The Treatment of Bipolar Depression

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Abstract

The treatment of bipolar disorder, including management of mania and depression in primary and secondary care, is well described in the NICE guidance on this subject1.. This article summarises and updates the guidance on the treatment of bipolar depression, describing the use of mood stabilisers in combination with antidepressants as well as the use of quetiapine and lamotrigine and thus provides practical advice on how bipolar depression can be managed in primary care.

Key words: bipolar disorder, bipolar depression, treatment, primary care, NICE

Key points

- Patients with bipolar depression should not be prescribed antidepressants alone due to risk of switching into mania and causing rapid cycling or mixed states, with increased risk of suicide.
- When prescribing an antidepressant, a mood stabiliser should also be prescribed.
- Antidepressants should be given during the depressive phase only and stopped when a patient is in remission from depression.
- Alternatives to antidepressants include lamotrigine and quetiapine; the latter is recommended in pregnant women.

Bipolar depression is an episode of depressive symptoms occurring on a background of mania or hypomania with previous depressive episodes. It is important to distinguish the management of bipolar depression from that of unipolar depression, as it is somewhat different. Often bipolar depression is misdiagnosed and managed as unipolar depression. It is important to avoid this misdiagnosis by taking a thorough history enquiring about previous manic or hypomanic episodes (2,3).

For many people with bipolar disorder the predominant experience of their illness is low mood and depression. Patients may tell professionals that the depression phase of bipolar disorder is of very severe intensity and is very debilitating, impacting profoundly on themselves and their families (2). During this depressive phase, patients often have atypical features, such as tendency to overeat for comfort and to sleep more than usual, especially during the day.
The treatment of bipolar depression differs from unipolar depression in that people with bipolar depression should not be prescribed antidepressants alone1. Patients treated with antidepressants only may be 'switched' into mania, rapid cycling or mixed states (4), with increased risk of suicide. Therefore antidepressants should be prescribed with a mood stabiliser. NICE also advises that antidepressants should only be prescribed during the depressive phase and should be stopped once the patient is in remission from depressive symptoms or when symptoms have been significantly less severe for eight weeks1. The dose of antidepressant should be reduced gradually over several weeks, while maintaining the mood stabiliser.

NICE guidance advises that if a patient is already taking a mood stabiliser and presents with an acute depressive episode, initially the dose of the mood stabiliser should be assessed to ensure that it is optimal. Lithium, as well as being a mood stabiliser, also has antidepressant properties, so it can contribute to treating bipolar depression5. If the patient has mild symptoms and is not considered to be at risk of developing severe symptoms, a 'watchful waiting' approach can be considered with

regular review. If symptoms are moderate or severe and the patient is already taking a dose-optimised mood stabiliser, prescribing an SSRI can be considered. Any patients started on an antidepressant should be reviewed regularly.

When an antidepressant is initiated, patients should be warned about a number of possible consequences1:
- The possibility of switching to hypomania or mania
- The fact that it can take "at least" two weeks for antidepressants to have an effect.
- The risks of stopping the medication and the need to take it as prescribed.
- The need to monitor for suicidal ideation, anxiety, agitation and akathisia.
- The need to seek help promptly for distressing adverse effects

Antidepressants should be avoided for patients with depressive symptoms who have rapid-cycling bipolar disorder, a recent hypomanic episode or recent functionally-impairing rapid mood fluctuations. NICE instead advises optimising the dose of mood stabiliser or the addition of a second mood-stabilising agent.

There is some evidence that antidepressants may be less effective in relieving depressive symptoms in patients with bipolar depression than in unipolar depression4,6. If the depression is not adequately treated with an antidepressant in combination with a mood stabiliser, lamotrigine or quetiapine can be used. There is considerable data for the efficacy of these two medications 6,7,8,9,10,11 and quetiapine is recommended by NICE for severe bipolar depression which is not responding to antidepressants alone. For moderate to severe bipolar depressive symptoms in pregnant women, quetiapine alone, or SSRIs (but not paroxetine) in combination with a mood stabiliser (but not valproate and preferably not lithium because of the risk of teratogenesis) can be used. These women should be monitored closely for signs of switching and the SSRI should be stopped if manic or hypomanic symptoms develop.

In summary, the management of a depressive episode in bipolar disorder is initially to recognise that this is bipolar depression rather than unipolar depression, to give antidepressants only in conjunction with mood stabilisers and to use atypical antipsychotics, particularly quetiapine, or to prescibe lamotrigine for those not responding to treatment. The importance of regular review and promptly stopping antidepressant medication following remission to prevent switching to mania has been highlighted.

GP Comments

What have I learned from this paper?

A key challenge for GPs and psychiatrists alike is to differentiate unrecognised bipolar depression from unipolar depression, as this has important treatment ramifications. Bipolar depression carries a much higher suicide risk and these patients may not respond to or may worsen with antidepressant monotherapy.

Mania is a straightforward diagnosis but bipolar depression (which is far commoner and may be more disabling than manic/hypomanic symptoms) is difficult to recognise because hypomanic episodes may not be noted by the patient or sought by their doctor. Collateral history with consent may be especially valuable. Patients with 'depression' who have a family history of bipolar disorder, young age of onset and atypical features (e.g marked fatigue, lead-like limb heaviness, hypersomnolence and hyperphagia) may actually have bipolar depression and should be referred for further evaluation. Pharmacotherapy, with a mood stabiliser, rather than an antidepressant (or if an antidepressant is needed, limiting treatment only to the depressed phase) requires expertise and GPs should work closely with their psychiatry colleagues to optimise diagnosis and treatment for these patients. It would be good practice to conduct a regular practice-based audit of patients with bipolar disorder who are taking antidepressants to ascertain if these are still required.

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