Bipolar Disorder Clinical Practice Pearls for Treating Special Populations and People with Co-Occurring Disorders

The Oregon Health Authority (OHA) recommends consultation with OPAL (Oregon Psychiatric Access Line) when prescribing providers treat people with bipolar disorder who:

- Are members of one or more special populations, or
- Have any of the co-occurring disorders mentioned in this document.

A prescribing provider can call OPAL at 503-346-1000, to speak with a specialist Monday-Friday from 9:00-5:00 p.m. OHA also recommends a perinatology consultation for providers who treat pregnant women.

Oregon Health Authority

Bipolar disorder and special populations

Women of childbearing age (1)(2)

- Do NOT use valproic acid (VPA) or carbamazepine (CBZ) if pregnant or planning to become pregnant.
- Take special care when prescribing mood stabilizers for women of childbearing age due to teratogenic effects.
- Create plans with the patient to:
  1. Minimize the risk of unplanned pregnancies while taking medications
  2. Manage bipolar disorder, should the patient wish to become pregnant, and
  3. Treat bipolar disorder symptoms should they develop when the patient is pregnant or nursing.
- Due to the increasing risk of affective disorders:
  - » Monitor more closely for symptoms during the post-partum period, and
  - » Consider an early resumption of treatment.
- Consider well-child visits an opportunity to screen both parents for mood disorders

Medication	Absolutely contraindicated	Use with caution	Insufficient data	Significant observational or retrospective data exists
Valproic acid (VPA)	X			
Carbamazepine (CBZ)	X			
Lithium		X		
Lamotrigine		X		
Oxcarbazepine			X	
Typical antipsychotics				X
Atypical antipsychotics			X	

Youth

Bipolar disorder is often difficult to accurately diagnose in children and young adults. There is a broad differential diagnosis for such symptoms and a high proportion of comorbidity with other psychiatric diagnoses.

- Before initiating medications in children, the clinician should confirm the diagnosis of bipolar disorder to the best of their ability. It's ideal, when possible, to consult with:
  - » A multidisciplinary team, and
  - » People who have a longitudinal relationship with the child.
- Children and young adults are more prone to metabolic side effects of medications. Make sure the diagnosis of bipolar disorder is firm before you initiate medications.
- Use the lowest effective dose. Periodic reviews should assess for dose reductions, if appropriate.
- Monitor patients closely for emergent side effects. Keep a low threshold on medication changes if metabolic side effects develop.

Geriatric

Many patients with bipolar disorder experience a change in cycles as they age. These cycles generally become more frequent and symptoms become less intense. Often patients have an increase in manic or hypomanic symptoms relative to depressive symptoms.

- Be conscious of teasing out emerging cognitive impairment from bipolar disorder symptoms.
- There is a very high risk of drug interactions and polypharmacy.
- Often you will need to lower medication doses to account for changes in factors such as physiology and bioavailability. You will need to monitor renal function, weight and orthostatic changes closely.
- Medication side effects may cause more impairment and risk as patients age.
- Frequently assess for dose reduction.
  - » There is more of a risk of cardiovascular death with the use of atypical antipsychotics medications.
- Patients need to have psycho-socio-spiritual supports.

Bipolar disorder and co-occurring disorders

Anxiety disorders

Patients with co-occurring bipolar and anxiety disorders may experience unique challenges, as their anxiety symptoms may benefit from the use of antidepressants, however:

- Generally, for patients with co-occurring issues, it is best to treat their anxiety without the use of antidepressants.
  - » Consider the following and more:
    - ◊ Psychotherapies
    - ◊ Relaxation techniques or exercises
    - ◊ Eye movement desensitization and reprocessing (EMDR)
    - ◊ Hypnosis, and
    - ◊ Acupuncture.
- If you have the patient use a serotonergic agent, clinical practice suggests that selective serotonin reuptake inhibitors (SSRIs) are the safest options.
- Serotonin and norepinephrine reuptake inhibitors (SNRIs) appear to present a higher risk of conversion to mania than SSRIs. If you have the patient use SNRIs, do so with more caution.
- Tricyclic antidepressants (TCAs) present a high enough risk to be contraindicated.
- Benzodiazepines present no risk of conversion to mania. However, think of the usual precautions around tolerance and addiction issues.

Attention deficit hyperactivity disorder (ADHD) (3)

Patients with both ADHD and bipolar disorder also experience unique challenges, as their ADHD symptoms may benefit from the use of stimulants, however:

- Bipolar disorder may become more difficult to manage with the use of stimulants. With stimulants, there is a risk of conversion to mania.
- Generally, it is best to treat a patient with these co-occurring disorders without the use of stimulants.
  - » Instead, non-pharmacologic treatments for ADHD should be considered, including behavioral therapies, cognitive behavioral therapy, occupational therapy, increasing physical activity, increasing "green time," biofeedback, acupuncture, etc.

- If you have the patient use a stimulant, clinical practice suggests it be at the lowest dose necessary.
- Atomoxetine and bupropion may present a slightly lower risk of conversion to mania than stimulants. Use these treatments with caution.

Substance use

Approximately 45% of patients with bipolar disorder in a clinical setting are also diagnosed with a substance use disorder. Many symptoms of intoxication or withdrawal mimic symptoms of mania or depression. (4)

- The risk of suicide is higher for people with bipolar disorder and co-occurring substance use disorder.
- In general, only make a diagnosis of bipolar disorder if recent or past symptoms were during a period of sobriety long enough that symptoms cannot be substance intoxication or withdrawal.
  - » If no such period of sobriety exists, a detailed chronology plotting substance use intensity and affective symptom intensity may be able to establish a connection (or lack thereof) between the two issues, thus clarifying diagnoses.
- While you clarify the diagnosis, consider the use of non-medication treatments for substance use. These treatments often overlap.
- Once you establish a diagnosis, choose medications to balance both clinical effectiveness and minimize substance-medication interactions.

Endnotes

1. Epstein, RA, Moore, KM and Bobo, WV (2014). Treatment of bipolar disorders during pregnancy: maternal and fetal safety and challenges. Drug, healthcare and patient safety, 7, 7–29. Dove Press; 2014 [cited 2020 Nov 24]Available from: https://doi.org/10.2147/DHPS.S50556
2. Rodriguez-Cabezas, L and Clark, C (2018). Psychiatric Emergencies in Pregnancy and Postpartum. Clinical obstetrics and gynecology 61(3): 615-627.
3. Kumar V, Varambally S. Atomoxetine Induced Hypomania in a Patient with Bipolar Disorder and Adult Attention Deficit Hyperactivity Disorder. Indian J Psychol Med. 2017;39(1):89-91. doi:10.4103/0253-7176.198954
4. Yatham LN, Kennedy SH, Parikh SV, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) and International Society for Bipolar Disorders (ISBD) 2018 guidelines for the management of patients with bipolar disorder. Bipolar Disord. 2018; 20(2):97-170. doi:10.1111/bdi.12609

Oregon Health Authority
HEALTH POLICY & ANALYTICS
Office of Delivery Systems Innovation
500 Summer St NE
Salem, OR 97301

You can get this document in other languages, large print, braille or a format you prefer. Contact Amanda Parish at 503-383-8142 or email amanda.b.parish@dhsoha.state.or.us. We accept all relay calls or you can dial 711.

OHA 3480 (12/20)