

THE BIPOLAR SPECTRUM: DO WE NEED A SINGLE ALGORITHM FOR AFFECTIVE DISORDERS?

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Key words: bipolar disorder - unipolar depression – diagnosis – treatment – guidelines - suicidality

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Increasing understanding of the bipolar spectrum of disorders has led to an increasing integration of concepts regarding the aetiology and treatment of affective disorders.

Thus, for example, we now understand that an illness, previously believed to be recurrent depressive disorder, may develop over time into a bipolar illness, and bipolar II illnesses may develop into bipolar I (Akiskal et al. 1995, Akiskal et al. 1996, Angst et al. 2000, Angst 2007, Benazzi et al. 2006, Benazzi et al. 2006).

It has also been suggested that there may be a continuum between Bipolar Disorder and the mood lability of Borderline Personality disorder (Benazzi et al. 2004, Benazzi et al. 2005).

Agitated depression may in fact be a mixed affective state, and injudicious use of powerful antidepressants in patients with undiagnosed bipolar disorder may lead to the development of mixed states or rapid cycling illness, as well as a complete switch from depression to mania (Akiskal et al. 2005).

Mixed states and rapid cycling states are linked with increased suicidality (Akiskal et al. 2005).

Meanwhile bipolar disorder, especially bipolar II disorder, remains a condition which is underdiagnosed and often inappropriately treated (Morselli et al. 2002, Tavormina et al. 2007, Tavormina et al. 2007, Tavormina et al. 2007). There is evidence that many patients with bipolar illness have a long duration of untreated illness analogous with the Duration of Untreated Psychosis in other psychotic illnesses (Morselli et al. 2002, Agius et al. 2007, Agius et al. 2007).

In recent years, there have also been concerns about whether general practitioners do effectively diagnose and effectively treat unipolar depression (Donaghue et al. 1996).

Unfortunately, NICE guidelines are separate for Unipolar Depression and Bipolar Illness; those for Unipolar illness advocate a 'stepped care' model, centred round primary care, while bipolar guidelines warn against injudicious use of antidepressants and the

use of mood stabilisers to prevent 'switching' to mania (NICE 2004, NICE 2006).

Primary care physicians are not warned to take a full longitudinal history in depressed patients, to identify bipolar illness, nor are they trained to use mood stabilisers in patients with bipolar II disorder, and in the risks of injudicious use of antidepressants.

In practice, early Bipolar disorder will be identified and treated if Primary Care Doctors are effective in identifying and treating early cases of depression or bipolar disorder which present to them (Paykel et al. 1992). We would suggest that care should be taken that, each patient who presents with major depression, both in primary and secondary care is asked to identify any period of elated mood which they have experienced, even if this has lasted for only a few days. A family history of bipolar illness or suicide, previous episodes of hypomania, at least three recurrent depressive episodes, cyclothymia, and a seasonal onset [winter in bipolar II and summer in bipolar I patients], and migraine have all been identified as indicators of the possibility of bipolar illness. (Akiskal et al. 2005). Identifying these markers will enable patients with bipolar illness to be identified, perhaps earlier than they otherwise would (Akiskal 2006a, Akiskal 2006b, Akiskal et al. 2006c, Akiskal et al. 2006d).

The cautions that antidepressant monotherapy for bipolar disorder may precipitate hypomanic or mixed states, which are strongly associated with self harm and completed suicide, (Rihmer et al. 2006a, Rihmer et al. 2006b). and that Venlafaxine seems more likely than other antidepressants to precipitate a switch to mania in bipolar depression should then lead to a policy that, once bipolar depression is identified earlier, mood stabilisers, including Lithium or atypical antipsychotics where necessary, could be used to treat the illness, rather than only antidepressants. We would suggest that a policy of early diagnosis and appropriate treatment of bipolar disorder is likely to be the most effective step that we can take to reduce the risk of suicide in patients with bipolar disorder (Hall et al. 2006a, Rihmer et al. 2006b, Rihmer et al. 2006c).

Appropriate care regarding the judicious use of Venlafaxine as a first line treatment in Unipolar Depression. must be seen as secondary to this (Cipriani et al. 2007, Agius et al. 2007).

For all of these reasons, We need a single algorithm for identifying and treating affective disorders in order to optimise suicide prevention in all our depressed patients.

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