BIPOLAR DEPRESSION:

'The Greatest Unmet Need'?

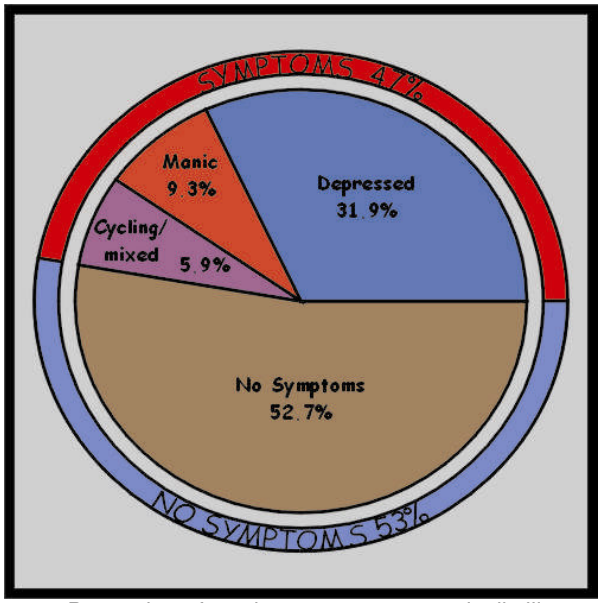
Bipolar depression is the under recognised and unappreciated phase of bipolar disorder, said the authors of a recently published paper[1]. In fact, bipolar disorder is often viewed as individuals experiencing mania; however, many patients never experience syndromal manic episodes[1]. This is further complicated as most patients with bipolar disorder present with depression, and are, therefore, commonly misdiagnosed to have major depressive disorder (MDD).[1]

The results of a survey conducted in 2000 confirmed this with 69% of bipolar patients being misdiagnosed, of which 68% were women who were misdiagnosed with depression and 28% were men who were misdiagnosed with schizophrenia.[2] This misdiagnosis was perpetuated with an average of four doctors being consulted before the correct diagnosis was made and *35%* of patients not being diagnosed as bipolar for ten years or longer.[2]

Bipolar depression is the predominant pole of bipolar disorder, with 68% of symptomatic weeks spent depressed, vs. only 20% spent manic and 12% cycling or mixed.[3]

Bipolar depression is also associated with a greater burden of illness, including reduced functioning, increased suicidal acts and higher economic costs. Depressive episodes tend to be longer, occur more frequently and patients relapse more frequently into depression rather than mania. [2] In fact, the massive impact of bipolar disorder on the well-being of patients is reflected in the suicide rate being 20-fold higher than in the general population, with 79% of suicides occurring during a depressive episode vs only 2% during pure mania.[4]

Unfortunately not only is bipolar depression under diagnosed[1], but it also represents the greatest unmet need. [2] Even amongst patients receiving intensive bipolar disorder treatment, 26% reported being symptomatic for most of the year, whilst 41% were intermittently ill; depressive symptoms being responsible for the majority of illness reported.[1] When bipolar disorder was compared to MDD, non response to unimodal antidepressants was 1.6 times more common and a loss of response occurred 3.4 times more in bipolar disorder. In addition, it has been shown that the use of antidepressants in bipolar disorder may induce switching or increase cycle frequency. [2]



Proportion of weeks spent symptomatically ill in bipolar I disorder. Based on a study3 with a mean follow-up of 12.8 years.

As a result, the management of bipolar disorder appears to be evolving. [2] It is suggested that mood should be stabilised from above baseline to prevent mania, without causing or worsening depression; and mood should be stabilised from be- low to produce an antidepressant effect, but without inducing switching or episode acceleration. [2] Studies have shown that no mood stabiliser has the same degree of efficacy in both poles of bipolar disorder and, therefore, mood stabilisation can only be achieved using agents that have complementary spectra of efficacy. [2] For example, lithium was shown to be superior to placebo in preventing the return of manic and hypomanic symptoms, but no better than placebo at preventing the return of depressive episodes. [2]

As such, new therapeutic options for bipolar depression represent the single greatest unmet need in the management of bipolar disorder. [2]

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