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BIPOLAR AFFECTIVE DISORDER AND CHRONIC COCAINE USE: A BRIEF LITERATURE REVIEW

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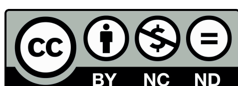

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INTRODUCTION

Bipolar affective disorder (B.A.D.), originally called "manic-depressive insanity", is a psychiatric condition characterized by severe mood swings, involving periods of elevated mood and depression interspersed with periods of remission, and is associated with cognitive symptoms specific physical and behavioral [1, 2, 3]. B.A.D. (Bipolar affective disorder) can be subdivided into two main types: Type I, in which it is necessary to complete a manic episode, which may have been preceded or followed by hypomanic and depressive episodes, and type II, in which there is no episode that characterizes only hypomania. Furthermore, there is an important differential diagnosis, cyclothymic disorder, which requires at least two years of the presence of multiple hypomanic symptoms that do not meet criteria for a hypomanic episode and multiple periods of depressive symptoms that do not meet criteria for a major depressive episode. [3, 4].

The genetic heritability of B.A.D. is well established in the literature. As for gender, some studies suggest a prevalence of women over men, however, there is no consensus on this aspect. The literature brings the age of onset as being between the end of adolescence and the beginning of adulthood, however, it is known the difficulty in specifying this age, due to the fact of methodological difficulties for considering the onset of B.A.D. (Bipolar affective disorder) [5].

B.A.D. (Bipolar affective disorder) coexists with other psychiatric comorbidities, namely: anxiety disorders, eating disorders, attention deficit hyperactivity disorder, personality disorders and use of psychoactive substances. The relationship between B.A.D. (Bipolar affective disorder) and substance use is

expressive, and it is estimated that 50% of bipolar I patients use licit or illicit drugs. This association is relevant due to the fact that bipolar patients present, therefore, greater dysfunctionalities in their behavior, resulting in greater impulsivity. Furthermore, therapeutic adherence is compromised [6].

In this context, there are many works that relate the use of cannabis with B.A.D. (Bipolar affective disorder), but the literature is scarce regarding its association with the use of cocaine.

GOALS

To analyze and describe the main aspects of bipolar affective disorder and chronic cocaine use in the last 10 years.

METHODS

This is a narrative review, in which the main aspects of bipolar affective disorder and chronic cocaine use in the last 10 years were analyzed. The beginning of the study was carried out with theoretical training using the following databases: PubMed, sciELO and Medline, using as descriptors: "Cocaine" AND "bipolar" AND "depression" AND "drugs" AND "epidemiology" in the last 10 years. Because it is a narrative review, the present study does not have risks.

RESULTS AND DISCUSSION

B.A.D. (Bipolar affective disorder) prevalence estimates are consistently low, close to 1%, being more prevalent in females [5]. The average age of onset of the first symptoms of B.A.D. (Bipolar affective disorder) is 20 years of age [7]. The recurrence rate of episodes is greater than 90%, and 10% to 15% of patients will have more than ten episodes during their lifetime. Recurrent episodes can cause deterioration in functioning, and the number of episodes can have a negative impact on the prognosis of these individuals. [7]. Depressive symptoms are predominant about 3.5 times more frequent than those of mania and 5 times more frequent than mixed or rapidly cycling symptoms [7].

Cocaine can be used in several ways, with inhalation being the most used. according to studies, about 4% of the Brazilian population has already tried the drug, with a prevalence of users close to 4%[8]. It is a substance extracted from the Erythroxylon coca bush. Cocaine is a benzoylmethylecgonine, being the main alkaloid found in the leaves of Erythroxylon coca and other species of its genus. Cocaine is extracted from the leaves of the plant, in two phases. In the first, the leaves are pressed with sulfuric acid, kerosene or gasoline, forming coca paste, which contains up to 90% of cocaine sulfate. the neurotransmitter reuptake mechanism [9].

Within the psychopathological complications of cocaine use, psychotic symptoms are very common, with transient paranoia being the most common. Classic tingling hallucinations can also occur, although they are rare. Cocaine can precipitate the onset of psychosis in vulnerable patients. In this sense, the use of cocaine has been associated with a worse evolution, a greater number of relapses, a worse response to conventional treatments and a greater possibility of the appearance of adverse and unwanted effects in patients with mental disorders such as schizophrenic psychosis or bipolar disorder. The treatment of patients with this type of dual pathology, psychosis and cocaine use, must be approached from a global perspective with psychopharmacological and psychotherapeutic treatment [10].

Individuals who develop substance use disorders during youth have an approximately three-fold increase in the likelihood of developing a mood disorder11. Amphetamine or cocaine use can induce or prolong manic periods with high levels of energy and

excitement. During depressive episodes, stimulants are used in an attempt to alleviate depressed mood or low energy levels. [12].

Therefore, the use of psychoactive substances by people with B.A.D. (Bipolar affective disorder) can aggravate the condition, since it is linked to the increase in the recovery time of symptoms and hospitalizations [6].

Studies that address patients with B.A.D. (Bipolar affective disorder) and drug users reveal that the overlapping of symptoms related to psychoactive substances and psychiatric comorbidity constitute a limiting factor for the clinical diagnosis. Thus, greater attention is needed regarding the therapeutic approach [13].

As for treatment, especially non-drug treatment, the Cognitive Behavioral Therapy approach stands out, which presents satisfactory results in the management of bipolar patients comorbid with drugs. In addition, psychoeducation is necessary as a subsidy in adherence to the therapeutic process, in order to avoid the chronicity of the disorder. [6].

With regard to drug treatment, the use of Divalproate and Sodium Valproate in users of cocaine and alcohol has shown good results in that, in addition to stabilizing mood, they also act by controlling impulsivity, explosive behavior and the cessation of cravings. [6].

CONCLUSION

The literature is still scarce in relation to publications about the specific use and abuse of cocaine in patients with B.A.D. (Bipolar affective disorder). However, the poor prognosis resulting from overlapping psychiatric comorbidities is well known. Substance abuse can lead to more severe conditions, with a lower therapeutic response and a higher rate of hospitalizations. In this sense, singular and cautious therapy is essential for these cases, aiming at greater effectiveness and adherence to treatment.

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