Review On Bipolar Depression

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Abstract:
Bipolar disorder is a chronic illness, which may require lifelong treatment. Patients will spend 3-5 times more days in the depressed episode then in manic phase. Due to this variability in episodes, polypharmacy is used quite frequently in practice through the evidence to do this remains quite limited. Many positive and negative outcomes can occur from these practice. Bipolar disorder is the 6th leading cause of disability developed world among those between the ages 15 and 44 years age groups. Sertonin is one of the neurotransmitter in the brain, and one of that strongly affects the person mood. Clozapine (clozapril), Olanzapine (zyperexa), Risperidone (risperdal), and Ziprasidone (zeldox), and the clozapine maybe helpful as mood stabilizer for people who do not respond to lithium and anticonvulsant.

Keywords:- Bipolar disorder, depression, factors, review, treatment.

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Introduction:

Bipolar disorder is a highly prevalent disorder with poor symptomatic and psychosocial outcome. Depression is the phase of bipolar illness which probably represents the greatest burden in paients. Bipolar spectrum disorders are a major public health problem, with estimates of lifetime prevalence in the general population of the United States at 3.9 percent,1 with a range from 1.5 to 6.0.Bipolar disorder is also associated with significant mortality risk, with approximately 25 percent of patients attempt-ting suicide and 11 percent of patients completing. Bipolar disorder is also associated with significant mortality risk, with approximately 25 percent of patients attempting suicide and 11 percent of patientscompleting.

Etiology and Pathophysiology:

The causes of bipolar disorder are genetic factors, neurochemical factors and environmenttal factors.

Genetic factors in Bipolar Disorder:

Bipolar disorder tends to be familiar, meaning that it "runs in families." About half the people with bipolar disorder have a family member with a mood disorder, such as depression. A person who has one parent with bipolar disorder has a 15 to 25 percent chance of having the condition. A person who has a non- identical twin with the illness has a 25 percent chance of illness, the same risk as if both parents have bipolar disorder. A person who has an identical twin (having exactly the same genetic material) with bipolar disorder has an even greater risk of developing the illness about an eightfold greater risk than a nonidentical twin

Neurochemical factors in Bipolar Disorder:

Three important brain chemicals are noradrenalin, (norepinenephrine), serotonin, and dopamine. Norepinephrine and 5 hydroxytrytamin (serotonin) have been consistently linked to psychiatric mood disorder such as depresssion and bipolar depression the brain chemical serotonin is connected to many body functions, sleepwakefulness, eating sexual activity, learning, and memory. Biochemical im-

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balance in the brain that makes a person vulnerable to experiencing mood episodes.

Environmental factors in Bipolar Disorder:

A life event may trigger a mood episode in a person with a genetic disposition for bipolar disorders. Even without clear genetic factors, altered health habits, alcohol or drug abuse or hormonal problems can trigger an episode. Among those at risk for the illness, bipolar disorder is appearing at increasingly early ages.

Symptoms of Bipolar Disorder:

In bipolar disorder it is a combination of depressive and manic episodes. Firstly,the symptoms of mania:

- Increased of energy level, activity, and restlessness
- Excessive high- euphoric mood
- Extreme irritability
- Talking very fast
- Distractibility, can't concentrate well
- Unrealistic beliefs
- Poor judgement
- Increased sexual drive

Types of Bipolar Disorder:

There are four types of bipolar disorder bipolar I, bipolar II, cyclothymia and bipolar disorder not otherwise specified (BP-NOS).

Bipolar-I disorder:

In bipolar- I disorder, the person has manic episodes and almost always experience depresssion at some stages. This occurs at least seven days, or by manic symptoms that are so severe that the person needs immediate hospital care.

Bipolar-II disorder:

The person have only hypomanic (the milder form of mania) this disorder may be hard to recognise if the person is seen as normally excitable, highly energised, andvery productive.

Cyclothymia (rapid cyclic bipolar disorder):

There are at least four episodes per year, in any combination of mania, hypomania or depression. This is seen in 5 to 15% of people with bipolar disorder .and this is more chronic unstable mood disorder.

Bipolar disorder not otherwised specified (BP-NOS):

Bipolar NOS ("not otherwise specified") refers to a condition in which people have experienced periods of elevated mood, but do not meet criteria for any of theother three defined subtypes of bipolar disorder. For example, a person can have some symptoms of hypomania followed by an episode of depression. Because the symptoms of hypomania never lasted that long, the person would not qualify for a diagnosis of bipolar II, since he or she did not have a full-blown hypomanic episode.

Mania:

People with bipolar disorder go through unusual mood changes. Sometimes they feel very happy and "up," and are much more active than usual. This is called mania. Mania typically causes obvious problems in daily functioning and often leads to serious problems with a person's relationships or work functioning.

Diagnosis:

Diagnosis is based on the self-reported experiences of an individual as well as abnormalities in behaviour reported by family members, friends or co-workers, followed by secondary signs observed by a psychiatrist, nurse, social worker, clinical psychologist or other clinician in a clinical assessment. There are lists of criteria for someone to be so diagnosed. These depend on both the presence and duration of certain signs and symptoms. Assessment is usually done on an outpatient basis; admission to an inpatient facility is considered if there is a risk to oneself or others. The most widely used criteria for diagnosing bipolar disorder are from the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, the current version being DSM-IV-TR, and the World Health Organization's International Statistical Classification of Diseases and Related Health Problems, currently the ICD-10. The latter criteria are typically used in Europe and other regions while the DSM criteria are used in the USA and other regions, as well as prevailing in research studies.

Medication:

Table 1. Agents Used for Bipolar II Disorder

Class	Agent	Dosing	Common Side Effects
Mood stabilizers	Lithium	300 mg bid-tid *Usual target dose:* 900-1,800 mg daily in divided doses (renally adjust)	Nausea, tremor, polyuria, thirst, weight gain, loose stools, cognitive impairment, renal impairment, thyroid disorder, cardiac rhythm disturbances
Anticonvulsants	Carbamazepine	100-200 mg daily divided into once or twice daily doses *Usual target dose:* 800-1,000 mg daily in divided doses	N/V, diarrhea, hyponatremia, rash, pruritus, leukopenia, fluid retention, neurotoxicity
	Lamotrigine	25 mg daily titrated slowly to 200 mg daily	Stevens-Johnson syndrome, toxic epidermal necrolysis, rash, nausea
	Valproate	750 mg divided bid-tid *Usual target dose:* 1,500-2,500 mg daily in divided doses	Neural tube defects in fetuses, weight gain, vomiting, hair loss, easy bruising, tremor, GI discomfort (less in divalproex), hepatic failure, thrombocytopenia, pancreatitis
Antipsychotics	Aripiprazole	10-30 mg daily *Usual target dose:* 15-45 mg per day	Headache, N/V, constipation, insomnia, akathisia
	Haloperidol	5-15 mg daily in 1 or 2 divided doses or 0.2 mg/kg per day	EPS, akathisia, tardive dyskinesia
	Olanzapine	10-15 mg daily *Usual target dose:* 10-30 mg (or up to 50 mg) daily at bedtime or in 2 divided doses	Sedation, constipation, dry mouth, increased appetite, weight gain, orthostatic hypotension
	Quetiapine	100 to 200 mg once or twice daily *Usual target dose:* 400-800 mg (or up to 1,200 mg) at bedtime or in 2 divided doses	Headache, dry mouth, constipation, weight gain, sedation, dizziness, orthostatic hypotension
	Risperidone	1-2 mg once or twice daily *Usual target dose:* 4-8 mg once at bedtime or twice daily	Elevated prolactin, akathisia, sedation, dyspepsia, nausea, weight gain
	Ziprasidone	40 mg twice daily *Usual target dose:* 40-80 mg twice daily (up to 200 mg)	Headache, sedation, EPS, akathisia, dizziness
Antidepressants	Fluoxetine	10-40 mg daily	Nausea, headache, insomnia, sexual dysfunction, worsening of depression, manic episodes (in bipolar patients), increased suicidality in children

First one is the mood stabilizers. Different types of mood stabilizer are– lithium,the first mood stabilizing medication approved by the U.S. food and drug administration (FDA) for treatment of mania.

Other treatments:

- Electroconvulsive Therapy- If the medication and psychotherapy does not work, electroconvulsive therapy (ECT) may be useful, ECT formally known as 'shock therapy'. Before ECT is administratersed, a patient takes a muscles relaxant and is put under brief anaesthesia. On average ECT treatment last from 30-90 sec. people who have ECT usually recover after 5-15 min and are able to go have same day. It is effective but not first line drug. ECT may cause some short term side effect, including confusion, disorienttation, and memory loss. But this side effect typically clears soon after treatment.
- Sleep Medication- Those have trouble sleeping usually sleep better after getting treatment for bipolar disorder.
- Herbal Supplement- In general there is not much research about herbal or natural supplements. An herb called St. John's wort (*hypericum perforatum*) often marketed as natural antidepressant may cause switch to mania in some people with bipolar disorder.

Scientist also researching omega- 3 fatty acid (found in fish oil) to measure their usefulness of long term treatment of bipolar disorder.

Side effects of Antidepressant drug:

The psychiatrist prescribing the medication or pharmacist can also answer questions about side effects. Over the last decade, treatments have improved, and some medications now have fewer or more tolerable side effects than earlier treatments. However, everyone res-

ponds differently to medications. In some cases, side effects may not appear until a person has taken a medication for sometime. People being treated for bipolar disorder should not stop taking a medication without talking to a doctor first. Suddenly stopping a medication may lead to “rebound,” or worsening of bipolar disorder symptoms. Other uncomfortable or potentially dangerous withdrawal effects are also possible.

CONCLUSION:

Bipolar disorder is a serious mental illness with significant negative impact on multiple domains of an individual’s life. Its diagnosis and treatment presents many clinical challenges. The optimal management of bipolar disorder requires both pharmacological and psychosocial treatments to be delivered in a collaborative manner to achieve the best possible outcome.

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