EM CASE OF THE WEEK

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December 11, 2022 I Vol 15 I Issue 2

# Bipolar Disorder

A 23-year-old man was brought in by police on a Baker Act after he was found was found screaming outside of his friend's home at night. The patient's friend noticed he had been more energetic than usual over the past 5 days, and recently threatened his friend with an icepick. This has never happened before.

During the interview the patient is cooperative and paces the room while speaking rapidly. He insists that his friend was "being dramatic" and doesn't understand that he needs to install software into his friend's brain so they can talk to spirits who live behind screens.

He denies any medical problems, prior hospitalizations, any history of smoking, alcohol use, or drug use. No suicidal or homicidal ideation.

Physical exam and laboratory results are within normal limits. The patient is cooperative and agreeable to taking medication at this time.

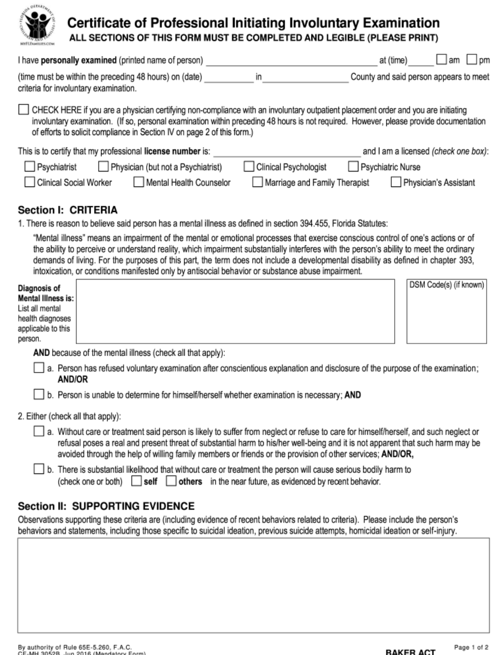
**Which of the following is the most appropriate next step of management?**

**A. IM Benzodiazepine**

**B. Oral atypical antipsychotic**

**C. Electroconvulsive therapy**

**D. Lamotrigine**



**Certificate of Professional Initiating Involuntary Examination**
**ALL SECTIONS OF THIS FORM MUST BE COMPLETED AND LEGIBLE (PLEASE PRINT)**

I have **personally examined** (printed name of person) ______________________ at (time)_____ ☐ am ☐ pm (time must be within the preceding 48 hours) on (date) _________ in _______________ County and said person appears to meet criteria for involuntary examination.

☐ CHECK HERE if you are a physician certifying non-compliance with an involuntary outpatient placement order and you are initiating involuntary examination. (If so, personal examination within preceding 48 hours is not required. However, please provide documentation of efforts to solicit compliance in Section IV on page 2 of this form.)

This is to certify that my professional **license number** is: ______________________ and I am a licensed *(check one box)*:
☐ Psychiatrist ☐ Physician (but not a Psychiatrist) ☐ Clinical Psychologist ☐ Psychiatric Nurse
☐ Clinical Social Worker ☐ Mental Health Counselor ☐ Marriage and Family Therapist ☐ Physician's Assistant

**Section I: CRITERIA**

1. There is reason to believe said person has a mental illness as defined in section 394.455, Florida Statutes:

"Mental illness" means an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with the person's ability to meet the ordinary demands of living. For the purposes of this part, the term does not include a developmental disability as defined in chapter 393, intoxication, or conditions manifested only by antisocial behavior or substance abuse impairment.

**Diagnosis of Mental Illness is:** List all mental health diagnoses applicable to this person. | DSM Code(s) (if known)

**AND** because of the mental illness (check all that apply):

☐ a. Person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; **AND/OR**

☐ b. Person is unable to determine for himself/herself whether examination is necessary; **AND**

2. Either (check all that apply):

☐ a. Without care or treatment said person is likely to suffer from neglect or refuse to care for himself/herself, and such neglect or refusal poses a real and present threat of substantial harm to his/her well-being and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; **AND/OR,**

☐ b. There is substantial likelihood that without care or treatment the person will cause serious bodily harm to (check one or both) ☐ **self** ☐ **others** in the near future, as evidenced by recent behavior.

**Section II: SUPPORTING EVIDENCE**

Observations supporting these criteria are (including evidence of recent behaviors related to criteria). Please include the person's behaviors and statements, including those specific to suicidal ideation, previous suicide attempts, homicidal ideation or self-injury.

By authority of Rule 65E-5.260, F.A.C.
CF-MH 3052B, Jun 2016 (Mandatory Form) **BAKER ACT** Page 1 of 2

Figure 1. Certificate of Professional Initiating Involuntary Examination per the Florida Mental Health Act of 1971 (Florida Statute 394.451-394.4789), the "Baker Act."

This allows for the the involuntary institutionalization and examination of an individual for up to 72 hours. The patient must be examined by a receiving facility within 72 hours. The 72-hour period begins when the patient arrives at the hospital and ceases when the attending physician documents that the patient has an emergency medical condition.

This act can be initiated by a patient, close friends and relatives, judges, law enforcement, physicians, or mental health professionals.

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**The correct answer is B. Oral atypical antipsychotic**

A. Benzodiazepines are a mainstay of treatment, however oral medications are most appropriate in compliant patients.

C. ECT is not a first line in an emergent setting. ECT is a treatment for refractory depression, psychosis, and suicidal ideation after the acute period.

D. Lamotrigine is not used to manage mania. It is used to manage bipolar depression.

# Discussion

Bipolar disorder is a severe illness characterized by recurrent episodes of depression and elevated mood. It is associated with irritability, changes in sleep and other cognitive, physical, or behavioral symptoms. Per a World Mental Health survey of the USA and 10 other countries, Bipolar I disorder affected 0.6% of the surveyed population, with a primary manic episode most commonly occurring in persons < 25 years old.[1,2]

Bipolar I is characterized by mania, and per the DSM-5, requires at least 1 manic episode of at least 1-week duration (or less time if hospitalization is necessary). Manic episodes may appear with grandiosity, flight of ideas, psychomotor agitation, and must be sufficiently severe to impair normal functioning without the influence of substance use or other medical conditions. Bipolar II disorder has criteria for at least one major depressive, one hypomanic episode, no prior manic episodes, and must also cause impairment in normal functioning.

Differential diagnosis of Bipolar disorder includes organic causes such as delirium, dementia, and medication/drug use, as well as other psychiatric disorders such as depression, anxiety, acute psychosis, and panic attack.

General workup in the emergency department (ED) may include EKG, laboratory testing including point of care glucose, CBC, chemistry, LFTs, ASA, acetaminophen, urine toxicology, EtOH, urine pregnancy. More specific testing may be appropriate to rule out hepatic encephalopathy, thyroid disorder, intracranial hemorrhage, urinary tract infection, tuberculosis, meningitis, or encephalitis.

Many patients living with Bipolar Disorder are subject to significant social and financial strife, with decreased quality of life and a worsened prognosis for other chronic conditions. This is emphasized by their suicide rate: 25%-50% of patients with bipolar disorder will have at least one lifetime suicide attempt, with a suicide completion rate approximately 20-30 times higher than the general population.[2]

# Treatment

Treating a patient with acute mania requires urgent hospitalization. Treatment should include non-pharmacologic options like verbal de-escalation and offering the patient comfort items such as blankets, meals, pillows. Ideally, patients should be placed in a quiet room. If examination warrants, the patient's room may need to be cleared of objects that could be used in self-harm or aggression.

The initial goal of pharmacologic treatment in the ED is to calm the patient without oversedation. For agitated or aggressive patients requiring immediate therapy in the emergency department, options include haloperidol, droperidol, diphenhydramine, risperidone, ziprasidone, olanzapine and benzodiazepines.

## Treatment (continued)

Long-term therapy

Lithium, atypical antipsychotics (e.g., aripiprazole), or anticonvulsants (e.g., valproate) as first-line monotherapy for management of bipolar disorder. Approximately 50% of patients respond well to this treatment for the acute manic phase.[2,3] First-line combination therapy normally involves atypical antipsychotics and lithium or valproic acid. In general, combination therapy reportedly has a 20% increase in efficacy compared to monotherapy.[2,3]

Second-line agents for patients with inadequate response includes monotherapy with olanzapine, carbamazepine, ziprasidone, and haloperidol or combination therapy with olanzapine plus lithium or divalproex.

ECT is now also recommended as a second-line option and can be efficacious; some studies show >80% of patients treated will show marked improvement.[2]

## Take Home Points

- **Acute mania requires hospitalization.**
- **Consider primary Mania (Bipolar Disorder I) in patients presenting with an initial manic episode, especially patients in their teens or twenties.**
- **In patients <12 years old or patients >40 years old, suspect secondary causes of first-time mania such as adverse drug effects or another medical condition.**
- **Oral medications should be given before intramuscular agents when treating compliant patients without acute agitation.**

### About the Author

Xavier Jacques is a 4th year medical student from FIU HWCOM. He completed his Emergency Medicine rotation at Broward Health Medical Center in October 2022 and plans on pursuing a career in Psychiatry.

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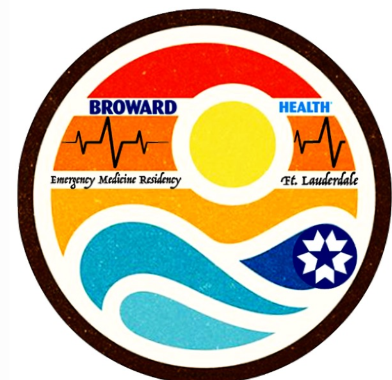

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