Guideline 8: Mania (Bipolar I Disorder)

8A. Diagnosis of Nonpsychotic Mania[Question 6]

The experts considered elevated, expansive, or irritable mood that persists for at least 1 week the single most important discriminating feature in diagnosing nonpsychotic mania in an older patient. The other features they endorsed agree closely with the DSM-IV criteria for a manic episode.

(***bold italics*** = features rated "extremely important" by at least 50% of the experts)

Most important discriminating features	Also consider
Elevated, expansive, or irritable mood that persists for at least 1 week	Workup rules out a medical illness (e.g., multiple sclerosis, stroke) that could be causing the manic symptoms
Inflated self-esteem or grandiosity for at least 1 week	No evidence that the patient has recently used a drug (e.g., cocaine, antidepressant medication) that can cause manic symptoms
Flight of ideas or subjective experience that thoughts are racing, occurring frequently for at least 1 week	The symptoms are not better accounted for by schizoaffective disorder, schizophrenia, or delusional disorder
Excessive involvement in pleasurable activities that have a high potential for negative consequences (e.g., buying sprees, foolish business investments)	Increase in goal-directed activity or psychomotor agitation for at least 1 week
Decreased need for sleep for at least 1 week	Distractibility for at least 1 week

8B. Diagnosis of Psychotic Mania[Question 6]

The two most important diagnostic features for psychotic mania are hallucinations or delusions and elevated, expansive, or irritable mood. The experts endorsed the same additional features as for nonpsychotic mania, but placed more emphasis on ruling out schizophrenia, schizoaffective disorder, and delusional disorder as well the effects of drugs and other substances.

(***bold italics*** = features rated "extremely important" by at least 50% of the experts)

Most important discriminating features	Also consider
Hallucinations or delusions that occur only when the manic symptoms are also present	Workup rules out a medical illness (e.g., multiple sclerosis, stroke) that could be causing the manic symptoms
Elevated, expansive, or irritable mood that persists for at least 1 week	Increase in goal-directed activity or psychomotor agitation for at least 1 week
Inflated self-esteem or grandiosity for at least 1 week	Distractibility for at least 1 week
Flight of ideas or subjective experience that thoughts are racing, occurring frequently for at least 1 week	
Decreased need for sleep for at least 1 week	
The symptoms are not better accounted for by schizoaffective disorder, schizophrenia, or delusional disorder	
Excessive involvement in pleasurable activities that have a high potential for negative consequences (e.g., buying sprees, foolish business investments)	
No evidence that the patient has recently used a drug (e.g., cocaine, antidepressant medication) that can cause manic symptoms	

8C. Selecting Treatments for Mania[Question 26]

The first-line recommendation for ***mild mania*** was a mood stabilizer alone. The experts would also consider discontinuing an antidepressant if the patient is receiving one.

For ***severe nonpsychotic mania***, the experts would first discontinue any antidepressant the patient may be receiving and would treat the patient with a mood stabilizer combined with an antipsychotic. They would also consider using a mood stabilizer alone.

For ***psychotic mania***, the treatment of choice was a mood stabilizer combined with an antipsychotic (rated first line by 98% of the experts). The experts also recommended discontinuing any antidepressant the patient may be receiving. High second-line options for psychotic mania were ECT, a mood stabilizer plus an antipsychotic plus a benzodiazepine, or an antipsychotic alone. The editors note that one might consider using an antipsychotic alone if there is concern about delirium developing.

There was no first-line recommendation for treating a ***mixed episode***; high second-line options were a mood stabilizer plus an antipsychotic or a mood stabilizer alone.

(***bold italics*** = treatment of choice)

	Preferred	**Also consider**
Mild mania	A mood stabilizer alone	Discontinue antidepressant if patient is currently receiving one
Severe nonpsychotic mania**	Discontinue antidepressant if patient is currently receiving one* A mood stabilizer plus an antipsychotic*	A mood stabilizer alone**
Psychotic mania	***A mood stabilizer plus an antipsychotic*** Discontinue antidepressant if patient is currently receiving one*	Electroconvulsive therapy (ECT) A mood stabilizer plus an antipsychotic plus a benzodiazepine An antipsychotic alone
Mixed episode	*(None)*	A mood stabilizer plus an antipsychotic A mood stabilizer alone

*Very high second line.

**57% of the experts rated a mood stabilizer plus an antipsychotic first line (with 32% giving it a rating of "9") and 48% of the experts rated a mood stabilizer alone first line.

8D. Selecting Antipsychotics for Use in Combination With a Mood Stabilizer to Treat Mania With Psychosis[Question 27]

Risperidone and olanzapine at the dosages shown below were first-line options for use in combination with a mood stabilizer to treat mania with psychosis. Quetiapine was a high second-line choice. Although the experts gave high second-line ratings to a combination of a mood stabilizer and an antipsychotic in severe nonpsychotic mania, there was less support for the specific antipsychotics we asked about in nonpsychotic mania than in psychotic mania, with risperidone, olanzapine, and quetiapine all rated second line, probably reflecting less support for using an antipsychotic in nonpsychotic than psychotic mania. If it is decided to use an antipsychotic drug to treat nonpsychotic mania, the experts would recommend using slightly lower doses.

Preferred	**Also consider**
Risperidone 1.25–3.0 mg/day Olanzapine 5–15 mg/day	Quetiapine 50–250 mg/day