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Commentary: Bipolar disorder—services need to catch up with rapidly developing evidence base

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The article above powerfully describes the misery and anguish that bipolar disorder causes.¹ Bipolar disorder is characterised by disabling swings of mood between mania (and mixed mania and depression) and depression. In the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV), it is subdivided depending on the severity of the manic symptoms: bipolar I disorder is diagnosed when episodes of mania or mixed episodes occur with or without episodes of depressive illness, and bipolar II disorder is diagnosed when depression occurs with less severe episodes of elevated mood (hypomania) that do not lead to dysfunction or disability.^{w1} The lifetime prevalence of bipolar I disorder is around 0.5%; including bipolar II and less severe bipolar spectrum disorder increases this to around 5%.² The aetiology of bipolar disorder remain uncertain. It is strongly familial, although the precise genetic causes remain elusive.³ After the first diagnosis of mania, most patients achieve symptomatic recovery, but relapse is common, and after four years only about one third recover to premorbid function.³ Bipolar disorder is now recognised to be one of the commonest causes of worldwide disability especially within the 15–44 age group.³ Despite that, the needs of patients with bipolar disorder are almost completely ignored by UK policymakers, which makes service development very difficult.^{w2} Compared with schizophrenia, bipolar disorder is under-researched.^{w3}

Management of bipolar disorder includes specific treatment for the acute manic or mixed and depressive phases of the illness and long term strategies for relapse prevention. Historically, most effort has been put into researching pharmacological

treatments for acute mania. Antipsychotics and other drugs, including lithium and valproate, are effective in the acute phase of mania.³ There is very little evidence that psychosocial interventions are effective in mania. There is still limited evidence for interventions in the depressive phase of the illness, despite the fact that this accounts for the most substantial disability associated with the disorder^{w4 w5} although this situation is rapidly improving. Antidepressants such as selective serotonin reuptake inhibitors seem to alleviate symptoms of depression, although trial data are scarce,^{w6} and the risk of precipitating manic or mixed episodes and mood destabilisation means that combination therapy with an antimanic drug is advised when there is a history of mania (such as bipolar I disorder).² For that reason, other drugs such as mood stabilisers (lithium, valproate, lamotrigine) and, increasingly, atypical antipsychotics, for example, quetiapine, are often recommended as first line therapies.^{2 4 w7} The current draft NICE guideline amply demonstrates the substantial uncertainty that currently prevails about the most appropriate first line treatment for bipolar depressive episodes,⁴ and the BALANCE 2 trial currently in development seeks to address this (<http://cebmbh.warne.ox.ac.uk/balance/balance2/index.html>). Very little evidence currently supports the use of psychosocial interventions in acute depressive episodes in bipolar disorder.³

Bipolar disorder is often a relapsing illness, and many patients will need long term chronic disease



See web references w1–w9 on bmj.com

management to prevent relapse and optimise functioning. Lithium carbonate has long been the main long-term drug and there is reasonable evidence that it is effective, particularly in preventing manic episodes.⁵ Lithium also appears to have an antisuicidal effect in mood disorders.¹⁸ More recently, fashion and convenience have led to an increase in the prescribing of valproate, and the evidence for this drug is now accumulating.⁴ The BALANCE trial comparing lithium, valproate, and combination therapy with lithium plus valproate is currently under way (<http://cebmbh.warne.ox.ac.uk/balance/balance1/index.html>). In general the long term drug treatment of bipolar disorder is under-researched, and many drugs, particularly antiepileptics and unproved combinations, are used off-licence and with little evidence of efficacy. Psychosocial interventions such as family psychoeducation, cognitive behaviour therapy, and symptom recognition training are promising, although the evidence is still fairly limited.³

The optimal long term management of bipolar disorder remains a specialist activity entailing expert psychopharmacological management, psychosocial interventions, and self management. Evidence is emerging that specific collaborative disease management programmes may improve outcomes.¹⁹

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- 1 Johnston S. My bipolar expedition. *BMJ* 2006;332:30-2.
- 2 Goodwin GM. Evidence-based guidelines for treating bipolar disorder: recommendations from the British Association for Psychopharmacology. *J Psychopharmacol* 2003;17:149-73.
- 3 Geddes J. Bipolar disorder. *Clin Evid* 2005;1158-81.
- 4 National Collaborating Centre for Mental Health. Bipolar disorder: The management of bipolar disorder in adults, children and young people, in primary and secondary care (draft) <http://www.nice.org.uk/page.aspx?o=278260>
- 5 Geddes JR, Burgess S, Hawton K, Jamison K, Goodwin GM. Long-term lithium therapy for bipolar disorder: systematic review and meta-analysis of randomized controlled trials. *Am J Psychiatry* 2004;161:217-22.