Transcript Details

This is a transcript of a continuing medical education (CME) activity. Additional media formats for the activity and full activity details (including sponsor and supporter, disclosures, and instructions for claiming credit) are available by visiting:
https://reachmd.com/programs/cme/the-journey-from-diagnosis-to-effective-management-of-bipolar-i-and-ii-depression/15295/

Released: 03/31/2023
Valid until: 03/31/2024
Time needed to complete: 1h 46m

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

The Journey from Diagnosis to Effective Management of Bipolar I and II Depression

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCME curriculum.

Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

Dr. Singh:
Hello. My name is Manpreet Singh. I am at Psychiatry in Stanford University, and today we're going to be talking about the Journey from Diagnosis to Effective Management of Bipolar 1 and 2 Depression. The bipolar spectrum is a really important one to understand, even Kraepelin thought and conceptualized that bipolar disorder, so many years ago, as being on a continuum. And because it's on a continuum, it can lead to misdiagnosis because at any given time, you might be anywhere on this spectrum, starting from more of the depression-dominant aspect of the condition to maybe more of the manic aspect of the condition, and because it's episodic, another potential challenge in terms of getting to the right diagnosis and quickly. You know, these classifications might be useful for clinical practice, to understand the distinctions between bipolar 1 disorder, bipolar 2 disorder, unspecified, and then major depressive disorder as a completely separate entity. But, frankly, humans don't work that way. They are on a continuum. Nature isn't always cut very cleanly at its seams, and this is really important because treatment response, whether it's to an antidepressant or a mood stabilizing agent, as well as links to family history of bipolar disorder, can offer some helpful clues to, as a diagnostician, trying to figure out where on this continuum does my patient fall.

We can use probabilistic approaches to help us make an accurate diagnosis. For example, you can use clinical history, treatment history and symptoms all layered together to make and arrive at a bipolar diagnosis. And any of these factors, in and of themselves, aren't necessarily diagnostic, but they help you understand that this is a condition that can have layers of potential risk factors, and being attuned to each of those layers – whether it's a family history, the number of lifetime episodes, the number of hospitalizations, rapid onset of depressive episodes, a greater severity of the depressive episodes, the quality of the depression – helps you tune in, and maybe even stimulate you to think about whether or not you ought to be ruling out bipolar disorder. Similarly, looking at treatment history. People who don't respond well to antidepressant or in fact, in – experience antidepressant-induced manias, might be likely to be on the path towards bipolar disorder, so that's something to also keep track of. And the symptoms, like psychotic features, atypical depressive symptoms, sub-threshold mania symptoms, impulsivity aggression hostility, and co-occurring substance use can all point towards a diagnosis of bipolar disorder.

So if we think of bipolar disorder on a continuum, or on a spectrum, then we can imagine that treatments might also fall along a spectrum. So we'll be looking at this, sort of color coded from blue to red, where depression is indicated in more of the blue phase of illness, and then mania in more of the red phase, and purple somewhere in between.

If you have bread-and-butter depression without any, any history of mania or hypomania, then you're going to treat it with an antidepressant. But, when you see any evidence of mania or hypomania symptoms, then you might ask yourself, are they coinciding and overlapping with depressive episodes? Might second generation antipsychotics in that context make sense? Or, am I doing an acute mood stabilization of someone who is floridly manic, who might need to be on a mood stabilizer to begin with, and then continue from

there. Only patients with essentially no symptoms of mania or hypomania should be considered for antidepressant therapy. And, unipolar depression, bipolar disorder – does it matter in terms of choosing the best treatment? You bet it does. And that's why ruling out mania and hypomania becomes so critical, early in the stages of diagnostic evaluation.

So, antidepressant monotherapy for bipolar depression? Might you even try it, ever? Try not to, please. Antidepressant monotherapy really should not be used in patients, even with a hint of hypomania or mania, or even a family history of bipolar disorder requires some thought and consideration. We don't have enough empirical data to really exclude antidepressant therapy for anyone who has a family history of bipolar disorder, and doesn't present with any lifetime mania or hypomania symptoms, but those data are coming, I promise you. You will most likely not know if your depressed patient has ever had any risk of mania or hypomania, or a family history, if you don't ask, so please ask, every time, with every patient. And any patient on antidepressant monotherapy should regularly be monitored for response to that therapy and the emergence of hypomania.

Here is a landscape of second generation antipsychotics for adult bipolar disorder. The treatment landscape includes, again, a combination of 5HT2 and dopamine receptor antagonists and partial agonists, and you've gotten – you've got FDA approvals for certain ones, that are for bipolar depression, including bipolar 1 depression and bipolar 2 depression. And I will point to 2 that are FDA approved for bipolar 2 depression, including lumateperone and quetiapine. Just so you have a sense of the abbreviations, DMX stands for depressive mixed state, and MMX stands for mania with mixed features. And you can, again, see that the armamentarium is broad and there are lots of FDA approved options, but you can also see that there are some gaps here, in – for maintenance treatment, as well as for the treatment for unipolar depression with mixed features, as I mentioned to you before, which does not have FDA approval.

Mood stabilizers for adult bipolar disorder include a number of agents that have had a number of clinical trials, including carbamazepine, lamotrigine, lithium and valproate. You have FDA approvals for bipolar mania for 3 out of the 4 agents, and FDA approval for bipolar maintenance for lamotrigine and lithium. But as you can see here, we have many more unmet needs for patients in terms of efficacy and FDA approvals for bipolar depression. There's no mood stabilizer that's approved for use of de – in depression, of any kind – unipolar, mixed or bipolar – and there are some data for the efficacy of lamotrigine or valproate for bipolar depression, but we don't have approvals for maintenance for – sorry, for bipolar depression treatment with mood stabilizers. And lithium is well known for its anti-suicide effects. Sadly, not utilized enough, but neither lithium nor carbamazepine monotherapy is recommended for treatment of bipolar depression. So we tend to use these agents for acute mood stabilization and acute manic episode.

For kids, here is the treatment landscape, and just to add to this landscape of unmet needs, we still need more FDA-approved agents for bipolar 1 depression, and for longer term treatment, but the 2 that are approved for bipolar 1 depression – 1 depression – are olanzapine+fluoxetine down to age 10, and lurasidone down to age 10. We do not have any FDA-approved treatments for bipolar 2 depression in kids.

So there are some unmet needs from the treatment of bipolar disorder, in terms of the bipolar landscape. We've got a number of evidence-based therapeutics, but we have some work to do. In terms of screening, we often tend to either overdiagnose or underdiagnose bipolar disorder. If we ask about mania and hypomania every single time, with every patient, we are less likely to miss it, and we are also less likely to overcall something that's not there, if we do the due diligence and look for diagnostic criteria. In terms of diagnosis, there are a few unmet needs here to consider. We need to assess for symptoms and episodes, as well as disorder criteria. We unfortunately don't have a blood test, or other diagnostic tests that's going to definitively say that someone has bipolar disorder, so it really requires clinical acumen. And sometimes, it can be hard in a busy practice, to implement measurement-based care, use a screen, or use a mania rating scale, or a depression rating scale, in the clinic or practice, and I hope that someday we can get reimbursed for doing that. But patients can be empowered to use mood apps, and mood charting can be a very effective tool in finding and screening for episodes of depression and mania. Treatment is a no one-size-fits-all game right now. We need personalized treatments to help patients feel better, well – faster and with the right treatments. We have few FDA-approved treatments for bipolar 2 disorder. Some treatments may even increase the risk for mania induction, including the antidepressants, and adherence can be challenging so you have to mitigate the number of trial and error episodes that you have with your patients, in terms of treatment, so that you can increase trust. And side effects are prevalent, so we need better drugs that have a more favorable side effect profile. Thankfully, some of our newer agents do have more favorable side effect profiles so patients don't have to decide between akathisia or sedation and weight gain, for a treatment of choice. And finally, we need to be thinking about our patients. Our patients are at the center of our diagnostic and treatment journey, and if we can effectively engage with them and partner with them on what matters most to them, we might be able to not just build trust but also get them effectively evaluated and treated. Thank you so much for your time and attention. I hope this was helpful to you.

Announcer:
You have been listening to CME on ReachMD. This activity is jointly provided by Global Learning Collaborative (GLC) and TotalCME,

Inc. and is part of our MinuteCME curriculum.

To receive your free CME credit, or to download this activity, go to ReachMD.com/CME. Thank you for listening.