PEDIATRIC BIPOLAR DISORDER

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BIPOLAR DISORDER

- A complex psychopathological mood disorder causing significant impairment in children.
- SPECTRUM INCLUDES:
  - Bipolar I: full manic episode
  - Bipolar II: depression with hypomania
  - Bipolar not otherwise specified

HOW THE DIAGNOSIS VARIES IN CHILDREN

- The diagnosis in children is very difficult because symptom presentation is variable and largely dependent on developmental age.
- The duration of episodes in children may be as short as 1 to 2 days.
- Mood symptoms can be chronic, can present as predominantly mixed episodes, or can continuously cycle rapidly, with severe irritability or aggression as the usual presenting symptoms.
- Also seen are disruptive behavior, hyperarousal, racing thoughts, elation, and grandiosity

FURTHER COMPLICATIONS TO THE DIAGNOSIS IN CHILDREN

- Bipolar disorder has a high rate of comorbidity with:
  - ADHD
  - Anxiety
  - Conduct
  - Substance abuse
  - Oppositional defiant disorders

BIPOLAR DISORDER AND ADHD

- Manifests a more severe course of illness
- May present with psychosis and comorbid depression often requiring hospitalization
- Although there is some overlap between ADHD and bipolar disorder – the symptoms of bipolar disorder include:
    - Mania
    - Flight of ideas
    - Decreased need for sleep
    - Exhibition of sexual tendencies

DIFFICULT DIAGNOSIS

- Identifying symptoms and making a diagnosis can be harder in children than in adults.
- Children have difficulty noticing and describing symptoms and providing accurate accounts of time of onset and duration of symptoms.

RISK FACTORS FOR BIPOLAR DISORDER

- Combination of genetic and environmental
- Genetic endowment of parents might contribute to family dysfunction, predisposing already genetically affected offspring to evolution of the disorder
- Family history is the most significant risk factor
- Early depression, anxieties, and dysregulated behavior may be useful markers for later development of the disorder

CONTROVERSIES ABOUT BIPOLAR DISORDER

- For much of the 20th century it was thought that children could not experience major depression and it was also thought that bipolar disorder was uncommon in children
- However, retrospective analyses with adult patients with bipolar disorder showed that symptoms began earlier than expected
- Bipolar disorder in children is poorly defined, which can lead to misdiagnosis and inappropriate treatment

EPIDEMIOLOGY

- Combined rate of bipolar I and II disorder was 2.9% with lifetime prevalence of 1.9% for children ages 13 to 14 and 4.3% for children ages 17 to 18.

CLINICAL ASPECTS

- Traditional criteria for bipolar disorders include periods of depression alternating with mania or hypomania.
- Most likely diagnosis begins by parental or school concerns.
- Laboratory testing or imaging is no necessary unless there are concerns for substance use or a psychotic disorder.

DIFFERENTIAL DIAGNOSIS

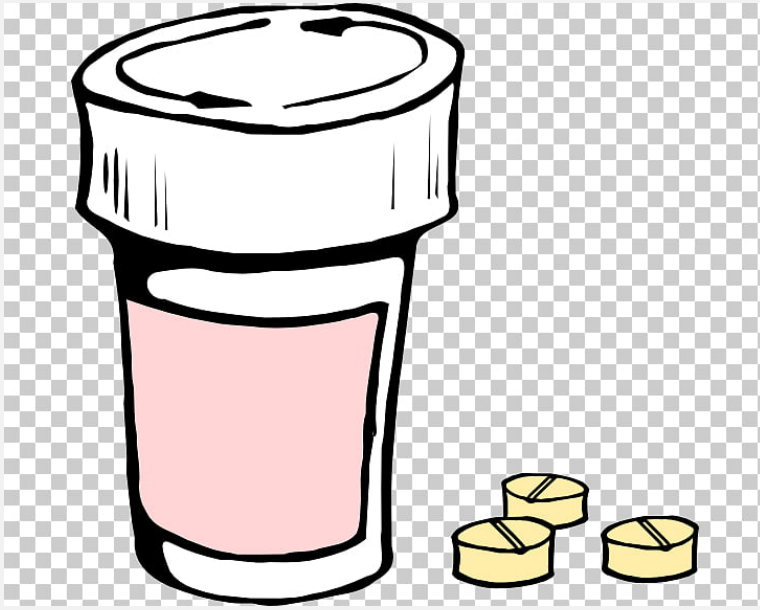
- Normal teenager development can include mood swings, chronic and episode irritability, angry arguments, irregular sleep, hypersexual thoughts, impulsive behavior, and an inflated sense of self-esteem.
- However when thinking about bipolar disorder the symptoms are developmentally inappropriate compared with their peers, are extreme in intensity, occur in multiple settings, and cause significant functional difficulties.

MANAGEMENT

- Medications are the mainstay of treatment
- Also family groups, individual therapies focused on relationships and sleep, dialectical behavioral therapy, and CBT.
- Always make sure you ask whether they currently want to hurt themselves or others in order to ensure their safety.

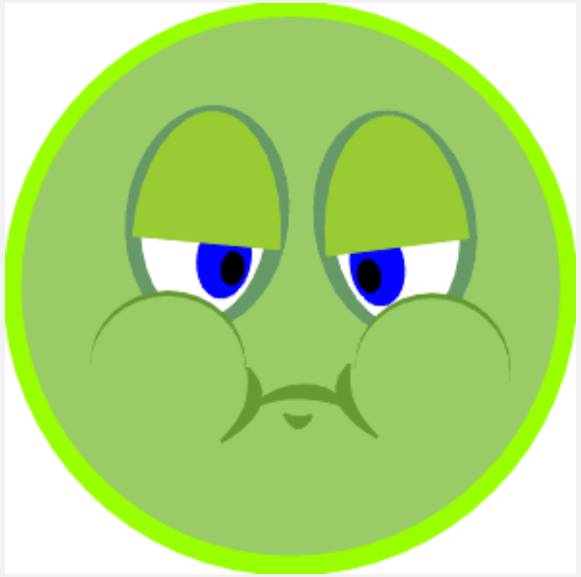
MOOD-STABILIZING MEDICATIONS

- Second generation neuroleptics (second generation antipsychotics)
  - Risperidone
  - Ziprasidone
  - Aripiprazole
  - Quetiapine



ADVERSE EFFECTS OF NEUROLEPTICS

- Nausea
- Vomiting
- Constipation
- Sedation
- Headaches



METABOLIC ADVERSE EFFECTS

- Weight gain
- Hypertension
- Dyslipidemias
- Insulin insensitivity

RARE BUT SERIOUS ADVERSE EFFECTS

- Extrapyramidal movement disorders: dystonia and tardive dyskinesia

INTERVENTION

- The primary care physician can offer an opportunity for intervention in terms of nutritional counseling and anticipatory guidance
- Weight should be monitored monthly
- Blood pressures monitored closely
- Fasting cholesterol levels and fasting glucose levels should be measured every 3 months during adjustments of the dose and on an annual basis thereafter

RESOURCES:

- Bipolar Disorders, Maria T. Nanagas, Pediatrics in Review November 2011
- Mood and Affect Disorders, Michael Tang and Elizabeth Pinsky, 2015