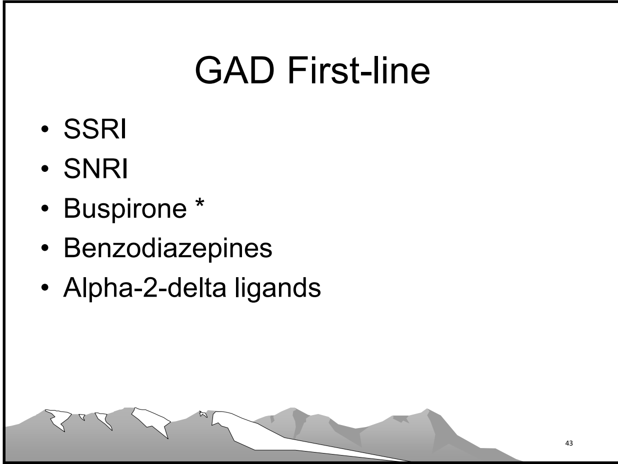
41

Diagnostic Criteria for GAD

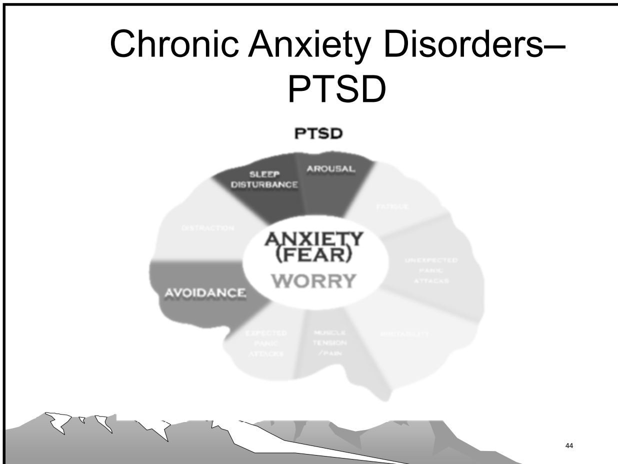
- Must have anxiety and worry *and*
- At least one other symptom
- Symptoms have occurred most days for at least 6 months.
- There is social or occupational impairment as a result of symptoms.
- Very often onset in childhood



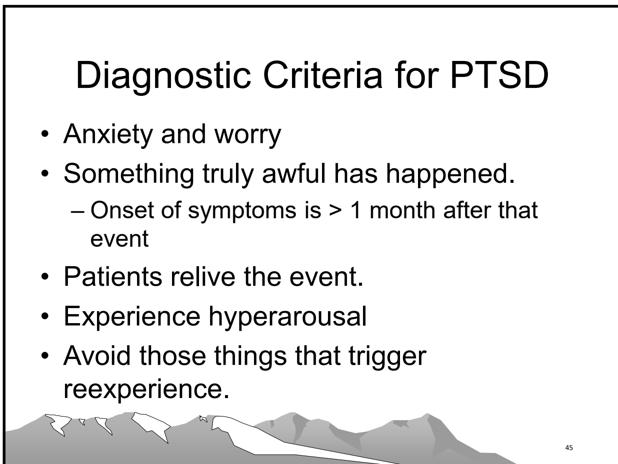
42



43



44



45

PTSD First-line Pharmacotherapies

- Pharmacotherapy typically *not* the preferred approach to PTSD management.
- When pharmacotherapy is indicated
  - SSRI
  - SNRI

46

46

Chronic Anxiety Disorders Panic Disorder

47

47

Diagnostic Criteria for Panic Disorder

- Anxiety and worry
- Patient experiences *unexpected* panic attacks.
- Lives in fear of repeat attacks
- Frequently avoids places and activities that they associate with attacks
- Has occurred for at least one month
- Onset typically in early 20s

48

48

Panic Disorder First-line

- SSRI
- SNRI
- Benzodiazepines
- Alpha-2-ligands

49

49

Chronic Anxiety Disorders Social Anxiety

50

50

Diagnostic Criteria for Social Anxiety Disorder

- Anxiety and worry
- Inordinate anxiety during circumstances in which they are observed by others
- Duration of at least six months
- Social or occupational dysfunction

51

51

Social Anxiety First-line

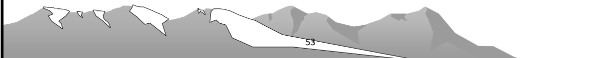
- Pharmacotherapy is not the foundation of care
- When drug therapy is indicated
  - SSRI
  - SNRI
  - Alpha-2-ligands
  - ** Beta blockers as an alternative option

52

52

Case Study

57-year-old Female



53

53

Case Study

- This 57-year-old female presents to a primary care clinic for treatment of anxiety.
- Friends and family have encouraged her to do so.
  - She is resistant.

54

54

Case Study
(continued)

- Her husband is going through a very complicated treatment plan for a cancer.
  - His prognosis is poor.
  - She is not coping well with her own anxiety.

55

55

Case Study
(continued)

- She admits to a history of anxiety "all of her life."
  - Otherwise, she denies psychiatric history.
- Medical history includes dyslipidemia, surgical hypothyroidism and "borderline" HTN.
- There is no substance abuse.

56

56

Case Study
(continued)

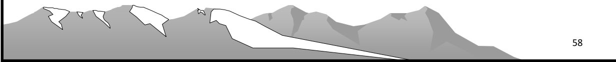
- HPI– This patient reports that she has been anxious all her life.
  - In grade school, always "worried about something"
  - Admits to worrying about "everything"
    - Unable to identify specific sources of worry

57

57

Case Study
(continued)

- The patient denies panic attacks.
- Admits that she is in constant motion
- Reports episodes of getting "scared" with a racing heart and trouble breathing
  - She "waits these out" and they resolve.



58

58

Case Study
(continued)

- She admits to…
  - Lifelong trouble sleeping
    - Worse now due to husband being very ill
  - Daily fatigue
  - Often irritable and quick to get angry
  - Difficulty concentrating
- She denies muscle pain.

59

59

Case Study
(continued)

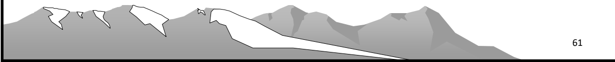
- The patient reports an attempt at SSRI therapy years ago produced homicidal ideation.
- The medication was immediately stopped.
  - She was advised never to take an SSRI again.

60

60

Case Study
(continued)

- At this time, the patient is afraid to take any medication for anxiety due to risk of HI.
- Refuses to consider benzodiazepines for fear of becoming addicted.



61

61

Case Study
(continued)

- Admits to only making this appointment because her husband
  and friends insisted
- She has no way to relieve anxiety.
  - Used to smoke but had to stop due to husband's cancer

62

62

Analysis of HPI

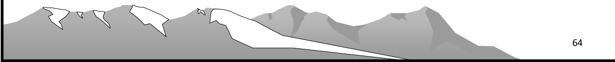
- Worry +
- Anxiety +
- Sleep disturbance +
- Fatigue +
- Irritability +
- Difficulty concentration +
- Muscle tension –

63

63

Case Study
(continued)

- Physical exam
  - Appropriately dressed and groomed
  - Attends to hygiene
  - Good eye contact
  - Coherent thought
  - Voice well modulated



64

64

Case Study
(continued)

- Physical exam (cont.)
  - Affect is anxious.
  - BMI of 17.3 kg/m^2
  - Vital WNL; pulse was 94 bpm, BP 138/82 mm Hg
  - Otherwise PE normal

65

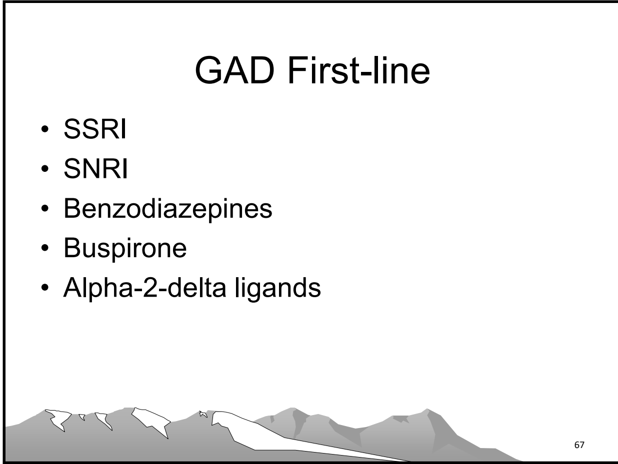
65

Case Study
(continued)

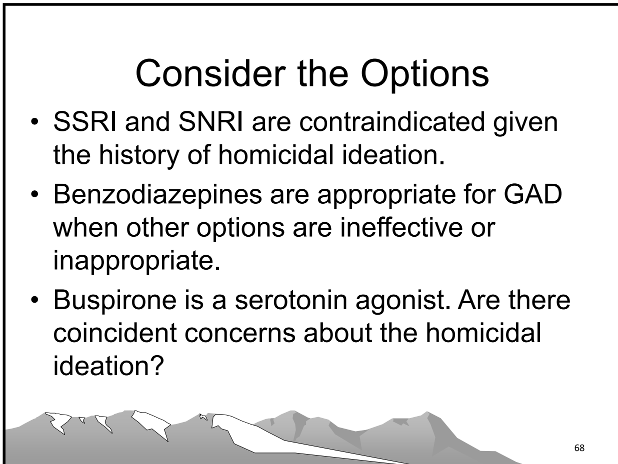
- What's your diagnostic impression?
  - First, we rule out supraphysiologic thyroid hormone replacement.
  - TSH was 5.2 mIU/L; FT_4 15 pmol/L.
- Once we rule out physiologic cause, which anxiety disorder is most likely?
  - Generalized anxiety disorder

66

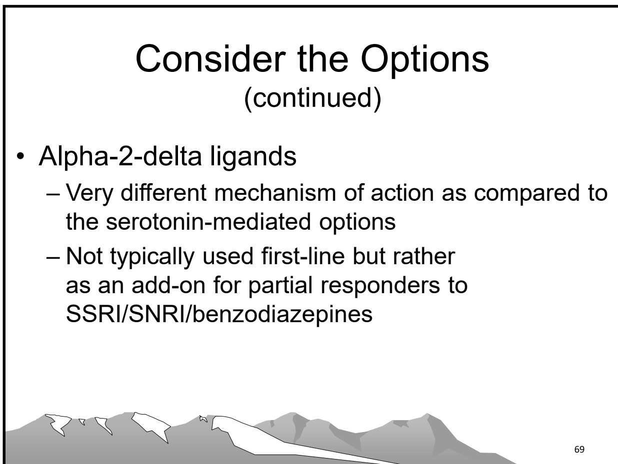
66



67



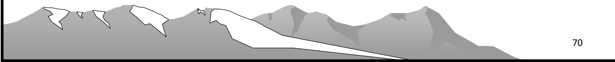
68



69

What did we do?

- We made an aggressive attempt to convince her to take a benzodiazepine.
- She refused, which left us with buspirone and alpha-2-delta ligands.



70

70

71

71

Shared Decision Making

- We discussed the pros and cons of each of the remaining two choices.
- Despite the patient's trepidation, we started buspirone 7.5 mg BID.
- Follow-up in one-week to ensure that she was not homicidal.

72

72

One-week Follow-up

- She was not homicidal and tolerating well.
- No effects, but no adverse effects
- Dose was increased to 10 mg BID; advised to follow up in 1-week

73

73

Second One-week Follow-up

- On therapy for 2 weeks total and 10 mg BID × 1 week
  - She felt like things were starting to improve.
- She was very excited that her husband even commented on the fact that she seemed a little better.
- Dose was increased to 15 mg BID; advised to follow up in 2 weeks.

74

74

Follow-up 1-month After Start of Rx

- One-month after starting buspirone and 2 weeks at 15 mg BID, the patient was ecstatic.
- She was sleeping; she was eating and had gained 4 lb (1.8 kg) from her first office visit.
- Her husband accompanied her to reinforce how well she was doing.

75

75

Chronic Maintenance

- She remains on 15 mg BID.
- Her husband has since died, but she maintains that the buspirone has changed her life.
- While the subsequent events of her husband's cancer were very difficult, she has maintained control of her anxiety.

76

76

77

77

References

Combs, H. (2014). Anxiety disorders in primary care. *Medical Clinics of North America, 98*, 1007-23.

Manning. J.S. (2010). Tools to improve differential diagnosis of bipolar disorder in primary care. *The Primary Care Companion to the Journal of Clinical Psychiatry, 12*(suppl 1): 17-22.

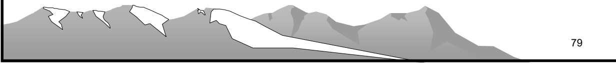
Sadock, B.J., Sadock, V.A., & Ruiz, P. (2015). *Kaplan & Sadock's synopsis of psychiatry* (11th ed.). Phila: Wolters Kluwer.

78

78

References

Stahl, S. M. (2013). Essential psychopharmacology (4th ed.). Cambride: University Press.



79

79