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UNDERSTANDING AND MANAGING BIPOLAR DEPRESSION

Why is recognition of Bipolar Depression important?

Recognising bipolar depression in patients is crucial as untreated episodes increase the risk of attempted and completed suicide in patients. An accurate diagnosis also guides medication choices for optimal outcomes. Primary care providers, as first responders, play a critical role in the detection and management of bipolar disorder for effective outcomes to be possible. Accurate diagnosis can also be vital in identifying co-occurring conditions and assisting patients in understanding their treatment options.

Bipolar disorder is relatively common, affecting 2.8% of the adult population. While Bipolar I Disorder is equally prevalent in males and females, Bipolar II Disorder is more commonly diagnosed in females. The age of onset of Bipolar disorder is late adolescence into early adulthood. The average time it takes for a patient to reach a correct diagnosis is ten years, indicating the complexity of the diagnosis. Bipolar Disorder is a chronic illness with remissions and exacerbations arising even when patients are on medication, with 50% of their time being unwell.

How Bipolar I and II present in patients also differ. In patients with Bipolar II, more time is spent unwell, with the predominant mood state being depression. In Bipolar I Disorder in comparison to Bipolar II the mood state is more frequently elevated.

Patients living with Bipolar Disorder have significant and chronic interpersonal and occupational difficulties. The completed suicide rate in these patients is approximately 10%, with attempts of suicide falling in the 30% - 50% region. Suicide attempts are increased in patients presenting with mixed depressive states. Significant functional and cognitive impairments are associated with untreated lengthy episodes of Bipolar Disorder.

Misdiagnosis

60% of patients who go on to be diagnosed with Bipolar Disorder initially are misdiagnosed with Unipolar Depression, specifically those presenting with Bipolar Depression. The reasons for misdiagnosis vary. Firstly, there seems to be an incomplete understanding of Bipolar Disorder by healthcare professionals. Bipolar disorder that presents first with a depressive state is often overlooked, especially in patients with no history of mania. There is also, at times, a failure to differentiate symptoms that can help differentiate Unipolar and Bipolar depression.

Misdiagnosis has many consequences and direct implications for adequate and relevant treatment. Consequences include the inappropriate use of antidepressant agents, lending itself to an increased acute risk of switching from depression to mania or hypomania, and a delay of proper treatment. Often if an antidepressant is prescribed for these patients, they may initially get well, and after that, it may 'stop working'.

Diagnosis

Making an accurate diagnosis of bipolar depression entails knowing the DSM 5 criteria of a major depressive episode, which includes five symptoms for at least two weeks (one needs to be a depressed mood or anhedonia). Exploring a patient's history of a past manic or hypomanic episode or atypical responses to antidepressants plays a crucial role in diagnosis.

A helpful mnemonic screening tool for bipolar depression or the presence of Bipolarity is WHIPLASHED. This tool can be used in all patients presenting atypical signs or poor treatment response to typical antidepressant pathways. The more WHIPLASHED features the patient has, the higher the

likelihood that you are dealing with a bipolar disorder rather than a unipolar depression.

Worse or "wired" when taking antidepressants, which includes failed trials and switching antidepressants
Hypomania or hyperthymic temperament
Irritability and mixed features during the presenting episode of Depression
Psychomotor retardation
Loaded family history of **B**ipolar Disorder
Abrupt onset and/or termination of depressive bouts
Seasonal or postpartum pattern of depression
Hyperphagia and hypersomnia
Early age at the onset of depression (younger than 25 years)
Delusions, hallucinations, or other psychotic features, which are more present in Bipolar Disorder

Management

The management of bipolar depression ascribes to general principles and assessment of medication status:

- A risk assessment determines if the patient needs in or out-patient care.
- Laboratory investigations are often needed, if not recently done to exclude any medical causes of depression and substance use.
- Recent discontinuation of psychotropics medication and response to previous medications
- Consideration of Electroconvulsive Therapy (ECT) – specifically in those who are a high suicide risk, present with psychotic depression, or are catatonic

Treatment options for bipolar depression are various. Pharmacological treatments include mood stabilisers, antipsychotics, and antidepressants, while non-pharmacological treatments include lifestyle changes, sleep hygiene, light therapy, and psychotherapy.

Pharmacotherapeutic agents in monotherapy include Quetiapine at 300 – 600mg (although evidence exists for efficacy at 150mg and above), Lithium at a target of 0.8 – 1.2meq/l, and Lamotrigine at a target of over 200mg (with a need to titrate slowly 25mg every two weeks), Carbamazepine, Olanzapine and Fluoxetine, and Valproate. Please see the South African Psychiatry Guidelines or EMGuidance for more information – link to bipolar guidelines. https://sajp.org.za/index.php/sajp/article/view/942 .The consensus is that if a patient is depressed on an antidepressant, switch or stop the antidepressant by tapering or cross-titrating.

Quetiapine is generally well-tolerated and is effective in preventing depression during maintenance treatment. It has a rapid onset of action and is also suitable for treatment for mixed Episodes. Like all atypical antipsychotics, side effects, specifically metabolic ones, must be closely monitored (specifically weight gain). Lithium is effective in its treatment of acute bipolar depression and prevention of mood episodes, not to mention its efficacy in treating mania. It is considered a first-line agent for treating bipolar depression and is ranked at Level 2 for efficacy. Lamotrigine is also rated at Level 2 for efficacy in treating acute bipolar depression. It is a first-line treatment option due to its demonstrated efficacy in maintenance treatment and tolerability profile. It is effective in combination with Lithium and Quetiapine for treating bipolar depression. The concern with using Lamotrigine is the need for a slow taper upwards, making it unsuitable as a monotherapy in severely depressed individuals.

Agents not recommended for treating bipolar depression are antidepressant monotherapy, Aripiprazole monotherapy, Ziprasidone monotherapy, Gabapentin, and Risperidone.

The International Society for Bipolar Disorders (ISBD) Antidepressant Task Force has guidelines for prescribing antidepressants for bipolar depression. Experts agree that practitioners should use antidepressants in bipolar depression with caution. This is especially true for patients who switched to mania or hypomania when previously treated with antidepressants. Considering a low dose of an antidepressant alongside an adequate dose of a mood stabiliser or atypical antipsychotic is an option. It's crucial to weigh each patient's potential risks and benefits when prescribing antidepressants. Moreover, monitoring patients for signs of mania or hypomania is essential, especially in the initial weeks or after adjusting the dosage. If a patient doesn't show improvement after 4-6 weeks, experiences severe side effects, or transitions into mania or hypomania, the antidepressant treatment should be halted.

For Bipolar depression, recommended therapeutic approaches include Cognitive Behavioural Therapy (CBT), Family Therapy, and Interpersonal Rhythm Therapy.

Patients must receive education about medication adherence, recognising signs of relapse, maintaining sleep hygiene, understanding side effects, identifying stressors and triggers, exercising, joining support groups, maintaining a balanced diet, and seeking family support. Engaging in a collaborative discussion about adherence is crucial, given the approximately 50% non-adherence rate in bipolar disorder. It's essential to understand the reasons for non-adherence, as the repercussions of non-compliance and symptom relapse can be profound. Such setbacks might lead to job losses, academic struggles, substance abuse, family conflicts, debt accumulation, legal issues, risky behaviours, and a deterioration of the disorder itself.

Bipolar depression is a complex disorder often misdiagnosed as unipolar depression, leading to delayed and inappropriate treatment. Early recognition and accurate diagnosis are vital to mitigate severe consequences such as suicide attempts. Treatment comprises a blend of pharmacological and non-pharmacological methods, with some agents, like Quetipaine, Lithium and Lamotrigine, emerging as primary options. Patient education and adherence is essential, given the profound repercussions of non-compliance and symptom relapse.

References available on request. MHM