



Opinion

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Theranostics of Brain, Spine & Neural Disorders

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Bipolar Disorder is Now a More Common Disease to be Treated



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Opinion

Bipolar disorder, which is also known as manic-depressive psychosis (bipolar disorder type 1), is a disease that causes mood disorders manifested in both depression and excitation phases. These phases appear either in reaction to stress or for no apparent reason and may be of varying intensity and intersect with periods of stability. It is a category of mood disorders defined by the abnormal fluctuation of mood, oscillating between periods of elevated mood or irritability (mania or in its less severe form of hypomania), periods of depression and periods of normal mood (euthymia).

It happens to everybody to live periods of happiness, sadness, excitement and to be confronted with certain difficulties. However, in the case of bipolar disorder, these changes are out of proportion. They reach such intensity that the person does not realize that he or she is going beyond the limits, or the person is so depressed that she is paralyzed and is haunted by suicidal thoughts. This state brings problems with the family, at work, financial problems, sometimes judicial. The disease can lead to hospitalization in manic states or in states of intense depression.

Bipolar disorder can be expressed differently and not recognized from the outset. Unfortunately, this is the most frequent situation. Some epidemiological data illustrate this reality: from 3 to 8 years of evolution before the diagnosis was made correctly and a specific treatment was put in place, intervention of 4 to 5 different doctors. The search for periods of exaltation is a good means of establishing the diagnosis; but it is not always obvious to the patient to understand that the periods when he felt particularly well had the same origin as the periods when he felt ill. Given the frequency of bipolar disorder and the importance of the prognostic issue, the search for signs of bipolarity should be systematic in the face of any depressive episode. It should be codified in order to facilitate the diagnostic procedure.

The official classifications of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and the International Classification of Diseases (ICD-11) distinguish three types of bipolar disorder:

A. Bipolar type I: characterized by one or more manic or mixed episodes and depressive episodes of variable intensity (diagnosis may be made even in the absence of depressive disorder). An organic cause, iatrogenic or toxic does not make it possible to retain this diagnosis:

B. Bipolar type II: defined by the existence of one or more hypomanic episodes and one or more major depressive episodes:-Cyclothymia: which often begins in adolescence, is presenting with many periods of moderate depression or hypomania, from a few days to a few weeks. Cyclothymic disorder is an attenuated form of bipolar disorder.

It is clear that biological factors are involved because there are anomalies in the production and transmission of brain chemicals called neurotransmitters, as well as hormonal abnormalities, including cortisol also involved in stress. These anomalies are themselves linked to genetic factors, which explains the family predisposition. It is therefore the interaction of biological and environmental factors that best explains the occurrence of bipolar disorder.

Medications called mood stabilizers are used primarily to regulate mood and prevent relapses. The mood stabilizers which have been shown to be effective include lithium salts, anticonvulsants (anti-epileptics) such as valproate, carbamazepine and lamotrigine. Their mechanisms of action seem to operate differently.

Nowadays, the use of lithium is less common, due to the constraints of the drug (need for a blood test and blood tests to adjust the dose and to monitor lithium levels in the blood, dose effective, being very close to the toxic dose). Psychiatrists tend more and more often now to prescribe antipsychotics, which act as mood stabilizers. This may be olanzapine, aripiprazole or quetiapine. These antipsychotics are actually effective more or less in preventing bipolar disorder.

Antidepressants have long been prescribed abusively in depressive episodes of bipolar patients. Often due to lack

of knowledge of the illness that was confused with unipolar depression. Antidepressants after a honeymoon of about two years in bipolar patients, aggravate the symptomatology and should be proscribed except in episodes of acute and intense depression

in association with a mood stabilizer. Treatment approaches should consider not only euthymia as a goal but also cognitive and functional improvement of patients with such a complex disorder.



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