The Lowdown on Bipolar Disorder

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An estimated 10% to 15% of individuals with bipolar disorder (BD) commit suicide.

The burden of BD illness on individuals and their families and support systems is significant. With depression causing more disability than any other manifestation of BD,[1] better treatment strategies are needed.

In about 70% of cases, there is a significant delay in diagnosis of BD.

More than two-thirds of individuals found to have BD are initially misdiagnosed, most with major depression (unipolar). There is an average lag of seven to 10 years for the diagnosis of BD.

It is important to keep BD in differential diagnosis when diagnosing major depression.

Bipolar disorder I (BDI) affects approximately 1% of the population. Patients with BDI are symptomatically ill about half their lives, with depressive symptoms present about one-third of the time.

A further 3.7% are believed to have bipolar disorder II (BDII), cyclothymia or BD not otherwise specified. Individuals with BDII have also been found to have depressive symptoms representing about half of their illness symptoms.[2]

Most of the robust research to date has been with individuals with BDI.

There is an overwhelming amount of BD literature, yet there remains much debate about treatment.

The previous decade of literature has led to guidelines and reviews recommending the use of mood stabilizers as a first-line treatment for BD, despite the fact they have not been shown to have the effectiveness of antidepressants.

Antidepressants, however, have the potential to lead to switching the depressed phase to mania, mixed states or rapid cycling. Despite this, many patients with BD are on long-term antidepressant therapy.

"Novel" mood stabilizers and atypical antipsychotics are being studied for the treatment of BD.

Lamotrigine has emerged as a first-line treatment for BD. However, one must be vigilant for the potentially serious rash (0.1%) that may occur while using lamotrigine.

Other treatments for bipolar depression include:

- quetiapine and olanzapine/fluoxetine,[3,4]
- electroconvulsive therapy (ECT) for mania and depression,
- the 2002 American Psychological Association Guidelines recommends lithium or lamotrigine and
- the International Consensus Group on Bipolar I Depression Treatment Guidelines recommends olanzapine/fluoxetine in conjunction with lithium or lamotrigine.

It is recommended that mood stabilizers be used in every stage of the illness.

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Psychotherapy is a very important aspect of treatment in all phases of BD.

Whether using supportive psychotherapy in the acute phase of illness, psychoeducation in the early recovery phase or cognitive and family therapy, it is clear that psychotherapy is an important adjunct to medication in the treatment of BD.

The therapeutic alliance is an integral part of treatment and family physicians are front-line, providing valuable continuity of care.

New findings are being published at a breakneck pace.

Depression and depressive cycling remain substantial problems in about two-thirds of intensively treated bipolar outpatients.[5] It is clear this phase of BD illness requires further study and pharmacologic research is progressing rapidly.

Questions that remain to be answered include:

- Do we contribute to the rapid cycling by continuing treatment with antidepressants after resolution of the depressed phase?
- Do the mood stabilizers confer sufficient protection against switching when an antidepressant is used?
- How can we generalize the overwhelming amount of evidence in the literature to our patient population?

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References

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