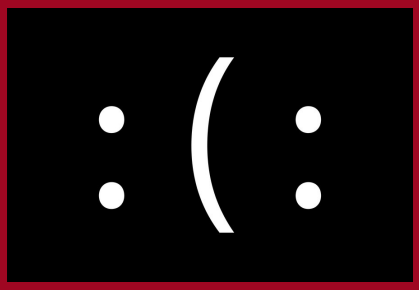
MARCH 2016 VOLUME #2 ISSUE 29

EM CASE OF THE WEEK

BROWARD HEALTH MEDICAL CENTER DEPARTMENT OF EMERGENCY MEDICINE

AUTHOR: MATTHEW DAVID, MS IV
EDITOR: ANDREA SARCHI, DO



http://bipolaranonymous.org/wp-content/uploads/2015/07/bipolar.jpg

The lifelong prevalence of bipolar affective disorder, or manic-depressive illness (MDI), including subsyndromal forms in the United States, has been noted to range from 3.7% to 3.9%. However, the prevalence in patients who present with depression is higher in primary care (21-26%) and psychiatric clinic (28-49%) settings

EM CASE OF THE WEEK

EM Case of the Week is a weekly "pop quiz" for ED staff. The goal is to educate all ED personnel by sharing common pearls and pitfalls involving the care of ED patients. We intend on providing better patient care through better education for our nurses and staff.

Bipolar Affective Disorder

A 32-year-old male presents to the ED with the complaint that he hasn't slept for the last 72 hours. He is slightly agitated and also complains about an obscure injury to his left knee. The patient exhibited tangential conversation with pressured speech and flight of ideas. When attempting to gain patient history he was easily distracted and would not answer direct questions. Vital signs revealed he was tachycardic at 107 bpm, with BP, Temp, RR and O2 sat all WNL. Physical exam was benign, including his left knee that had no tenderness to palpation, limited ROM or any erythema/swelling. Which of the following statements regarding Bipolar Affective Disorder is FALSE?

A. Patients in manic episode threatening to harm others may be discharged home on medications with close follow up.

B. Symptoms may include grandiosity, diminished need for sleep, racing thoughts and excessive talking.

C. Antipsychotics are indicated for the acute manic phase.

D. A Bipolar Manic Episode could present similar to substance abuse or medication side effects.

E. Blood studies should be performed on patients with suspected bipolar disorder in order to rule out other causes of symptoms.

BROWARD HEALTH MEDICAL CENTER

Broward Health Medical Center
Department of Emergency Medicine
1625 SE 3rd Ave
Fort Lauderdale, FL 33316

http://i.cdn.turner.com/cnn/2011/HEALTH/03/07/US.highest.bipolar.rates/t1larg.US.highest.bipolar.rates.jpg

Take Home Points

- The initial clinical evaluation of patients with a possible diagnosis of bipolar disorder includes a psychiatric and general medical history, mental status and physical examination, and focused laboratory tests
- Approximately 10 to 15 percent of bipolar patients die by suicide, which is greater than the rate of suicide in the general population
- For patients with severe manic episodes, the initial treatment is lithium or valproate plus an antipsychotic, rather than just monotherapy

Bipolar Affective Disorder

The correct answer is A – this patient meets the criteria for inpatient management. Patients diagnosed with bipolar mania or depression and severe symptoms must be referred for urgent/emergent mental health intervention. The indications for inpatient treatment in a person with bipolar affective disorder, or manic-depressive illness, include the following:

- Danger to self
- Danger to others
- Delirium
- Marked psychotic symptoms
- Total inability to function
- Total loss of control (e.g. excessive spending, undertaking a dangerous trip)
- Medical conditions that warrant medication monitoring (e.g. substance withdrawal/intoxication)

Patients with a possible diagnosis of bipolar depression must also be referred for urgent/emergent mental health intervention if they present with serious delusions, visual/auditory hallucinations, confusion, catatonic behavior, extreme negativism/mutism, and/or inappropriate affect of a bizarre or odd quality.

Discussion:

Bipolar disorder frequently disrupts mood, energy, sleep, cognition, and behavior, and patients thus struggle to maintain employment and interpersonal relationships. Pharmacotherapy within the context of a positive therapeutic alliance is central to minimizing morbidity and the risk of suicide or harm to others.

Manic episodes involve clinically significant changes as described above. It is important to approach patients in suspected manic episodes with care for safety of self and to anyone around. Patients can become very agitated, paranoid and even violent when a clinician attempts to give them medical care.

▶ **What is the DSM-5 diagnostic criteria for manic episode?**

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy, lasting at least one week and present most of the day, nearly every day (or any duration if hospitalization is necessary).

B. During the period of mood disturbance and increased energy or activity, three (or more) of the following symptoms (four if the mood is only irritable) are present to a significant degree and represent a noticeable change from usual behavior:

- Inflated self-esteem or grandiosity
- Decreased need for sleep
- More talkative than usual or pressure to keep talking
- Flight of ideas
- Distractibility
- Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation (i.e. purposeless non-goal-directed activity).
- Excessive involvement in activities that have a high potential for painful consequences (e.g. engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments).

C. The mood disturbance is sufficiently severe to cause marked impairment in social or occupational functioning or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.

D. The episode is not attributable to the physiological effects of a substance (e.g. a drug of abuse or medication) or to another medical condition.

▶ **What is the differential diagnosis?** Substance abuse (e.g. EtOH, amphetamines, cocaine, hallucinogens, opiates), multiple personality disorder, oppositional defiant disorder, medications (e.g. antidepressants can propel a pt into mania), hyperthyroidism, schizoaffective disorder, schizophrenia, PTSD

Management

Treatment of mood elevated syndromes (i.e. manic and hypomanic episodes) begins with an initial psychiatric history and mental status examination that emphasizes symptoms of the mood episode, particularly risk of suicide, aggressiveness, and violence to others, as well as signs of catatonia. The assessment should also pursue comorbid disorders (e.g. substance use disorders) that require treatment. The evaluation includes a general medical history, physical examination, and focused laboratory studies to establish whether the mood syndrome is due to the direct physiologic effects of a general medical condition, and to rule out any contraindications to treatment (e.g. renal impairment and use of lithium, or hepatic disease and use of valproate).

▶ **What is first line pharmacotherapy for severe, acute manic episodes?** Severely ill patients with acute mania typically require treatment with a medication combination. Lithium plus an antipsychotic is the current recommendation; however, valproate plus an antipsychotic is a reasonable alternative. Providers generally combine lithium or valproate with haloperidol (or another first-generation antipsychotic) or an atypical antipsychotic such as aripiprazole, olanzapine, quetiapine, or risperidone.

Patients who are acutely agitated may also require intramuscular medications as well as seclusion and physical restraints.

References:

Bipolar disorder in adults: Clinical features. UpToDate. Web. Jan 4, 2016
Bipolar disorder in adults: Pharmacotherapy for acute mania and hypomania. UpToDate. Web. Jan 14, 2016
Bipolar disorder in adults: Assessment and diagnosis. UpToDate. Web. Jan 16, 2016

ABOUT THE AUTHOR:

This month's case was written by Matthew David. Matthew is a 4th year medical student from NSU-COM. He did his emergency medicine rotation at BHN in January 2016. Matthew plans on pursuing a career in surgery after