'No SAD Me': A memory device for treating bipolar depression with an antidepressant

Susana Sanchez, MD, Humaira Shoaib, MD, and Rashi Aggarwal, MD

Drs. Sanchez and Shoaib are PGY-4, and Dr. Aggarwal is an Assistant Professor, Department of Psychiatry, Rutgers New Jersey Medical School, Newark, New Jersey.

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Depression is the first affective episode in >50% of patients with bipolar disorder, and is associated with considerable morbidity and mortality.

The mean duration of a bipolar depressive episode is considerably longer than a manic episode; >20% of bipolar depressive episodes run a chronic course.[1] Evidence suggests that depressive episodes and symptoms are equal to, or more disabling than, corresponding levels of manic or hypomanic symptoms.[2]

Debate over appropriate therapy

Using antidepressants to treat bipolar depression remains controversial. Much of the debate surrounds concern that antidepressants have the potential to switch a patient to mania/hypomania or to destabilize mood over the longitudinal course of illness.[2]

Several guidelines for informing the use of antidepressants in bipolar depression have been published, including the International Society for Bipolar Disorders task force report on antidepressant use in bipolar disorders[3] and the guideline of the World Federation of Societies of Biological Psychiatry.[4] To summarize the most recent consensus on treating bipolar depression, we devised the mnemonic **No SAD Me**:

No n-antidepressant treatments should be considered as monotherapy before antidepressants are used. Consider lithium, lamotrigine, olanzapine, quetiapine, or lurasidone first for bipolar depression.[3]

S afe-to-use adjunctive antidepressants can be considered if the patient relapses to a depressive episode after antidepressant therapy is stopped. Consider using a selective serotonin reuptake inhibitor (SSRI) and bupropion (1) for an acute bipolar I or II depressive episode when the patient has a history of a positive response to an antidepressant and (2) as maintenance treatment with SSRIs and bupropion as adjunctive therapy.[2,3]

A void antidepressants as monotherapy. If using an antidepressant to treat bipolar I disorder, prescribe a mood-stabilizer concomitantly, even though the evidence for antidepressant-associated mood-switching is mixed and the ability of mood stabilizers to prevent such responses to antidepressant treatment is unproven.

D o not use tricyclic antidepressants (TCAs) or venlafaxine. Evidence does not show 1 type of antidepressant is more or less effective or dangerous than another. Nevertheless, TCAs and venlafaxine appear to carry a particularly high risk of inducing pathologically elevated states of mood and behavior.[3]

M onitor closely. Bipolar disorder patients who are being started on an antidepressant should be closely monitored for signs of hypomania or mania and increased psychomotor agitation. Discontinue the antidepressant if such signs are observed or emerge.

References

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