Is it ADHD, Bipolar Disorder or Something Else?

22nd Annual North Texas Family Medicine Update

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Objectives of this activity:

- Describe current diagnostic, management and therapeutic strategies for issues commonly and uncommonly seen in a family medicine practice;
- Formulate differential diagnoses for complaints common in a family medicine practice;
- Explore controversies related to established and recent data in patient care; and
- Identify challenges and opportunities to impact population health within a family medicine practice.

Why Discussion?

- A recent survey of primary care physicians found that they were far less knowledgeable and comfortable in diagnosing and treating adult ADHD compared to depression and anxiety disorders
- Lack of recognition doubles the annual medical costs of an undiagnosed ADHD individual compared to a person without the condition ($5651 vs $2771)
- Comorbidities, such as depression and anxiety, can also complicate or mask a diagnosis of ADHD
- Untreated adults with ADHD are more likely to be substance abusers, have marital problems, occupational and school problems, and incur more serious motor vehicle accidents
ADD and Bipolar

- ADHD (Attention Deficit Hyperactivity Disorder)
- ADD (Attention Deficit Disorder)
- Bipolar I Disorder
- Bipolar II Disorder
- Major Depressive Disorder

Differential Diagnosis

- Major Depressive Disorder
- Adjustment Disorder
- Medications
- Current Mental Status
- Medical Illnesses

Key Point

- Attention Disorders are pervasive
- Mood Disorders have a cyclical nature
Case Study 1

◆ 34 year old married waiter
◆ Frequently $ off in cash register at end of shift, generally does well at work, social, attentive to customers, enjoys his work.

Case Study 1

◆ Wife - frustrated
◆ He is unable to keep checkbook she took over after phone shut off
◆ Forgetful: birthdays, anniversaries, late picking up child
◆ She initiated the evaluation

Case Study 1

◆ History
◆ Diagnosed with ADHD combined type - age 6
◆ Treated effectively - Methylphenidate 6 years
◆ Discontinued in Junior High – thought he no longer needed it because he was no longer hyper
Key Point

- We now know that approximately 2 out of 3 children with ADHD will go on to become adults with ADHD and that about 80% of the adults with the disorder are undiagnosed and untreated.

Attention Deficit Hyperactivity Disorder

- A persistent pattern of inattention and or hyperactivity and impulsivity that is more frequently displayed and more severe than is typically observed in individuals at a comparable level of development
- Symptoms must have been present before age 7
- Symptoms MUST occur in at least 2 settings

Types

- Predominately inattentive
- Predominately hyperactive-impulsive type
- Combined, which is the most frequent
- Approximately half of the referred cases have co-morbid oppositional defiant disorder or conduct disorder
Inattentive Symptoms

- Fails to give close attention to details
- Has difficulty sustaining attention
- Does not seem to listen
- Fails to finish assignments
- Has difficulty organizing tasks
- Avoids tasks that require attention
- Often loses things
- Is easily distracted
- Is often forgetful

Hyperactive/impulsive

- Often fidgets or squirms
- Often leaves seat
- Runs about excessively
- Difficulty engaging in leisure activities
- Acts as if “driven” and always on the go
- Talks excessively
- Blurs out answers
- Has difficulty awaiting their turn
- Often interrupts or intrudes upon others

Natural course of ADHD

- As the individuals age the intensity of the hyperactive-impulsivity symptoms diminishes but not the inattention
- Adults with ADHD have greater difficulties sustaining employment, greater rates of drug and alcohol abuse, greater marital and family conflicts
Prevalence

- Pediatric Population 6-9%
- Adult Population 4-5%
- Consistent Prevalence World wide

Activity Comparisons

<table>
<thead>
<tr>
<th>Childhood</th>
<th>Adulthood</th>
</tr>
</thead>
<tbody>
<tr>
<td>Squirming, fidgeting</td>
<td>Inefficiencies at work</td>
</tr>
<tr>
<td>Can’t stay seated</td>
<td>Can’t sit in meetings</td>
</tr>
<tr>
<td>Can’t wait turn</td>
<td>Can’t wait in line</td>
</tr>
<tr>
<td>Runs/climbs excessively</td>
<td>Drives too fast</td>
</tr>
<tr>
<td>Can’t work play quietly</td>
<td>Self-selects to active job</td>
</tr>
<tr>
<td>Always on the go</td>
<td>Can’t tolerate frustration</td>
</tr>
<tr>
<td>Talks excessively</td>
<td>Talks excessively</td>
</tr>
<tr>
<td>Blurts out answers</td>
<td>Interrupts others</td>
</tr>
<tr>
<td>Intrudes and interrupts others</td>
<td>Makes inappropriate comments</td>
</tr>
</tbody>
</table>

Case 2

- Young college student no problems in earlier grades but now on probation at college
- Incomplete assignments declining test scores
- Parents provided a great deal of oversight and structure -lost when he went to college.
Inattention Comparison

<table>
<thead>
<tr>
<th>Childhood</th>
<th>Adulthood</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty sustaining attention</td>
<td>Poor motivation</td>
</tr>
<tr>
<td>Easily distracted</td>
<td>Difficulty sustaining attention</td>
</tr>
<tr>
<td>Doesn’t listen</td>
<td>Paralyzing procrastination</td>
</tr>
<tr>
<td>No follow-through</td>
<td>Slow, inefficient</td>
</tr>
<tr>
<td>Can’t organize</td>
<td>Poor time management</td>
</tr>
<tr>
<td>Loses important items</td>
<td>Disorganized</td>
</tr>
</tbody>
</table>

ADHD Treatment Options
(Stimulants)

<table>
<thead>
<tr>
<th>Class/Drug</th>
<th>Typical Doses</th>
<th>Common Adverse Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methylphenidate</td>
<td>20mg-100mg</td>
<td>Insomnia, anorexia, headaches, dysphoria, elevated BP</td>
</tr>
<tr>
<td>Dexmethylphenidate XR</td>
<td>5mg-20mg</td>
<td></td>
</tr>
<tr>
<td>Mixed amphetamine salts XR</td>
<td>10mg-60mg</td>
<td>Gi Disorders, dry mouth, anorexia, headache, insomnia, irritability</td>
</tr>
<tr>
<td>Lisdexamfetamine dimesylate,</td>
<td>30mg-70mg</td>
<td></td>
</tr>
</tbody>
</table>

ADHD Treatment Options
(Non-Stimulants)

<table>
<thead>
<tr>
<th>Class/Drug</th>
<th>Typical Doses</th>
<th>Common Adverse Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>amoxetine</td>
<td>40mg-120mg</td>
<td>Sleep disturbance, elevated BP, GI distress, nausea, headache</td>
</tr>
<tr>
<td>Tricyclic antidepressants if Depressed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Desimpramine, imipramine</td>
<td>100mg-300mg</td>
<td>Dry mouth, constipation, changes in weight, vital signs, ECG</td>
</tr>
<tr>
<td>Nortriptyline</td>
<td>50mg-100mg</td>
<td></td>
</tr>
<tr>
<td>Other antidepressants if Depressed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bupropion</td>
<td>150mg-450mg</td>
<td>Irritability, seizure risk, insomnia</td>
</tr>
<tr>
<td>Venlafaxine</td>
<td>75mg-225mg</td>
<td>Nausea, sedation, GI distress</td>
</tr>
</tbody>
</table>
Self Screen

Check box that best describes how you have felt/conducted yourself over past 6 months. Please give completed questionnaire to your healthcare professional during your next appointment to discuss results.

1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?
3. How often do you have problems remembering appointments or obligations?
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?

http://www.med.nyu.edu/psych/assets/adhdscreener.pdf

Self-Screen Score

◆ Add the number of checkmarks that appear in the darkly shaded area. Four (4) or more checkmarks indicate that your symptoms may be consistent with Adult ADHD. It may be beneficial for you to talk with your healthcare provider about an evaluation.

◆ The 18 item Checklist.
http://www.med.nyu.edu/psych/assets/adhdscreen18.pdf

Key Point - Impairment

◆ Review the entire Symptom Checklist with your patients and evaluate the level of impairment associated with the symptom.

◆ Consider work/school, social and family settings.

◆ Symptom frequency is often associated with symptom severity, therefore the Symptom Checklist may also aid in the assessment of impairments. If your patients have frequent symptoms, you may want to ask them to describe how these problems have affected the ability to work, take care of things at home, or get along with other people such as their spouse/significant other.
The woman who talks a lot

A 48 yo ♀ is seen in hospital. She is quite hyperactive, agitated, speaks rapidly and continuously. In addition to elevated mood, she is grandiose and frankly paranoid. Her manner is cooperative but overly familiar and her attire is a bit revealing. She jokes repeatedly about her circumstances.

The energetic man

A 40 yo ♂ is sent by his employer for a fitness-for-duty exam. He has been talking almost continuously for days, sexually propositioning his super-visees, and bursting into his boss’ office repeatedly with a “plan to save the company.” He has worked there for 12 years and generally been a good employee. There is no hx of psych illness.

The energetic man

He talks non-stop during his interview with you and seems grandiose but not psychotic. His physical exam is essentially normal.
Bipolar I Disorder

Definition:
- One or more current or prior Manic or Mixed Episodes
- Major Depressive Episodes have usually occurred but are not required for the diagnosis
- The mood symptoms are not better accounted for by a Psychotic Disorder including Schizoaffective Disorder

Bipolar II Disorder

Definition:
- One or more current or prior Hypomanic Episodes
- One or more current or prior Major Depressive Episodes
- Has never had full Manic or Mixed Episodes

Differential Diagnosis: Mania

- Other Mood Disorders
  - E.g., Bipolar I vs. BP II or Cyclothymia
- Other Non-Mood Disorders
  - E.g., Schizophrenia (disorganized type)
- General Medical Conditions
  - Hyperthyroid, Post-CVA, MS
  - Cushing’s, mass lesions
- Substance-Related Conditions
  - Alcohol, benzodiazepine withdrawal
  - Stimulant, cocaine abuse
Treatment:

- Unstable mood (Manic, Mixed, etc.) may be treated with:
  - Mood Stabilizers are a higher priority than Antidepressants
    - Lithium carbonate
    - Anticonvulsants
    - Second-Generation Antipsychotics
  - Antidepressants are generally to be used only during active depression
  - ECT may be employed in resistant cases

Initial Rx: Bipolar I, Manic/Mixed

- 1st: Lithium, Divalproex or an Atypical Antipsychotic
  - Favor Atypicals if psychotic features
- 2nd: Combine two of above
  - Li + anticonvulsant, or anticonvulsant + atypical
- 3rd: Combine all three
- 4th: ECT for failure to respond, especially in high-risk

Initial Rx: Bipolar I, Depressed

- 1st: Lithium, Divalproex or an Atypical Antipsychotic + Antidepressant
  - Mood stabilizer before antidepressant
  - Some use mood stabilizer alone, at first
  - Tricyclics least favored, of antidepressants
    - May trigger “switch” to mania or rapid cycling
    - Ideally, back off antidepressant when mood no longer depressed
- 2nd: More complex mood stabilizers and/or antidepressants, for incomplete response
The tired man

A 37 yo ♂ comes to your office complaining of several months of increased fatigue, broken sleep, poor appetite (but little weight loss) and trouble paying attention at work. He denies depressed mood, admits to reduced job satisfaction, describes poor concentration, vigorously denies morbid thoughts or suicidal ideation.

SIGECAPS

◆ S - Changes in sleep pattern
◆ I - Changes in interests or activity
◆ G - Feelings of guilt or increased worry
◆ E - Changes in energy
◆ C - Changes in concentration
◆ A - Changes in appetite
◆ P - Psychomotor disturbances
◆ S - Suicidal ideation

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