Call to Clinical Action

Evaluation and Diagnosis

1. Use the Mood Disorder Questionnaire (MDQ) to screen for bipolar disorder before treating unipolar depression or other mood complaints.
2. Conduct a comprehensive diagnostic evaluation for bipolar disorder when a patient screens positive on the MDQ or has signs or symptoms suggestive of bipolar disorder.
3. Evaluate patients for bipolar disorder when they have atypical presentations of depression, apparent treatment-resistant depression, a hypomanic or other adverse response to antidepressant medication, or symptoms suggestive of schizophrenia or psychosis.
4. Pursue corroborating information, with the patient's permission, from the relatives and/or friends of a patient being evaluated for bipolar disorder.
5. Assess patients for affective and comorbid symptoms concurrently, realizing that comorbidity is the rule in bipolar disorder.
6. Screen patients with bipolar disorder for psychosis even in the absence of mania.
7. Screen first-degree relatives of patients with bipolar disorder for the disorder.
8. Distinguish bipolar disorder from attention-deficit/hyperactivity disorder (ADHD) in children and adolescents through use of family history, developmental timelines, and symptom characterization.
9. Reassess children and adolescents for bipolar disorder when they fail to respond to appropriate therapy for ADHD.

Treatment Decisions

10. Consider tolerability as well as efficacy and safety when selecting agents, tailoring pharmacotherapy decisions to patients' acute and ongoing needs.
11. Consider how an agent's mechanisms of action are likely to affect both the manic and depressive poles of bipolar disorder in choosing treatment regimens.
12. Weigh the costs of inadequate treatment against the expense of medications and other interventions when assessing the cost-effectiveness of a treatment plan.
13. Realize that polypharmacy is the norm in treating bipolar disorder.
14. Whenever possible, add agents sequentially rather than starting them simultaneously in combination therapy.
15. Have a clear rationale for each agent included in a combination therapy regimen, and knowledge of the evidence regarding its use in that combination.
16. Usually focus on mood stabilization before addressing comorbidities, and seek to avoid treating comorbidities with mood-destabilizing agents.
17. Consider treating comorbid anxiety disorders with mood stabilizers and atypical antipsychotics with demonstrated efficacy in anxiety rather than with antidepressants.

Comprehensive Management

18. Involve family members and/or friends in the patient's care.
19. Provide patients and their families and friends with education about bipolar disorder and direct them to reliable sources of information about the disorder.
20. Stress to patients—and to their families and/or friends—that bipolar disorder is a long-term condition that requires lifelong treatment.
21. Question and counsel patients about medication tolerability, adverse effects, and adherence at each visit.
22. Employ mood charting and/or other means of patient self-assessment, while seeking corroborating information.
23. Look beyond reduction of symptoms to improvement in function at work, home, and in social settings when assessing remission.
24. Recognize sleep as one of the most reliable measures for assessing improvement or deterioration.
25. Assess the need for each component of the treatment regimen on a continuing basis.

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