Psychopharmacology for the Clinician
Psychopharmacologie pratique

To submit questions for this regular feature, please send them to the Journal of Psychiatry & Neuroscience, *CMA Media Inc., 1867 Alta Vista Dr., Ottawa ON K1G 3Y6, Canada; fax 613 565-5471; jpn@cma.ca. Please include details of any relevant case and your name, address, telephone and fax numbers as well as your email address.*

What is the best way to treat bipolar depression?

John, a 38-year-old man who has had one previous episode of depression after the break-up of a relationship, presents with moderately depressed mood of 3 months' duration. This time, there is no clear reason for the episode. John has no suicidal ideation. However, on further questioning he states that over the past 8 years he has also noticed periods of mild to moderate mood elevation lasting 1 to 5 days and accompanied by increased energy, decreased need for sleep, increased productivity and sometimes reckless behaviour. People have told him that during these times he speaks more rapidly and can be hard to interrupt. Bipolar type 2 disorder, with current depression, is diagnosed.

Although it is important to treat John's depression, the treating psychiatrist has concerns about prescribing antidepressants for a patient with bipolar disorder. What is the best approach? In managing this patient's condition, it is important to commence mood stabilization therapy. First-line medication for bipolar depression is lithium or lamotrigine. There is also some evidence for addition of antidepressants (including selective serotonin reuptake inhibitors [SSRIs] and bupropion) to lithium and for a combination of atypical antipsychotics and SSRIs. Various combinations of a mood stabilizer or atypical antipsychotic with an antidepressant appear to reduce the risk of a switch to a manic episode. To help improve compliance and response, it is important that at each visit the physician discuss treatment adherence and the side effects of the medications.

John is started on lithium, at a dose of 600 mg, taken nightly for 4 nights; the dose is then increased to 900 mg nightly. Laboratory testing shows that this dosage is not yielding the desired serum level the following morning of 0.8–1.0 mmol/L, so the dose is increased to 1200 mg nightly. One week later, fluoxetine is added to the lithium at an initial daily dose of 20 mg (taken in the morning), which is subsequently increased to 40 mg per day. Over the next 8 weeks, and despite adequate serum lithium levels (0.9 mmol/L) and ongoing cognitive behavioural therapy, the patient does not experience noticeable improvement in his symptoms. In the case of a patient already receiving lithium, current evidence supports the following options: adding or switching to lamotrigine, adding bupropion or adding divalproex. Lamotrigine should be initiated at 25 mg daily, increased to 50 mg daily at the end of week 2 and increased to 100 mg daily at the end of week 4. The dose can be further increased to 150 mg and then 200 mg daily if required. There is also increasing evidence for the role of atypical antipsychotics in bipolar depression, in combination or on their own. Most patients with bipolar disorder spend much more time in a depressed state, and managing bipolar depression can be challenging. Nonetheless, there is increasing evidence that using recognized treatments for depression (including certain antidepressants) can lead to gratifying responses without precipitating manic episodes.

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Competing interests: Dr. Silverstone has been a member of the advisory boards of AstraZeneca, Eli Lilly and Wyeth and has received speaker fees and travel assistance from these companies.

The information in this column is not intended as a definitive treatment strategy but as a suggested approach for clinicians treating patients with similar histories. Individual cases may vary and should be evaluated carefully before treatment is provided.