Bipolar I Disorder (Manic Episode)

1. PURPOSE

- To provide standardized guidelines for the identification, diagnosis, emergency stabilization, treatment, referral, and follow-up of patients presenting with Manic Episode in Bipolar I Disorder in a general hospital.

2. SCOPE

This SOP applies to:

- Emergency Department
- Outpatient Department (OPD)
- Inpatient Wards
- ICU (if severe agitation or medical instability)
- Psychiatry Department
- Medical Officers and Nursing Staff

3. DEFINITIONS

3.1 Bipolar I Disorder

- A psychiatric disorder characterized by at least one manic episode, as defined in the **Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition.**

3.2 Manic Episode

- A distinct period of abnormally elevated, expansive, or irritable mood and increased energy lasting at least 1 week (or any duration if hospitalization is required), associated with marked functional impairment.

4. RESPONSIBILITIES

4.1 Treating Physician

- Initial medical assessment
- Rule out organic causes
- Start emergency management
- Refer to Psychiatry

4.2 Psychiatrist

- Confirm diagnosis
- Initiate mood stabilizers/antipsychotics
- Assess risk (harm to self/others)

- Decide on admission

4.3 Nursing Staff

- Monitor behavior and safety
- Administer medications
- Maintain observation chart
- Implement safety precautions

5. CLINICAL FEATURES OF MANIA

Diagnosis requires:

- Elevated/irritable mood plus 3 or more (4 if irritable only):
- Inflated self-esteem or grandiosity
- Decreased need for sleep
- Increased talkativeness/pressured speech
- Flight of ideas
- Distractibility
- Increased goal-directed activity
- Excessive involvement in risky activities
- Symptoms must cause:
- Marked impairment
- Need for hospitalization
- Or psychotic features

6. INITIAL ASSESSMENT (EMERGENCY / OPD)

6.1 Immediate Evaluation

- Vital signs
- Level of agitation
- Risk of aggression
- Substance use history
- Medication history

6.2 Risk Assessment

- Harm to self
- Harm to others
- Impulsive behaviors
- Financial/social risk
- High-risk patients require immediate psychiatric consultation and possible admission.

7. DIFFERENTIAL DIAGNOSIS

- Substance-induced mood disorder
- Hyperthyroidism
- Delirium
- Schizophrenia
- Steroid-induced mood symptoms

8. INVESTIGATIONS

To rule out medical causes:

- CBC
- Thyroid function test
- Liver function test
- Renal function test
- Blood glucose
- Urine toxicology
- ECG (before certain medications)

9. MANAGEMENT PROTOCOL

9.1 Acute Agitation (Emergency Management)

- Ensure safety
- De-escalation techniques
- IM antipsychotic (haloperidol 5mg stat) & IV diazepam 10mg (slowly) can be given.
- Continuous monitoring

9.2 Pharmacological Treatment

- First-Line Options:
- Mood stabilizer (Lithium / Valproate)
- Atypical antipsychotic (Olanzapine, Risperidone, Quetiapine)
- Severe Mania:
- Combination therapy (Mood stabilizer + Antipsychotic)
- Psychotic Mania:
- Mandatory antipsychotic
- Consider ECT if severe or treatment-resistant

9.3 Inpatient Admission Criteria

Admit if:

- Severe agitation/aggression
- Psychotic symptoms
- Poor insight
- Risk to self/others
- Severe functional impairment
- Noncompliance with treatment

10. INPATIENT MANAGEMENT

- Structured low-stimulus environment
- Monitor sleep pattern
- Daily behavioral chart
- Monitor medication side effects
- Ensure hydration and nutrition
- Regular psychiatric review

11. DISCHARGE CRITERIA

- Stabilized mood
- Reduced agitation
- Adequate sleep
- No active risk
- Family education completed

12. FOLLOW-UP PROTOCOL

- First follow-up: within 1 week
- Monitor mood symptoms
- Monitor Lithium/Valproate levels (if applicable)
- Psychoeducation
- Long-term maintenance therapy
- Maintenance treatment typically continues long term to prevent relapse.

13. DOCUMENTATION

- Ensure documentation of:
- Mental status examination
- Risk assessment
- Diagnosis
- Medication chart
- Consent
- Family counseling

- ❖ Follow-up plan

Management of Bipolar I Disorder – Current Depressive Episode

1. Purpose

To provide standardized guidelines for assessment, diagnosis, treatment, referral, safety management, and follow-up of patients diagnosed with Bipolar I Disorder – Current Episode Depressive in a general hospital setting.

2. Scope

This SOP applies to Emergency Department, Outpatient Department (OPD), Inpatient units, Psychiatry Department, and all healthcare professionals involved in the management of adult patients with Bipolar I Disorder.

3. Definition

Bipolar I Disorder is characterized by at least one lifetime manic episode. The current episode depressive phase involves persistent depressed mood or loss of interest with associated cognitive, behavioral, and somatic symptoms causing functional impairment.

4. Responsibilities

• Emergency Physician/Medical Officer: Initial assessment, medical stabilization, and referral.
• Psychiatrist: Diagnostic confirmation and pharmacological management.
• Clinical Psychologist: Psychological assessment and psychotherapy.
• Nursing Staff: Monitoring safety, medication administration, and patient education.
• Medical Social Worker: Family counseling and discharge planning.

5. Procedure

A. Initial Assessment:
• Assess airway, breathing, circulation (ABCs) if in emergency setting.
• Record vital signs.
• Conduct detailed psychiatric history including past manic/hypomanic episodes.
• Assess for suicidal ideation, intent, or plan.
• Screen for substance use and comorbid medical conditions.

B. Diagnostic Evaluation:
• Detailed Mental Status Examination (MSE).
• Confirm diagnosis as per ICD/DSM criteria.

• Baseline laboratory investigations before initiating mood stabilizers (CBC, LFT, RFT, thyroid function tests as indicated).

C. Risk Assessment:
• Evaluate suicide risk using structured assessment tools if available.
• Assess risk of self-neglect, psychosis, or catatonia.
• Determine need for inpatient admission.

D. Management:
1. Pharmacological Treatment:
• Mood stabilizers (e.g., lithium, valproate) as first-line treatment.
• Atypical antipsychotics if indicated.
• Antidepressants only in combination with mood stabilizer and under psychiatric supervision.
• Monitor serum levels (e.g., lithium) as per protocol.

2. Psychotherapy:
• Cognitive Behavioral Therapy (CBT).
• Psychoeducation for patient and family.
• Interpersonal and Social Rhythm Therapy (if available).

3. Safety Measures:
• Remove access to means of self-harm.
• Close monitoring in high-risk cases.
• Consider admission for severe depression or suicidal risk.

E. Referral Criteria:
• High suicide risk.
• Psychotic symptoms.
• Severe functional impairment.
• Poor response to outpatient management.

F. Follow-Up:
• First follow-up within 1 week after discharge or medication initiation.
• Monitor medication adherence and side effects.
• Regular mood monitoring.
• Long-term maintenance therapy planning.

6. Documentation

- Document detailed assessment findings.
- Record diagnosis with episode specification.
- Maintain medication chart and monitoring records.
- Record informed consent and safety planning.

7. Emergency Red Flags

- Active suicidal intent or plan.
- Psychotic symptoms.
- Severe agitation or refusal to eat/drink.
- Lithium toxicity symptoms (if on lithium).