Are antidepressants useful in bipolar disease?

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.

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 quetiapine, 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].

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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 prescribed except in episodes of acute and intense depression in association with a mood stabilizer [13].

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