Case Reports: use of Consta in bipolar disorder
Case 1: Female age 39 at first presentation 1989.

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Gave 9 month history of low mood, preoccupations of neglecting the family and betraying a close friend. No suicidal ideation.

Family history of affective disorder (mother). Normal milestones, Married 18 years with 2 daughters. Working until developing index episode of illness.
No significant alcohol or drug abuse history.

Mental state exam: Well presented. Slowed up and very depressed. No psychotic symptoms and cognitive function intact.

Diagnosis: Endogenous depression Treatment: Trimipramine
Outcome: Good response within 2 months

Note of difficult marital relationship.

Next contact 01.93 Serious overdose against backdrop of depression, on lofepramine. In patient assessment: 12.92 to 03.93 Diagnosis of psychotic depression, "devil inside me" and "I am being manipulated" with suspicions that nurses were part of a play in the after-life"

Treatment: Lofepramine+ trifluoperazine. 4x ECT. Switch of maintenance treatment to trifluoperazine + sertraline
Revised diagnosis: Schizoaffective disorder.

Poor compliance a factor in relapse of further psychotic depression. Problems with affective flattening caused by antipsychotic.

Switch to amitriptyline as antidepressant. Problems with side effects, but some improvement in mood.

Pilgrimage to Ireland results in distress over compulsion to swear in Church. Depressive ruminations and delusions that again in Hell.
Response to increased neuroleptic dose 12/94 Ruminating about AIDS test that she demanded from GP. Problems with weight gain (60 to84kg).

Recurrence of ruminations about Church. Increased medication leads to symptomatic improvement but worse side effects. Attempt to reduce medication results in further relapse

12.95 Readmitted with psychotic depression. Religious delusions. Treatment venlafaxine + trifluoperazine

Readmission for psychotic depression Mood congruent delusions and hallucinations of the Devil.

Overdose associated with low mood. Doubtful compliance a factor.
Addition of carbamazepine 200mg bd.

Problems of extreme weight gain and sedation. Switch of antipsychotic to sertindole. Good response to change of medication with increased energy levels and being "better than for many years".

Relapse of psychotic symptoms, increase of sertindole to 24mg. Control regained, but 12.98 sertindole withdrawn from market
Started in Quetiapine. By 02.99 resolution of psychotic symptoms and more energetic than for many years.

Remains well for longest period since start of illness.

May 2000 Sudden relapse of illness through non-compliance; again psychotic depression, rapid recovery on recommencement of medication.

Medication Carbamazepine 200mg bd
Venlafaxine 187.5mg bd
Quetiapine 300mg bd

Remains well 02.02 Decides to leave husband due to marital difficulties.

Presents as Jesus Christ after religious retreat. Elated and grandiose. Understands that she is the second coming of Christ. Diagnosis of Mania

Admitted 08.02- 03.03 Apparent that relapse due to non-compliance again.

Course in ward very turbulent. Periods of suspicion and irritability. Continued affective elements, with delusions and paranoia prominent. These initially take the form of being on a mission to take people to Heaven. In this context the patient absconds to Glasgow airport and hides in the Chapel there waiting for a flight to Canada. Patient switched to oral risperidone, with a downswing in mood to depression with delusions of possession by Satan. Psychotic symptoms gradually settle although patient remains guarded and hostile. December 2002 started on injectable risperidone with a dose reaching 50mg every 2 weeks. Discharge home on venlafaxine and injectable risperidone. Patient has a further admission for 2 weeks in May 2003 which appears related to family problems and matters resolve rapidly. To date (Spring 2005) the patient remains very well with no recurrence of either mood disorder or psychotic symptoms.

Learning point: The patient was probably poorly compliant with oral medication for much of her period under psychiatric care. Compliance was not felt to be an issue owing to the profound reassurance on this issue by both the patient and her spouse. Only with an assured mechanism of delivery did the stability and control of the cyclical mood disorder occur.

Case 2: JC Male age 39 on presentation in 1997

Urgent presentation on the anniversary of suicide of the patient's 21 year old step-son. Patient found digging out ice from the back of the deep freeze, looking for his son and talking to no one while asking for forgiveness. Claims to here his son calling from the freezer unit. Initially settles from this distress but later the same night is in the street brandishing a sword, and holding a coin in his hand which he claims is the Holy Grail.
When seen at hospital there is pressure of speech, now an elated mood and paranoid ideas that people are intent on killing him. Patient believes that he is Christ reincarnate and that he has the constellation Ursa Major on his hand.

Past psychiatric history notable for both he and spouse using heroine and cannabis. Investigations at admission show normal EEG, CT scan shows mild atropy and a small lacunar infarct in the left globus pallidus area. SPECT scan shows a similar picture with increase uptake in the associated thalamic area.

Initial treatment is with sulpiride. Differential diagnosis drug induced psychosis or bipolar disorder.

Symptoms settle well and discharge home. 3 months later chaotic situation at home, attributed to drug misuse by patient and partner but no evidence of recurrence of psychotic symptoms. Patient appears to be complying with oral antipsychotic.

November 1999, similar presentation of hypomanic state. Patient has soaked himself in petrol and threatening self-immolation. On assessment denies seriousness of actions and describes his mood concentration and activity as excellent.

Mental state exam revealed a gaunt and disheveled barefoot individual who looked older than his years. His mood was elevated with clear thought disorder , grandiosity and persecutory delusions

By now patient is on methadone through the drug rehabilitation programme. Patient refuses to take oral antipsychotic or other oral drugs such as mood stabilizer. Commenced on zuclopentixol decanoate 200mg every week. By March 2000, he is no longer psychotic but there are concerns about his flattened affect, lack of volition and clear Parkinsonian symptoms caused by the conventional depot antipsychotic. Despite the use of procyclidine and a dose reduction these symptoms persist.

In May 2002 a decision is made to switch him to injectable risperidone (as part of a trial). By Novmeber of that year he is noted to be strikingly more animated, and active with little in the way of negative symptoms. These improvements persist over the next 12 months with no recurrence of either positive psychotic symptoms or abnormality of mood. He is more motivated, has reestablished contact with his wife and is now looking after his family on occasion. He remains on methadone but is not abusing illicit drugs.

In December 2004, he remains very well, has taken up painting water colours and has discontinued his methadone, He is not abusing illicit drugs and remains affectively stable. He remains on risperidone injection 25mg every 2 weeks.

Case 3: AB born 1958.

Onset of affective problems age 20 diagnosis varied between bipolar disorder and schizo-affective disorder.

Referred to our service 1996 at age 37 Employed as greenkeeper at local golf course for previous 10 years. Married with 2 young children.

Presentation was of mild irritability with some flight of ideas. This rapidly changed to a lowered mood with auditory hallucinations of a derogatory nature. Disturbed sleep pattern and loss of appetite.
Initial treatment was with low dose diazepam with symptomatic relief.

Family history: No psychiatric history

Born and raised locally, with successful progress through school. Then worked as greenkeeper for most of adult life.
Previous psychiatric history: 2 or 3 admissions in 1980's with diagnosis of bipolar illness but not placed on any long term medication.

On this admission, treated with haloperidol which stabilized symptoms through first half of 1996. Haloperidol discontinued, with relapse of hypomanic symptoms including pressure of speech, overspending and overactivity. Restarted on haloperidol 3mg tid. Develops problems with akathisia. Haloperidol stopped
3/97 Started on lithium carbonate 600mg nocte.
6/97 Increasingly agitated and aggressive; started on chlorprpomazine upto 450mg a day and lithium increased to 800mg per day.
Symptoms slow to settle, loses job after 15 years employment (due to illness)..

10/97 Low mood and depression. Has venlafaxine 75mg added and lithium increased to 1000mg. Mood swings to hypomania.. Venlafaxine stopped and mood stabilizes.

3/98 Akathisia worsens. Treatment with propranolol for akathisia

9/98 Elevated mood once more, much worse akathisia. Patient refuses previous antipsychotics, started on trifluoperazine 10mg bd. (plus lithium and procyclidine). Episode settles.

6/99 Fed up with lack of job and role. Given package of CBT for relapse prevention in bipolar disorder.

11/99 Further episode of overactivity Increased trifluoperazine results in worse akathisia . Stop trifluoperazine, trial of olanzapine 10mg increased to 15mg. (still on lithium).

1/01 Low mood, add on of lofepramine by 2/01 akathisia worse still, but no major change in treatment approach.

2/02 Upswing in mood, akathisia worsening compliance, switched to quetiapine. Illness worsens, with lowered mood, including mood congruent psychotic symptoms with critical negative auditory hallucinations. Quetiapine increased to 300mg bd. Patient gets worse, mood dips and start of sertraline 50mg. Psychotic symptoms persist even as mood recovers. Switch to amisulpride 300mg bd plus lithium and sertraline. Auditory hallucinations resolve within a week.

11/02 Mood again low, marital stressors, patient appears confused and considered to be toxic. Doubts are raised about reliable compliance. By 4/03 marriage breaking down; auditory hallucinations recur. Patient responds to amisulpride 350mg bd, but severe akathisia, but patient refuses to change antipsychotic.

Patient left by wife in early 2003. Nevertheless there appears to be improved affective range, better concentration and energy levels. Patient starts bird watching again. Akathisia still a problem.

Full case review recognizes persistent nature of psychotic symptoms and suggestion that trial of clozapine be considered. This takes place as inpatient, there is a good response to this medicine with reduction in psychotic symptoms. Discharge on clozapine 250mg lithium 1gm.

7/04 Elevated mood, pressure of speech, flight of ideas; readmitted until 8/04 after restabilisation of medication; compliance an issue. Readmitted again end of 8/04 with shift to low mood inactivity and self neglect. Preoccupations with past events and failure of marriage; felt to be delusional. At times seems confused. Lithium is discontinued while clozapine dose is increased to 300mg a day. Patient is less confused and is again discharged. Concerns again about compliance

16/12/04 Represents again with bizarre behaviour laughing for no reason, smothering face in ash and putting jam in ears "to stop voices". House very neglected and lots of bills. Again seems unlikely to have been compliant (medications found all over house), adding further to issues picke dup by clozapine monitoring service.

Started on oral then injectable risperidone. Patient continues to behave in bizarre fashion in ward for next 6 weeks, but then settles well. Patient reports feeling better than has been for many years. Appears more organized and more settled in mood. Starts to be indignant that not treated with this medicine years ago. No significant signs of akathisia. Patient discharged home on Consta 50mg plus 2mg oral risperidone as this is giving optimal symptom control. Concerns remain about the compliance with oral top up, but assured delivery by injection is effective. Patient dislikes injection but sees benefits in health

Learning point: Even apparent compliance through regular medication monitoring appears limited in effectiveness. This patient also clearly shows the need for higher doses of risperidone to get full symptomatic control.

Patient Status and Acute Mania: Baseline Characteristics of the EMBLEM study

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Objectives: To describe the baseline characteristics of inpatients and outpatients enrolled in the EMBLEM (European Mania in Bipolar Longitudinal Evaluation of Medication) study.

Methods: EMBLEM is a 2-year prospective, observational study on outcomes of patients experiencing a manic or mixed episode conducted in 14 European countries. Adult patients with bipolar disorder were enrolled within the standard course of care as in/outpatients if they initiated or changed oral medication with antipsychotics, anticonvulsants or lithium for treatment of acute mania (excluding dose changes). Patients were not enrolled if they participated in a simultaneous study that involved treatment intervention or/and an investigational drug. All treatment decisions are at the discretion of the treating psychiatrist. 530 psychiatrists enrolled 3681 patients between December 2002 and June 2004 using the same study methods assessing socio-demographics, psychiatric history, clinical status, functional status and pharmacological treatment patterns.

Results: Of 3536 eligible patients at baseline, 55% were female and mean age was 44.6 years (sd 13.4). Of these, 39% (n=1393) were inpatients and 61% (n=2140) were outpatients. Inpatients were more severely manic [CGI-BP mania mean 5.2 (sd 0.95) vs 4.5 (sd 0.89) and YMRS mean 30.6 (sd 10.15) vs 23.5 (sd 8.78)] than outpatients, were more likely to be experiencing their first manic episode (12% vs 6%)and have hallucinations/delusions during the current episode (59% vs 42%). Compared to outpatients, more inpatients have used cannabis (17% vs 8%), but not alcohol, in the previous 3 months and have had less depressive episodes in the previous 12 months Outpatients had higher treatment compliance. Functional impairment was more severe in inpatients, as measured by number of social contacts, living conditions, relationship status and work impairment. In terms of pharmacological treatment, more inpatients were taking combination therapy (44% vs 34%) upon presentation, with the most frequently prescribed medication typical antipsychotic and anticonvulsant. Lithium use was similar for inpatients (17%) and outpatients (20%) upon presentation. Inpatients took more concomitant medication (75% vs 58%), predominantly in the form of benzodiazepines. Outpatients took more anti-depressant medication (40% vs 22%) than inpatients.

Conclusions: The EMBLEM study population represents the largest naturalistic study on outcomes in bipolar disorder. Over one third of the patients enrolled into the study were inpatients who represent a more severe form of the disorder. Although the proportion of in- and outpatients may not represent the proportion of manic episodes in each of the treatment settings in each country, this study provides clinically relevant information about the status of manic patients and their treatment across Europe.

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