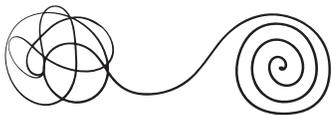


Bipolar_Disorder High yield

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Bipolar and Related Disorders (High Yield)

1. Bipolar I Disorder

- Definition: At least 1 **manic episode** (\pm hypomanic or depressive episodes).
- Mania (DIG FAST): ≥ 1 week of abnormally \uparrow mood/energy + ≥ 3 symptoms:
- Distractibility
- Indiscretion/Impulsivity (risky behaviors)
- Grandiosity
- Flight of ideas
- Activity/Agitation \uparrow
- Sleep need \downarrow
- Talkativeness (pressured speech)
- Important: Psychosis only occurs in mania \rightarrow automatically Bipolar I.
- Duration: ≥ 1 week (or any duration if hospitalization needed).

2. Bipolar II Disorder

- Definition: ≥ 1 **hypomanic episode** + ≥ 1 major depressive episode.
- Hypomania: Like mania but
- Lasts ≥ 4 consecutive days
- No marked impairment, no hospitalization, no psychosis.

3. Cyclothymic Disorder

- Definition: ≥ 2 **years** (≥ 1 in children) of fluctuating mild hypomanic & mild depressive symptoms.
- Do not meet criteria for hypomanic or major depressive episodes.
- Never symptom-free > 2 months.

4. Substance/Medication-Induced Bipolar and Related Disorder

- Symptoms due to drugs (e.g., corticosteroids, stimulants, antidepressants) or substances.

High-Yield Distinctions

- Mania vs Hypomania: Mania = ≥ 1 week, marked impairment, hospitalization, or psychosis. Hypomania = ≥ 4 days, no marked impairment, no psychosis.
- Bipolar I: Mania is enough.
- Bipolar II: Requires depression + hypomania (**never full mania**).
- Cyclothymia: Chronic, subthreshold symptoms.



Important Exam Pearls

- Antidepressants can trigger mania → Always check for bipolar disorder before prescribing!
- Suicide risk: Very high in bipolar disorder (especially Bipolar II).
- Genetics: Stronger heritability than unipolar depression.

Treatment

- Acute mania: **Lithium (gold standard)**, valproate, carbamazepine, atypical antipsychotics.
- Depression in bipolar: Use antidepressants with care (may trigger mania).
- Avoid: Antidepressant monotherapy (can precipitate mania).



Lithium carbonate.

- 0.6 – 1.2 mEq/L : Normal
- 0.6 – 1.5 mEq/L : Therapeutic
- 1.5 – 2 mEq/L : Mild toxicity
- 2 – 3.5 mEq/L : Moderate toxicity
- 3.5 mEq/L : Severe toxicity



Buzzwords for exams:

- “Manic patient hospitalized after spending sprees & no sleep” → Bipolar I.
- “4 days of high energy, increased productivity, no impairment” → Hypomania → Bipolar II.
- “≥2 years of fluctuating mood, never symptom-free >2 months” → Cyclothymia.

Very strong high yield

Comorbidity:

- ADHD is indeed the most common comorbidity in patients with bipolar disorder (especially in children/adolescents).
- This overlap often makes diagnosis difficult (both can show distractibility, impulsivity, hyperactivity).

Treatment Caution:

- Stimulants (methylphenidate, amphetamines) and other ADHD agents can exacerbate mania by increasing dopamine/norepinephrine.
- Clinical rule: Always stabilize mood first (with lithium, valproate, or atypical antipsychotics).
- After bipolar symptoms are controlled, then treat ADHD if symptoms remain functionally impairing.

