11 - Discontinuation

Discontinuation

Bipolar disorder CHAPTER 2 Above 2mmol/L, increased disorientation and seizures usually occur, which can progress to coma and ultimately death. In the presence of more severe symptoms, osmotic or forced alkaline diuresis should be used in a medical facility. Above 3mmol/L, peritoneal or haemodialysis is often used. These plasma levels are only a guide and individuals vary in their susceptibility to symptoms of toxicity. Neurotoxicity at normal plasma levels has also been described, as brain lithium levels may not be reflected by concentration in the plasma.54,55 Most risk factors for toxicity involve changes in sodium levels or in the way the body handles sodium, for example low salt diets, dehydration, drug interactions (see later Table 2.2) and some uncommon physical illnesses such as Addison's disease. Information relating to the symptoms of toxicity and the common risk factors (especially drug interactions) should always be given to patients when treatment with lithium is initiated.56 This information should be repeated at appropriate intervals to make sure that it is clearly understood. Pre-treatment tests Before prescribing lithium, renal, thyroid and cardiac function should be checked. As a minimum, the estimated GFR (eGFR),57 urea and electrolytes (U&Es) and TFTs should be checked. A baseline calcium level is also helpful. An electrocardiogram (ECG) is also recommended in patients who have risk factors for, or existing, cardiovascular disease. A baseline measure of weight is also desirable. Lithium is a putative human teratogen. Women of child-bearing age should be advised to use a reliable form of contraception. See the section on psychotropics and pregnancy (Chapter 7). On-treatment monitoring12,58 Plasma lithium, eGFR, U&Es and TFTs should be checked every 6 months. More frequent tests may be required in those who are prescribed interacting drugs, who are elderly or who have established chronic kidney disease. Weight (or body mass index [BMI]) should also be monitored. Lithium monitoring in clinical practice in the UK is known to be suboptimal59 although there has been a modest improvement over time.60 The use of automated reminder systems has been shown to improve monitoring rates.61 Discontinuation Intermittent treatment with lithium may worsen the natural course of bipolar illness. A much greater than expected incidence of manic relapse is seen in the first few months after abruptly discontinuing lithium,62 even in patients who have been symptom-free for as long as 5 years.63 Lithium treatment should not be started unless there is a clear intention to continue it for several years and where compliance can be reasonably assured.64 This advice has obvious implications for initiating lithium treatment against a patient's will (or in a patient known to be non-compliant with medication) during a period of acute illness. The risk of relapse is probably reduced by decreasing the dose gradually over a period of at least a month65 and avoiding decremental plasma level reductions of >0.2mmol/L.37

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