Peertechz

Medical Group

Archives of Depression and Anxiety

ISSN: 2455-5460 DOI CC By

Michel Bourin*

Department of Pharmacology, University of Nantes, France

Dates: Received: 18 November, 2017; Accepted: 12 December, 2017; Published: 13 December, 2017

***Corresponding author:** Michel Bourin, Neurobiology of anxiety and mood disorders University of Nantes, 98, rue Joseph Blanchart 44100 Nantes France, Tel: +33 610858103; +33 2; E-mail: michel.bourin@univ-nantes.fr; michel.bourin@univ-nantes.fr

https://www.peertechz.com

Short Communication

Are antidepressants useful in bipolar disease?

Short Communication

The treatment of bipolar depression is the subject of intensive research, as shown by the numerous references obtained only in the last year using the terms "bipolar depression and treatment" in MEDLINE. This is one of the signs of effervescence in the treatment of this affection leading to publication of consensus in North America and the United Kingdom which often don't deal with clinical realities [1]. These publications systematically evaluate best practices, validate first choices and point out areas where there is not enough literature to produce best clinical practices [2]. The treatment of bipolar depression is certainly an area where a large number of randomized, double-blind studies and a strong evidence-based treatment algorithm produce data to refine our practices. But, although these results are endorsed by respected experts in the field, the detailed study of the references shows that most of these studies are carried out on limited samples, which are not very representative of our clinical population. However, the STAR-D study, funded by the NIMH, gives us very interesting data in the treatment of recurrent depressions [3]. These data are based on a large sample of relevant clinical population and recruited in multicenter sites.

Recurrent depression should be differentiated from chronic depression, which does not have a free interval of symptoms. Bipolar depression is associated with: a family history of bipolar illness; beginning at a younger age; more frequent and more severe anxiety symptoms. It differs from a unipolar depression, which presents:

- Sadness;
- Insomnia;
- Cognitive symptoms [4], somatic and depressive behavior more marked.

The means of identifying a bipolar depression among the other depressions are therefore limited; especially since these are young and sometimes younger patients in whom the anxious symptoms (prodromal of bipolar illness) are attributed to a comorbid anxiety disorder or to a manic episode, which will be confused with a first one psychotic episode [5,6].

An often rare and delayed diagnosis

To try to explain why a diagnosis of depression is so common, while that of bipolar affective disease remains so rare and delayed, here are four conditions: First, hypomania is extremely difficult to distinguish from an intensely lived life. , especially in a young man whose bipolar illness began most often with depression. Secondly, if depression is painful, hypomania is subjectively and too often seen as a "competitive advantage", particularly in environments where the alacrity of the words, or even the excess of certain behaviors, will reinforce the "leadership". Thirdly, any new episode of depression carries a risk of manic or hypomanic evolution, whereas the repetition of depressive episodes leads us to reinforce, in our eyes, a diagnosis of unipolar depression and thus to reduce duration and acuity of our observation.

Finally, the duration of a hypomanic episode can be really short, sometimes a few hours, so much less than the four days required by the DSM-V to retain the diagnosis [7].

Treatment mood stabilizers

The treatment of bipolar depression is based on the use of mood stabilizing drugs. Lithium remains the reference, dethroned in the field by valproic acid. Lamotrigine has been shown to be highly effective in this specific indication [8].

Antipsychotics

The prescription of second generation antipsychotics is only indicated in the short term, as a first intention in mixed or atypical forms, increasing in resistant forms. We prefer the quietapine, which is a little better tolerated than other antipsychotics. Long-term prescribing of second-generation antipsychotics helps to reduce adherence to treatment, especially if the patient is young, as they leave metabolic and cognitive side effects [9].

Citation: Bourin M (2017) Are antidepressants useful in bipolar disease? Arch Depress Anxiety 3(2): 058-058. DOI: http://doi.org/10.17352/2455-5460.000025

Antidepressants

The prescription of first-line antidepressants is now strictly contraindicated, not only because of the risk of manic shift, but also and especially for iatrogenic risks on the course of bipolar illness [10]. The addition of an antidepressant to a mood stabilizer should be done cautiously in a resistant bipolar depression, because of the high risk of hypomania and mania. In this case, bupropion RR = 0.85 will be preferred to venlafaxine RR = 3.60 or sertraline RR = 1.67 [11]. This addition must be done for a limited period, with logic of increase, because the risk of hypomania or mania increases with the duration of prescription [12]. Nevertheless, the addition of antidepressants as the second molecule of choice in resistant bipolar depression persists. I have a most reserved opinion on this indication. I prefer the use of increasing antipsychotics if the diagnosis of bipolar depression is confirmed. Know the indications for antidepressants and their limitations in bipolar depression. The risk of having a bipolar episode is much higher and closer than that of presenting a manic episode in the course of a properly treated bipolar disorder (BP) in both BP1 and BP2 forms. Antidepressants have long been prescribed abusively in depressive episodes of bipolar patients. Often due to lack of knowledge of the illness that was confused with unipolar depression. Antidepressants after a "honeymoon" of about two years in bipolar patients, aggravate the symptomatology and should be proscribed except in episodes of acute and intense depression in association with a mood stabilizer [13].

References

1. Parker GB, Graham RK, Tavella G (2017) Is there consensus across international evidence-based guidelines for the management of bipolar disorder? Acta Psychiatr Scand 135: 515-526. Link: https://goo.gl/A12vmG

2. Fountoulakis KN, Young A, Yatham L, Grunze H, Vieta E, et al. (2017) The International College of Neuropsychopharmacology (CINP) Treatment Guidelines for Bipolar Disorder in Adults (CINP-BD-2017), Part 1: Background and Methods of the Development of Guidelines. Int J Neuropsychopharmacol 20: 98-120. Link: https://goo.gl/NHrxCr

3. Hollon SD, Shelton RC, Wisniewski S, Warden D, Biggs MM, et al. (2006) Presenting characteristics of depressed outpatients as a function of recurrence: preliminary findings from the STAR*D clinical trial. J Psychiatr Res 40: 59-69. Link: https://goo.gl/4PHNW3

4. Cipriani G, Danti S, Carlesi C, Cammisuli DM, Di Fiorino M (2017) Bipolar disorder and cognitive dysfunction: a complex link. Nerv Ment Dis 205: 743-756. Link: https://goo.gl/eD27yT

5. Holder SD, Edmunds AL, Morgan S (2017) Psychotic and bipolar disorders: antipsychotic drugs. FP Essent 455: 23-29. Link: https://goo.gl/bBh7Az

6. Bourin M, Thibaut F (2014) Can antipsychotic agents be considered as real antimanic treatments? Front. Psychiatry 5: 60. Link: https://goo.gl/sRPyQs

7. Bourin M (2017) Bipolar disorder is now a more common disease to be treated Theranostics Brain Disorder 1: 2. Link: https://goo.gl/c1b89u

8. Van den Ameele S, van Diermen L, Staels W, Coppens V, Dumont G, et al. (2017) The effect of mood-stabilizing drugs on cytokine levels in bipolar disorder: A systematic review. J Affect Disord 203: 364-373. Link: https://goo.gl/vKRyZk

9. Sajatovic M, Di Biasi F, Legacy SN (2017) Attitudes toward antipsychotic treatment among patients with bipolar disorders and their clinicians: a systematic review. Neuropsychiatr Dis Treat 13: 2285-2296. Link: https://goo.gl/jjF3xy

10. Fountoulakis KN, Yatham L, Grunze H, Vieta E, Young A, et al. (2017) The International College of Neuro-Psychopharmacology (CINP) Treatment Guidelines for Bipolar Disorder in Adults (CINP-BD-2017), Part 2: Review, Grading of the Evidence, and a Precise Algorithm. Int J Neuropsychopharmacol 20: 121-179. Link: https://goo.gl/FuJBPH

11. Post RM, Leverich GS, Nolen WA, Kupka RW, Altshuler LL, et al. (2003) A re-evaluation of the role of antidepressants in the treatment of bipolar depression: data from the Stanley Foundation Bipolar Network. Bipolar Disord 2003: 396-406. Link: https://goo.gl/ebTTfM

12. Ghaemi SN (2008) Why antidepressants are not antidepressants: STEP-BD, STAR*D, and the return of neurotic depression. Bipolar Disord 10: 957-968. Link: https://goo.gl/p2pRcw

13. Shim IH, Woo YS, Kim MD, Bahk WM (2017) Antidepressants and Mood Stabilizers: Novel Research Avenues and Clinical Insights for Bipolar Depression. Int J Mol Sci 18: pii: E2406. Link: https://goo.gl/kwUJai

Copyright: © 2017 Bourin M. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Citation: Bourin M (2017) Are antidepressants useful in bipolar disease? Arch Depress Anxiety 3(2): 058-059. DOI: http://doi.org/10.17352/2455-5460.000025