The many faces of bipolar disorder

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Case Summary:

A 27-year-old female, single, post-graduate student in engineering presented with worsening low mood for the past two months. She also complained of diminished interest in her studies, poor concentration in class, reduced appetite, poor sleep and lethargy. She sought treatment at the primary care clinic and was diagnosed with major depressive disorder (MDD). She was prescribed with an antidepressant and advised to attend regular follow-ups. However, she defaulted treatment and was lost to follow-up.

She presented six months later, just before her end of semester examinations. This time, she was accompanied by a friend who was concerned about her irritability and argumentative tendencies over the last week. She was more vocal, talkative and brimming with overconfidence. Her friend also noticed that she slept very little, but appeared overly energetic.

Questions

1. What is your provisional diagnosis?
2. What are the features which support your diagnosis?
3. What are the differential diagnoses?
4. How would you manage the above condition?

Answers

1. Bipolar disorder (BD) currently in manic phase.

2. She presented with two mood-related episodes, and one of which was mania. Her first presentation was consistent with MDD:
   - low mood
   - diminished interest
   - poor concentration
   - reduced appetite
   - poor sleep
   - lethargy

   She subsequently presented with mania:
   - irritability
   - increased energy
   - increased self-esteem (overconfidence and being vocal)
   - increased talkativeness
   - decreased need for sleep

   All patients presenting with mood symptoms should have organic causes ruled out. In this case, the most important differential diagnoses would be substance misuse disorder and thyroid disorders. Other psychiatric condition to be considered is borderline personality disorder.

   She has an acute episode which warrants a hospital referral. The mainstay of treatment is pharmacological which will be described further in the discussion. The treatment continuation during maintenance phase can be provided at the primary care.

Discussion

Management of BD is challenging due to the variety of clinical presentations, possibility of bipolarity and presence of comorbidities. The diagnosis is largely based on clinical presentations as well as mental state and physical assessments. International Classification of Disease and Health Related Problems 10th Revision (ICD10) categorises BD as having two or more episodes of mood disturbances, one of which has to be mania or hypomania and the other depression. An episode is defined as a distinctive period of mood disturbance fulfilling the respective criteria.

The case presented above may be familiar to many primary care physicians in which some BD patients may present initially with a depressive phase. Many of them are then diagnosed with MDD and treated

with antidepressants. Studies have found approximately 15% of patients with current episode of MDD are actually suffering from BD. The risk factors of bipolarity in patients currently presenting with MDD include:

- at least two mood episodes in the past
- a family history of mania
- occurrence of first psychiatric symptoms before of the age of 30
- current depressive episode lasting less than one month
- mood lability with antidepressants
- current mixed state

Duration of pharmacological treatment during acute phase depends on clinical response and tolerability to the treatment. In mania, the main pharmacological agents are mood stabilisers and antipsychotics. For acute depression, short-term antidepressants are used as adjunctive treatment to mood stablilisers. Treatment with antidepressants alone is not recommended for people with BD. The pharmacological treatment of acute mania consists of a variety of medication, ranging from classical mood stabilisers to atypical antipsychotics such as lithium, valproate, quetiapine and olanzapine.

In addition to pharmacological treatment, the use of psychosocial interventions such as cognitive behaviour therapy, psychoeducation and family based interventions significantly improve treatment adherence.

The key message in this case is to consider bipolarity in some people presenting with major depressive episode. Such cases need to be referred to the psychiatric services for further management.

Acknowledgements

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