Integrating Bipolar Disorder into primary care

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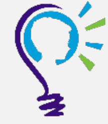

Disclosures

"Neither I nor my spouse/partner has a relevant financial relationship with a commercial interest to disclose."

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Medical Home Model

- Chronic disease
- Acute exacerbations
- Collaboration with subspecialists
- Co-morbidities
- Med management/monitoring
- Psychoeducation
- Family/caregiver support
- Community linkages

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Primary care provider’s role

- Not expected to diagnose
- Not expected to initiate treatment
- Should perform active monitoring for comorbid conditions and prodromal symptoms
- Should collaborate with mental health providers

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Comorbidity in BPD

- Anxiety disorders
- Substance abuse disorder
- Suicidality risk
- Obesity
- Metabolic syndrome
- Polycystic ovarian syndrome

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- Sarah is a 17 year old patient who is brought in by her mother who is worried about her daughter's sudden changes in personality and behaviors. She has no prior history of developmental or behavioral problems and has been treated for mild intermittent asthma in the past. She is currently finishing 12th grade, is on the school soccer team and has a part-time job after school. She has been accepted to a local college for the fall semester. She is described as a shy, quiet girl who has several close friends.
- For the past 72 hours, her mood has become more "boisterous"and she has been talking loudly and constantly about multiple topics. She hasn't been sleeping "more than an hour" at night, and is full of energy all day. Yesterday she quit her job, and this morning she told her mom that she and her boyfriend are going to fly to Florida next week to look for jobs and 'find out about applying for college" there.

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Is this a manic episode?

- elevated mood
- flight of ideas (racing thoughts)
- decreased need for sleep
- pressured speech
- risk taking behaviors
- uncharacteristically poor judgment

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Causes of Manic Symptoms

- Bipolar disorder
- Substance use/overdose (cocaine, PCP, amphetamines, alcohol)
- Medical illness or injury (encephalitis, thyrotoxicosis, tumor)
- severe stress, trauma, abuse
- medication side effects (steroids, antidepressant)

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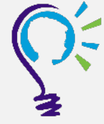

Office management of manic episode

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Initial assessment

- symptoms, severity, duration
- level of impairment
- vital signs, physical and neurologic exam, mental status
- safety risk
- support system
- community based resources

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Risk Assessment

- High risk (abnormal exam, unstable VS , severe/worsening symptoms, high degree of impairment, safety risk to self or others, no support system) Send to ER for further eval/treatment

- Lower risk (normal exam and VS, shorter duration/ fewer and milder symptoms and impairments, no safety issues, strong support system, availability of community resources) Obtain more detailed history, consider labwork, arrange linkages, call Project Teach!

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Moderate/low risk- history

- detailed ROS (*neurologic and endocrine)
- PMH
- Meds
- Fam hx
- psychosocial hx (recent stressors)
- substance use
- suicide screen (ASQ,CSSR)

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Crisis Intervention Plan

- contact mental health provider (Project Teach!)
- assess support team
- linkage to community resources
- Hotline # for crisis services
- lab work if indicated
- psycho-education to patient and family
- plan for follow up within 24 hours

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Chronic care - role of pcp

- recognize prodromal symptoms
- maintain UTD treatment plans and medications prescribed by mental health provider in the medical chart
- linkage to family support services in the community and available through national organizations' websites
- ongoing support and psycho-education to patient and family

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Medication

- Monitor medication compliance, efficacy and side effects at each office visit
- Collaborate with mental health provider regarding regular laboratory monitoring
- Know the common and serious side effects of prescribed medications
- Refer patient for additional care as needed (eg. dietician, ob/gyn)

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Role of families

- families play a major role in ongoing care/crisis management
- support/structure regular mealtimes, sleep schedules, family time, exercise, activities
- support/assist with treatment compliance (medication dosing, therapy appts)
- recognize prodromal symptoms
- maintain safety in the home (access to alcohol, firearms, meds)
- maintain a list of crisis hotline # and plan

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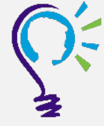

7 year old with behavior problems

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Case #2

- JJ is a 7 year old boy brought in by his mother for concerns about increasing frequency and severity of "rage attacks." He has these episodes at home and school multiple times a day and they last about 30-40 minutes. They consist of screaming, hitting, throwing and knocking over things. He was involved in a physical fight with a classmate this week and became verbally abusive to the teacher when she attempted to intervene. He has now been expelled from his private school. Paternal grandfather has bipolar disease. Mother wants him tested and is very worried that he has the same disorder.

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Guiding principles

- Aggression, impulse control, and emotional dysregulation are common presenting symptoms in pediatric primary care offices
- These symptoms have multiple causes
- Bipolar disorder is an extremely rare cause of these behaviors in pre-adolescence
- Role of pcp is to do a thorough assessment using standardized screening tools, gathering information from multiple sources (school, family, prior medical records), perform a physical exam, order appropriate labs, and engage the family as a partner from the outset. Project Teach is a valuable resource!

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