SOURCES OF FURTHER INFORMATION

Bipolar Fellowship Scotland
Studio 1016, Mile End Mill, Abbey Mill Business Centre,
Seedhill Road, Paisley PA1 1TJ
Tel: 0141 560 2050
www.bipolarscotland.org.uk

Breathing Space
Tel: 0800 83 85 87
www.breathingspacescotland.org.uk

Depression Alliance Scotland
3 Grosvenor Gardens, Edinburgh, EH12 5JU
Tel: 0131 467 3050
www.depressionalliance.org

MDF – The Bipolar Organisation
UK Head Office, Castle Works, 21 St George's Road, London SE1 6ES
Tel: 0845 340 540
www.mdf.org.uk

National Schizophrenia Fellowship (Scotland)
Claremont House, 130 East Claremont Street, Edinburgh EH7 4LB
Tel: 0131 557 8969
www.nsfscot.org.uk

Samaritans
Tel: 08457 90 90 90
www.samaritans.org.uk

Saneline
Tel: 08457 67 80 00
www.sane.org.uk

Scottish Association for Mental Health (SAMH)
Cumbrae House, 15 Carlton Court, Glasgow G5 9JP
Tel: 0141 568 7000
email: enquire@samh.org.uk • www.samh.org.uk

LEGISLATION

Adults with Incapacity (Scotland) Act 2000
www.scotland-legislation.hmso.gov.uk/legislation/scotland/acts2000/20000004.htm

Driver and Vehicle Licensing Agency (DVLA) Medical Rules
www.dvla.gov.uk/drivers/dmed1.htm

Mental Health (Care and Treatment) (Scotland) Act 2003
www.scotland-legislation.hmso.gov.uk/legislation/scotland/acts2003/20030013.htm

Mental Welfare Commission for Scotland
Argyle House, 3 Lady Lawson Street, Edinburgh, EH3 9SH
Tel: 0131 222 6111
email: enquiries@mwscot.org.uk • www.mwcscot.org.uk/

Office of the Public Guardian
www.publicguardian-scotland.gov.uk/html/welcome.htm

This Quick Reference Guide provides a summary of the main recommendations in the SIGN guideline on **Bipolar affective disorder.**

Recommendations are graded A B C D to indicate the strength of the supporting evidence.

Good practice points ☑ are provided where the guideline development group wishes to highlight specific aspects of accepted clinical practice.

Details of the evidence supporting these recommendations can be found in the full guideline, available on the SIGN website: **www.sign.ac.uk**

SIGN
Scottish Intercollegiate Guidelines Network

NHS Quality Improvement Scotland

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Quick Reference Guide

May 2005

COPIES OF ALL SIGN GUIDELINES ARE AVAILABLE ONLINE AT WWW.SIGN.AC.UK

Quick Reference Guide

Bipolar Affective Disorder

DIAGNOSIS

☑ Early and accurate diagnosis should be attempted to allow treatment as soon as possible after a first episode.

D **A diagnosis of bipolar affective disorder should be made after clinical assessment according to DSM or ICD criteria.**

☑ Clinicians should be aware of the instability of diagnosis during clinical review of patients with affective disorder.

SIGNS AND SYMPTOMS OF MANIA

Signs and symptoms of mania (or a manic episode) include:

- increased energy, activity, and restlessness
- excessively high, overly good, euphoric mood
- extreme irritability
- racing thoughts and talking very fast, jumping from one idea to another
- distractibility, cannot concentrate well
- little sleep needed
- unrealistic beliefs in one's abilities and powers
- poor judgement
- spending sprees
- a lasting period of behaviour that is different from usual
- increased sexual drive
- abuse of drugs, particularly cocaine, alcohol, and sleeping medications
- provocative, intrusive, or aggressive behaviour
- denial that anything is wrong.

SIGNS AND SYMPTOMS OF DEPRESSION

Signs and symptoms of depression (or a depressive episode) include:

- lasting sad, anxious, or empty mood
- feelings of hopelessness or pessimism
- feelings of guilt, worthlessness, or helplessness
- loss of interest or pleasure in activities once enjoyed, including sex
- decreased energy, a feeling of fatigue or of being slowed down
- difficulty concentrating, remembering, making decisions
- restlessness or irritability
- sleeping too much, or can't sleep
- change in appetite and/or unintended weight loss or gain
- chronic pain or other persistent bodily symptoms not caused by physical illness or injury
- thoughts of death or suicide, or suicide attempts.

ACUTE TREATMENT FOR MANIA

A
- **Acute manic episodes should be treated with oral administration of an antipsychotic drug or semi-sodium valproate.**
- **Lithium can be used if immediate control of overactive or dangerous behaviour is not needed or otherwise should be used in combination with an antipsychotic.**

☑ Intra-muscular injection of antipsychotics and/or benzodiazepines (lorazepam) should be used in emergency situations, in accordance with local protocols.

☑ Benzodiazepines may be used as adjunctive treatment in acute mania where sedation is a priority.

☑ Patients who suffer an acute manic episode whilst on maintenance treatment with an anti-manic drug should have their dose of anti-manic drug optimised. Treatment with an antipsychotic or valproic acid should be initiated as appropriate.

☑ Severe, treatment-resistant mania may require electro-convulsive treatment.

☑ Combination therapy with several anti-manic agents from different classes may be required in treatment resistant cases.

☑ Duration of treatment will be determined by the reduction of symptoms, the emergence of side effects and the need to provide treatment for residual symptoms and prevent relapse.

☑ Antidepressant drug treatment should be reduced and discontinued during an acute manic episode.

☑ A clear terminology should be implemented to avoid confusion in the prescription of sodium valproate and semisodium valproate, as well as the different lithium salts and preparations.

ACUTE TREATMENT FOR DEPRESSION

B **An antidepressant in combination with an anti-manic drug** (lithium, semisodium valproate or an antipsychotic drug)**, or lamotrigine is recommended for the treatment of acute bipolar depression in patients with a history of mania.**

☑
- Patients maintained on mood stabilisers who suffer a depressive episode should be started on an antidepressant after optimising their mood stabiliser.
- Interactions between serotonergic antidepressants, antipsychotic drugs and lithium and the risk of triggering mania or rapid cycling should be considered when selecting an antidepressant.

☑ ECT may be considered for patients with bipolar depression at high risk of suicide or self-harm.

PHARMACOLOGICAL RELAPSE PREVENTION

A **Lithium is the treatment of choice for relapse prevention in bipolar affective illness.**

A **Lithium should be prescribed at an appropriate dose with a daily dosing regimen.**

A **The withdrawal of lithium should be gradual to minimise the risk of relapse.**

☑ In general practice, lithium should be prescribed in the context of a shared care protocol to minimise side effects and toxicity.

☑ Before embarking on maintenance treatment with lithium patient and doctor should consider severity of the last episode, number, frequency and severity of previous episodes, personal factors, such as a wish to become pregnant or the wish to avoid sick leave from work or education.

A **Carbamazepine can be used as an alternative to lithium, particularly in patients with bipolar II, or when lithium is ineffective or unacceptable.**

A **Lamotrigine can be used as a prophylactic in patients who have initially stabilised with lamotrigine, particularly if depressive relapse is the greater problem.**

PSYCHOSOCIAL INTERVENTIONS

B **Evidence based psychosocial interventions should be available to patients in addition to pharmacological maintenance treatment, especially if complete or continued remission cannot be achieved.**

REPRODUCTIVE HEALTH ISSUES

D
- **The dose of the combined oral contraceptive should be adjusted accordingly when given with an enzyme-inducing drug.**
- **Women should be warned that the efficacy of the COC is reduced.**
- **Barrier methods of contraception should also be used for maximal contraceptive effect.**

Further information and recommendations on reproductive health issues are available in the full guideline.

SUICIDE PREVENTION

D **Acute and maintenance lithium treatment of patients with bipolar affective disorders should be optimised to make every effort to minimise the risk of suicide.**