Bipolar Depression Algorithm

Dana Wang1, Arash Ansari2, David N. Osser1

1Department of Psychiatry, Harvard Medical School, VA Boston Healthcare System, Brockton Division, Brockton MA
2Department of Psychiatry, Harvard Medical School, Brigham and Women’s Faulkner Hospital, Jamaica Plain, MA

BACKGROUND

The psychopharmacology algorithm project at the Harvard South Shore Psychiatry Program started in 1999 and 2010. Developments over the past 4 years suggest another update is needed.

METHODS

The 2010 algorithm and associated references were re-evaluated. A literature search was conducted on PubMed including review articles and recent studies to see what changes in the recommendations were justified. Exceptions to the main algorithm for special patient populations, such as patients with mixed states, ADHD, PTSD, substance use disorders, anxiety disorders, and women of childbearing potential and pregnant women, and those with common medical and psychiatric comorbidities were considered.

RESULTS

ECT is still a 1st line option for patients in need of urgent treatment. Lithium is still the first-line pharmacotherapy. There are now three choices for second line: lamotrigine and quetiapine from before, and lurasidone is added. If psychotic symptoms are present, lamotrigine is less favored. After sequential trials of these four treatments, the next node considers valproate which has a small evidence base, or an antidepressant (bupropion and SSRIs preferred). Olanzapine monotherapy and olanzapine/fluoxetine (FDA-approved) are still postponed due to metabolic side effects. In mixed and rapid cyclic cases, avoid antidepressants. Combinations of the above options are considered in cases of partial response.

CONCLUSIONS

This revision incorporates new treatments such as lurasidone and important new studies and organizes the evidence systematically.

SELECTED REFERENCES


COMORBID CONDITIONS

Posttraumatic Stress Disorder

Attention Deficit/ Hyperactivity Disorder

TREATMENT OF WOMEN AT RISK OF PREGNANCY

Cardiac disease or presence of QTc-prolonging drugs

COMORBID CONDITIONS

- Common symptoms require differentiation (irritability, insomnia, decreased concentration).
- PTSD related insomnia and anxiety could be treated with prazosin instead of antipsidrugs. Quetiapine could be reasonable (weight gain).
- Lamotrigine has efficacy in BP depression and PTSD.

RECOMMENDATIONS

- Given the high prevalence of this comorbidity, patients should be on a mood stabilizer before adding any stimulus to address ADHD symptoms or excessive daytime fatigue.
- Patients should be informed of the apparent high risk of mood destabilization.
- Psychotherapeutic approaches should be preferred if possible.
- Avoid valproate in any woman with the potential to become pregnant: should the patient become pregnant it may already be too late to remove it before harm is done.
- Carbamazepine is almost as harmful and should be avoided.
- Lithium preferred over valproate and carbamazepine.
- The atypical antipsychotics with efficacy in BD are first choice. Though data are very limited in pregnancy, lamotrigine may be considered.
- A recent review of published cases concluded that electroconvulsive therapy may be a last resort treatment, contrary to previous impressions. But, if steps are taken to decrease potential risks taking into account both mother and fetus, it can be used for severe depression, catatonia, medication resistant illness, extremely high suicide risk, psychiatric agitation, severe physical decline due to malnutrition or dehydration or other life threatening conditions.
- Procedure should be administered in hospital emergency setting or delivery room involving skilled team of psychiatrist, gynecologist/obstetrician, and anesthesiologist.
- Prescribe as few drugs as possible – ideally, one. When pregnancy occurs during treatment, it is usually best to continue the previous therapy to avoid exposure to multiple agents. Exception: if on valproate or carbamazepine (probably switch).
- Adjust doses as pregnancy progresses. Blood volume expands 30% in third trimester. Plasma level monitoring is helpful.
- Consider the risk of relapse or withdrawal while switching medications or changing doses.
- Anticholinergic drugs should not be prescribed to pregnant women except for acute, short-term need. Depot antipsychotics should not be routinely used in pregnancy: infants may show extrapyramidal symptoms for several months.
- Close follow up in post-partum and aggressive medication adjustment is recommended post-delivery.
- If risk of QTC prolongation is a significant concern, quetiapine would be relatively undesirable. Consider haloperidol.
- Review the patient’s medications for other QTC-prolonging agents and monitor for risk factors for Torsade’s such as bradycardia and electrolyte abnormalities.