

# Bipolar spectrum disorders

## *New perspectives*

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### ABSTRACT

**OBJECTIVE** To review new perspectives on diagnosis, clinical features, epidemiology, and treatment of bipolar II and related disorders.

**QUALITY OF EVIDENCE** Articles were identified by searching MEDLINE and ClinPSYCH from January 1994 to August 2001 using the key words bipolar disorder, type II or 2; hypomania; spectrum; or variants. Reference lists from articles were reviewed. Overall, the quality of evidence was not high; we found no randomized controlled trials that specifically addressed bipolar II or bipolar spectrum disorders (BSDs).

**MAIN MESSAGE** Characterized by elevated mood cycling with depression, BSDs appear to be much more common than previously thought, affecting up to 30% of primary care patients presenting with anxiety or depressive symptoms. Hypomania, the defining feature of bipolar II disorder, is often not detected. Collateral information, semistructured interviews, and brief screening instruments could improve diagnosis. Antidepressants should be used with caution. The newer mood stabilizers or combinations of mood stabilizers might be the treatments of choice in the future.

**CONCLUSION** Family physicians, as primary providers of mental health care, should try to recognize and treat BSDs more frequently. These disorders are becoming increasingly common in primary care populations.

### RÉSUMÉ

**OBJECTIF** Passer en revue les nouveaux points de vue sur le diagnostic, les caractéristiques cliniques, l'épidémiologie et le traitement des troubles bipolaires II et des problèmes afférents.

**QUALITÉ DES DONNÉES** Des articles ont été identifiés par des recensions dans MEDLINE et ClinPSYCH de janvier 1994 à août 2001 à l'aide des mots clés en anglais pour trouble bipolaire, type II ou 2; hypomanie; spectre; ou variantes. La liste des références des articles a été passée en revue. Dans l'ensemble, la qualité des données probantes n'était pas élevée; nous n'avons trouvé aucune étude aléatoire contrôlée portant précisément sur les troubles bipolaires II ou les troubles du spectre bipolaire (TSB).

**PRINCIPAL MESSAGE** Caractérisés par des cycles d'humeur exaltée suivie de dépression, les TSB semblent plus communs qu'on ne le pensait antérieurement, touchant jusqu'à 30% des patients en soins de première ligne qui présentent des symptômes d'anxiété ou de dépression. L'hypomanie, la caractéristique déterminante du trouble bipolaire II, n'est souvent pas dépistée. Des renseignements collatéraux, des entrevues semi-structurées et des instruments concis de dépistage pourraient en améliorer le diagnostic. Il faut user de prudence dans le recours aux antidépresseurs. Les plus récents psychorégulateurs pourraient se révéler le traitement privilégié à l'avenir.

**CONCLUSION** Les médecins de famille, à titre de principaux dispensateurs de soins de santé mentale, devraient essayer de reconnaître et de traiter plus fréquemment les TSB. Ces troubles deviennent de plus en plus fréquents dans les populations de première ligne.

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*Cet article a fait l'objet d'une évaluation externe.*

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**B**ipolar disorder (formerly called manic-depressive illness) manifests as episodes of mania or hypomania in association with depressive episodes. The fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) classifies bipolar disorder into type I (with manic episodes), type II (with hypomanic episodes), and NOS (variants not yet well defined).<sup>1</sup> Classic descriptions of bipolar disorder usually refer to type I.

Mania is usually clearly identifiable, partly because severe symptoms (that often include psychotic symptoms such as grandiose or paranoid delusions or hallucinations) and serious impairment of function generally make hospitalization necessary. Hypomania, however, is much more difficult to recognize. Diagnostic criteria for hypomanic episodes (**Table 1**) are similar to those for mania, but symptoms and impairment of psychosocial function are less severe. In fact, some patients are more productive during hypomanic episodes. While the mood of patients with mania and hypomania is usually euphoric or expansive, it can also be primarily irritable or anxious.

Recent research has expanded the concept of bipolar II disorder to include other conditions that involve hyperthymic mood (elevated or irritable mood states that do not meet criteria for hypomania).<sup>2,5</sup> These conditions, referred to as bipolar spectrum disorders (BSDs), are commonly encountered in primary care populations because of their recurrent and fluctuating nature, but are underdiagnosed in clinical practice.<sup>6,7</sup> A substantial proportion of patients with recurrent or treatment-resistant depression could well have BSDs.<sup>8,9</sup>

This article reviews the concept, diagnosis, and treatment of BSDs, focusing on bipolar II disorder. Given that most patients with mood disorders are treated in primary care settings, it is important that family physicians diagnose and manage their patients with BSDs more effectively. Bipolar I disorder will not be discussed because several clinical guidelines deal with management of this classic form of bipolar disorder.<sup>10-12</sup>

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**Table 1. Criteria for hypomanic episodes**

- |    |  |
|----|--|
| A. | A distinct period of persistently elevated, expansive, or irritable mood lasting throughout at least 4 days that is clearly different from the usual nondepressed mood.  |
| B. | During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if mood is only irritable) and have been present to a notable degree: <ol style="list-style-type: none"> <li>1. Inflated self-esteem or grandiosity</li> <li>2. Decreased need for sleep (eg, feels rested after only 3 hours of sleep)</li> <li>3. More talkative than usual or pressure to keep talking</li> <li>4. Flight of ideas or subjective experience that thoughts are racing</li> <li>5. Distractibility (ie, attention too easily drawn to unimportant or irrelevant external stimuli)</li> <li>6. Increase in goal-directed activity (socially, at work or school, or sexually) or psychomotor agitation</li> <li>7. Excessive involvement in pleasurable activities that have a high potential for painful consequences (eg, unrestrained buying sprees, sexual indiscretions, or foolish business investments)</li> </ol> |
| C. | An unequivocal change in functioning uncharacteristic of the patient when not symptomatic  |
| D. | Disturbance in mood and change in functioning are observable by others   |
| E. | Episode is not severe enough to cause marked impairment in social or occupational functioning or to necessitate hospitalization, and there are no psychotic features   |
| F. | Symptoms are not due to the direct physiologic effects of a substance (eg, street drug, medication, or other treatment) or a general medical condition (eg, hyperthyroidism)   |

Data from American Psychiatric Association.<sup>1</sup>

### Quality of evidence

A search through MEDLINE and ClinPSYCH using the key words bipolar disorder, type II or type 2; hypomania; spectrum; or variants, was conducted for the period January 1994 to August 2001. Relevant articles were identified and their reference lists reviewed. Articles on diagnosis and natural history of the disorders reported on epidemiologic studies, naturalistic follow-up studies, or cohort studies conducted in specialty clinics. Only a few studies were conducted in primary care populations. There were no randomized controlled trials of treatment specifically for bipolar II disorder or other BSDs. Treatment studies usually had mixed samples of bipolar I and II disorders and did not report differential outcomes for each subtype.

### Diagnosis and clinical features

**Bipolar II disorder.** The hallmark of bipolar II disorder is the presence of hypomanic episodes (Table 2<sup>1</sup>) that last at least 4 days. Diagnostic criteria exclude situations where hypomanic symptoms occur only during use of antidepressants or other drugs. Hypomanic symptoms are seldom recognized in clinical practice because patients do not recognize hypomania as a problem (at least early in the course of the disorder), because some hypomanic episodes are associated with enhanced productivity, and because mood has natural diurnal and annual rhythms.<sup>2</sup>

**Table 2. Criteria for bipolar II disorder (with hypomania)**

- A. Presence (or history) of one or more major depressive episodes
- B. Presence (or history) of at least one hypomanic episode
- C. Never had a manic episode or mixed episode
- D. Mood symptoms are not better accounted for by schizoaffective disorder or other psychotic disorders
- E. Symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

*Data from American Psychiatric Association.<sup>1</sup>*

The mood swings and irritability seen during hypomania might also be difficult to distinguish from personality disorders, especially those of the so-called cluster B spectrum (histrionic, borderline, or narcissistic personality disorders). When symptoms are purely a result of these disorders, they vary consistently in reaction to circumstances rather than in response to a switch in internal state. Presence of vegetative symptoms, such as sleep and appetite disturbance or change in level of energy independent of external events, will also help distinguish mood disorders from personality disorders.

Unfortunately, because personality disorders often coexist in patients with bipolar II disorder (up to 32.5% in one sample<sup>13</sup>), clinicians face a diagnostic dilemma in differentiating them. For such cases, a trial of treatment might be warranted.

Patients with bipolar II disorder often present first with depressive episodes and might not have hypomanic episodes until they have had several episodes of depression. An 11-year follow-up study of 559 patients with depression found that 3.9% subsequently “switched” to mania (bipolar I) and 8.6% switched to hypomania (bipolar II).<sup>8</sup> Predictors that differentiated eventual bipolar II disorder from unipolar depression included female sex, early age of onset, mood lability, substance abuse, minor antisocial acts, and serious

marital and occupational or educational disruption. Lifetime risk of suicide attempts among patients with bipolar II disorder appears to be much higher than among those with bipolar I disorder or unipolar depressive disorder. Also, bipolar II disorder is associated with poor psychosocial function, chronic episodes, and poor outcome.<sup>8</sup> Patients with bipolar II disorder sometimes go on to have clear-cut manic episodes, and thereby convert to bipolar I disorder.

Bipolar II disorder appears to be associated frequently with “atypical” depressive symptoms also. These symptoms involve mood reactivity (where mood can improve markedly in response to external events) associated with increased appetite, carbohydrate craving, weight gain, oversleeping, extreme fatigue, and interpersonal sensitivity (long-standing, extreme sensitivity to actual or perceived rejection, particularly romantic rejection).<sup>14</sup>

**Other bipolar spectrum disorders.** It has been increasingly recognized that bipolar II disorder probably exists within a spectrum of conditions characterized by hyperthymic mood states (Table 3).<sup>4,15</sup> An expanded concept of BSDs has been proposed to classify types: type III (depressive episodes with antidepressant-induced hypomanic episodes); type IV (depressive episodes with premorbid hyperthymic temperament, ie, hyperthymic mood persisting for several years as a baseline mood state punctuated by episodes of depression); and cyclothymic disorder (chronic, frequent shifts from mild hypomania to mild depression without an extended [2-month] period of normal mood).<sup>2,4,5</sup> There might also be “soft” bipolar features, such as recurrent but brief hypomanic episodes lasting less than 4 days. These conditions are not specifically categorized in DSM-IV, but can be

**Table 3. Current and proposed bipolar spectrum disorders: Patterns of mood episodes.**

DISORDER	PATTERN OF MOOD EPISODES
Bipolar I	Clear-cut manic episodes
Bipolar II	Recurrent depressive episodes with clear-cut hypomanic episodes (lasting at least 4 days)
Bipolar III	Recurrent depressive episodes with antidepressant-induced hypomanic episodes, or recurrent hypomanic episodes lasting less than 4 days
Bipolar IV	Recurrent depressive episodes with baseline hyperthymic mood state
Cyclothymia	Frequent shifts from mild depressive episodes to mild hypomanic episodes without intervening periods of normal mood

subsumed under the diagnosis of bipolar disorder, not otherwise specified.

Patients with bipolar II and other bipolar spectrum disorders might also be at higher risk of developing rapid cycling bipolar disorder.<sup>16</sup> Rapid cycling refers to frequent mood episodes or switches, defined as four or more full-length mood episodes (ie, depression or hypomania or mania), or switches between depression and hypomania or mania per year. Although rapid cycling was originally described at the turn of the 19th century as a temporary phase in the course of manic-depressive illness, it can also be associated with antidepressant use and subclinical hypothyroidism.<sup>9</sup> Use of antidepressants, particularly tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs), can worsen rapid cycling and result in unstable mood states that resemble BSDs.<sup>9,17</sup>

**Clinical diagnosis of bipolar spectrum disorders.** Given the difficulty of identifying BSDs, family physicians must have a high index of suspicion for hypomanic symptoms in their clinical assessment of depression. In particular, patients with early onset, atypical features, or recurrent or chronic episodes of depression, or who are refractory to antidepressant treatment, should be carefully assessed for BSDs. Based on their review, Ghaemi et al<sup>18</sup> propose that family history of BSD and antidepressant-induced hypomania be given greatest weight in considering BSD diagnosis.

**Table 4** lists screening questions for hypomania. Physicians should also ask about somatic symptoms because patients might not recognize elevated or irritable moods and because hypomania is unlikely without accompanying vegetative symptoms. Because patients might not be aware of hypomanic symptoms, collateral information from family or friends can be helpful. Patients should also be encouraged to use a simple mood diary: rating their mood on a scale from

**Table 4. Screening questions for bipolar spectrum disorders**

Have you ever had periods where your mood was very good, or too good, for no good reason?

Have you had periods where you were very irritable or anxious for no reason?

Were these periods accompanied by racing thoughts?

Were these periods accompanied by reduced need for sleep?

Were these periods accompanied by greatly increased energy?

Did your friends or family feel you were not your usual self?

1 (most depressed) to 10 (most high) and keeping track on a calendar is a feasible way to chart mood swings over extended periods.

Use of semistructured clinical interviews can improve detection of bipolar II disorder. Systematic diagnostic assessment almost doubled the rate of detection of bipolar II disorder (from 22% to 40%) in one multisite study.<sup>3</sup> In a primary care setting using a semistructured interview, 27% of depressed patients were found to have a bipolar II diagnosis.<sup>19</sup> Unfortunately, semistructured interviews are onerous to administer and are not commonly used in clinical settings. A self-rated screening questionnaire for hypomania, the Mood Disorders Questionnaire (MDQ), has recently been developed (**Figure 1**). It takes approximately 5 to 10 minutes to administer, and has a sensitivity of 73% and specificity of 90% compared with semistructured interviews.<sup>20</sup>

**Epidemiology**

Community studies have shown the prevalence of bipolar disorder to be 0.5% to 1.5%.<sup>21</sup> The diagnosis of hypomania is often difficult to make using non-clinical interviews, so bipolar II disorder could be inadequately diagnosed in these studies. In a large community cohort, the prevalence of bipolar disorder (types I and II) by DSM-IV criteria was 5.5%.<sup>22</sup> A further 2.6% of the sample, however, could be classified as having bipolar disorder when “brief” hypomania (recurrent episodes of hypomania lasting 1 to 3 days) was included. The validity of relaxing the DSM-IV 4-day minimum duration criterion for hypomania was supported by a similarity between the two groups in family history of mood disorders, history of suicide attempts, and treatment for depression.<sup>22</sup>

The prevalence of BSDs might be as high as 70% in patients with atypical depression<sup>23,24</sup> and 50% in patients referred to specialists for treatment-resistant depression.<sup>25,26</sup> In primary care populations, up to 30% of patients presenting with depressive or anxiety symptoms could have BSDs.<sup>6,19</sup>

There might be substantial comorbidity associated with bipolar II and BSDs. High rates of bipolar II disorder have been reported in patients with obsessive-compulsive disorder, panic disorder, social anxiety disorder, and body dysmorphic disorder.<sup>27,28</sup> Studies have shown that patients with comorbid personality disorders are younger at onset and exhibit more suicidal behaviours than those with “pure” BSDs, but this comorbidity does not substantially affect the course or clinical features of the disorder.<sup>8,29</sup>

**Figure 1. Mood disorders questionnaire for diagnosing hypomania:** *Diagnosis of hypomania is positive if 7 or more items are endorsed in question 1, YES is the answer for question 2, and MODERATE or SERIOUS problem is checked for question 3. Sensitivity and specificity of these criteria compared with semistructured interviews are 73% and 90%, respectively.<sup>19</sup>*

	<b>YES</b>	<b>NO</b>
1) Has there ever been a period of time when you were not your usual self and....		
... you felt so good or so hyper that others thought you were not your normal self or you were so hyper you got into trouble?	—	—
... you were so irritable that you shouted at people or started fights or arguments?	—	—
... you felt much more self-confident than usual?	—	—
... you got much less sleep than usual and found you didn't really miss it?	—	—
... you were much more talkative or spoke faster than usual?	—	—
... thoughts raced through your head or you couldn't slow your mind down?	—	—
... you were so easily distracted by things around you, you had trouble concentrating or staying on track?	—	—
... you had much more energy than usual?	—	—
... you were much more active or did many more things than usual?	—	—
... you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	—	—
... you were much more interested in sex than usual?	—	—
... you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	—	—
... spending money got you or your family into trouble?	—	—
2) If you checked YES to more than one of the above, have several of these ever happened during the same period? <i>Please circle one response only.</i>	<b>YES</b>	<b>NO</b>
3) How much of a problem did any of these cause you—like being unable to work; having family, money, or legal troubles; getting into arguments or fights?  <i>Please circle one response only.</i>		
<b>No problem    Minor problem    Moderate problem    Serious problem</b>		

*Reproduced with permission from the University of Texas Medical Branch at Galveston.<sup>19</sup>*

## Treatment

Given the prevalence, psychosocial disability, and health care costs of bipolar disorder,<sup>30</sup> there are remarkably few studies of treatment for this condition. There are even fewer studies of treatment specifically for bipolar II disorder. Some treatment studies have mixtures of patients with bipolar I and II disorder, but these studies often do not report differentiated outcomes. Clinical guidelines highlight the limited evidence for treatment of bipolar depression and bipolar II disorder.<sup>10,12,10-33</sup>

**Mood stabilizers.** Mood stabilizers, such as lithium and sodium valproate, are the mainstays of treatment for bipolar I disorder,<sup>34</sup> but there are no placebo-controlled studies of mood stabilizers for bipolar II disorder. Naturalistic, long-term, follow-up studies have suggested that lithium is as effective in preventing mood swings (both mania and depression) in bipolar II as in bipolar I disorder,<sup>35</sup> but outcome analysis excluded patients who required more than intermittent (12 weeks or less) adjunctive treatment with antidepressants, so there might have been selection bias for lithium responders. A randomized controlled trial comparing lithium with carbamazepine in 78 patients with bipolar II disorder found no difference in outcome between groups after 2.5 years of follow up.<sup>36</sup> Other naturalistic studies, however, have found lithium to have only modest benefit in bipolar II disorder.<sup>8</sup> Small open-label studies suggest a role for sodium valproate in treatment of BSDs.<sup>37,38</sup>

**Antidepressants.** Patients with bipolar II disorder often have greater distress and spend much more time depressed than hypomanic. Monotherapy with antidepressants can be considered for bipolar II depression, but there is risk of antidepressant-induced switches into hypomania or mania or rapid cycling. Unfortunately, there are no placebo-controlled studies of antidepressants specifically for bipolar II disorder. The largest antidepressant study compared open-label treatment with fluoxetine monotherapy in 89 depressed patients with bipolar II disorder with 89 age- and sex-matched patients with unipolar depression and 661 unmatched unipolar patients.<sup>39</sup> There were no differences in acute response between groups with open-label fluoxetine treatment. The bipolar II group had a low hypomanic switch rate (3.8%), but the rate was significantly higher than in the matched unipolar group (0.3%,  $P < .01$ ). In a subsequent 1-year prospective maintenance fluoxetine phase, there was no difference in relapse rate in

bipolar and unipolar groups. The switch rate during this maintenance phase was similar in the bipolar II and unipolar groups (2% vs 1%, respectively). Another report<sup>40</sup> found that fluoxetine monotherapy was helpful for acute and maintenance treatment of 16 patients with bipolar II depression. A recent comprehensive review and analysis disputed the validity of this suggestion of similar switch rates in use for maintenance.<sup>18</sup>

Other studies found that open-label venlafaxine (immediate release) monotherapy was beneficial in 17 patients with bipolar II depression; no manic switches were observed during 6 weeks of treatment.<sup>41</sup> Bupropion monotherapy was also helpful in a small number of patients with bipolar II disorder.<sup>42</sup> Older studies found that tranylcypromine and imipramine were effective, but switch rates were higher with these medications (20% switched to hypomania or mania within 12 weeks).<sup>43</sup>

Recently authors have argued that there is evidence for the usefulness of antidepressants only for acute bipolar depression, rather than maintenance. They stress the risk of worsening the long-term course and report finding that only 20% of bipolar patients even require short-term use.<sup>18</sup>

**Other treatments.** Attention has focused recently on newer anticonvulsants,<sup>44</sup> including gabapentin,<sup>45-49</sup> lamotrigine,<sup>50</sup> and topiramate,<sup>51</sup> as effective mood stabilizers for bipolar I disorder, but only small-sample, open-label, preliminary studies have been done. These medications, alone or combined with lithium and sodium valproate, might be less likely to induce hypomania or rapid cycling than antidepressants. Atypical antipsychotics such as risperidone, olanzapine, and quetiapine are also being investigated for treatment of bipolar disorder, both in combination with mood stabilizers and as monotherapy.<sup>52</sup> Benzodiazepines, such as clonazepam, might be useful, primarily as adjunctive treatment for anxiety and agitation.<sup>53</sup> Other somatic treatments for bipolar depression, such as electroconvulsive therapy, light therapy, and sleep deprivation, can also be considered, even though evidence for their efficacy is limited.<sup>54</sup>

Finally, psychosocial treatments, such as cognitive-behavioural and interpersonal therapy, are well validated in treatment of depressive disorders,<sup>55</sup> but again there is only limited evidence for their use in bipolar disorder,<sup>56,57</sup> and no studies have specifically addressed bipolar II patients. Regulation of sleep patterns and social rhythms might also be very useful for patients with bipolar disorder.<sup>58</sup> These treatments are

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currently being evaluated for bipolar depression, and it is likely they will be important in clinical management of patients with BSDs.

**Clinical recommendations.** Given the dearth of evidence for treatment, recommendations for clinical management of patients with bipolar II disorder and BSDs are based on expert opinion (**Table 5**).<sup>59,60</sup> Although many patients need treatment with mood stabilizers, the decision to use them for bipolar II depression is still made on a case-by-case basis. Factors such as cycle length, frequency and severity of past episodes of hypomania, age of onset, sex, and duration of depressive episodes relative to hypomanic episodes should be considered in the decision.<sup>59,61</sup> Patients with frequent or more severe hypomanic episodes, rapid shifts in mood, or rapid cycling should be treated with mood stabilizers. Patients who do not respond well to antidepressant monotherapy, or who have cycle acceleration while taking antidepressants, should be treated with mood stabilizers. Long-term follow up is critical for monitoring cycle acceleration or emerging treatment resistance if antidepressant therapy is used.

If patients do not respond to monotherapy (with antidepressants or mood stabilizers), then combinations of medications (antidepressant plus mood stabilizer; mood stabilizer plus mood stabilizer) should be considered.<sup>60</sup> Rapid-cycling bipolar disorder in particular might require treatment with a combination of mood stabilizers.<sup>62</sup>

Serum levels of mood stabilizers should be monitored when appropriate (eg, for lithium or sodium valproate); dosages might have to be titrated to achieve serum levels at higher therapeutic ranges.<sup>38</sup> Liver function tests and adverse events must also be monitored, and drug interactions considered, especially with carbamazepine and SSRIs.<sup>63,64</sup> Patients should be educated about the need to keep to regular routines of sleep and social activities. Having patients chart their moods on an ongoing basis is useful for diagnostic and outcome evaluation.

**Conclusion**

Family physicians have been identified as the single most frequent providers of mental health care in Canada.<sup>65</sup> They must increase their index of suspicion for BSDs because these disorders are increasingly recognized as common in primary care populations. Diagnosing BSDs is crucial for optimizing management of depression and avoiding rapid cycling, which can be worsened by indiscriminate use of antidepressants.

**Table 5. Medication options for bipolar spectrum disorders**

MEDICATIONS	EVIDENCE FOR USE
<b>MOOD STABILIZERS</b>	
Lithium	Naturalistic studies show similar positive effects for bipolar I and II disorders
Carbamazepine	Randomized controlled trial of lithium vs carbamazepine found no differences in outcome
Sodium valproate	Open-label studies only
Gabapentin, lamotrigine, topiramate	Open-label studies only
<b>ANTIDEPRESSANTS*</b>	
Fluoxetine	Positive results for acute and maintenance treatment of bipolar II depression
Venlafaxine-XR	Open-label studies only
Bupropion-SR	Open-label studies only
Imipramine	High switch rates seen with tricyclic antidepressants, so they are relatively contraindicated in bipolar disorder
Tranlycypromine	High switch rates seen with monoamine oxidase inhibitors, so these are relatively contraindicated in bipolar disorder
<b>ADJUNCTIVE TREATMENTS</b>	
Atypical antipsychotics (olanzapine, quetiapine, risperidone)	Under investigation
Benzodiazepines (eg, clonazepam)	Primarily for anxiety and agitation

\*If antidepressants are used as monotherapy, patients must be closely monitored for switch to hypomania or rapid cycling. Other antidepressants are likely to be effective for bipolar II depression also, but they have not been studied.

There are effective acute treatments for BSDs, including mood stabilizers, adjunctive medications, and judicious use of antidepressants, but, unfortunately, there are no systematic data on long-term prognosis. New mood-stabilizing medications (anticonvulsants and atypical antipsychotics) could improve treatment of BSDs in the future. ❖

**Competing interests**

**Dr Yatham** received research funding from, and sits on the Advisory Boards of, the pharmaceutical companies Eli Lilly, Janssen-Ortho Inc, Astra Zeneca, and Glaxo SmithKline. **Dr Lam** received research funding from Eli Lilly, Astra Zeneca, Lundbeck,

Merck-Frosst, and Servier and sits on the Advisory Boards of Bristol-Myers Squibb, Eli Lilly, Lundbeck, Organon, Pfizer, and Wyeth-Ayerst.

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## Editor's key points

- Bipolar disorders span a spectrum of conditions from well recognized mania and depression to more common combinations of hypomania and depression. The most common of these is bipolar II disorder, which is defined by cycles of hypomania and depression.
- Bipolar II and other bipolar spectrum disorders are more common in family practice than was previously recognized. They affect up to 30% of patients presenting with anxiety or depression.
- Hypomania often goes undetected because it presents subtly. Regular screening, semistructured interviews, and information from families can improve the rate of diagnosis. Family physicians should consider it in patients with atypical depression or poor response to usual antidepressant treatment.
- Treatment usually starts with mood stabilizers and adds, as required, antidepressants (usually transiently) or newer mood stabilizers. All antidepressants could push patients' mood to hypomania or mania, but there seems to be less risk of the newer serotonin reuptake inhibitors.

## Points de repère du rédacteur

- Les troubles bipolaires comportent un large spectre d'états allant de la manie et de la dépression bien reconnues à des combinaisons plus fréquentes d'hypomanie et de dépression. Le plus fréquent de ces troubles est le trouble bipolaire II, défini par des cycles d'hypomanie et de dépression.
- Les troubles bipolaires II et les autres troubles du spectre bipolaire sont plus courants dans la pratique familiale qu'on ne le reconnaissait auparavant. Ils touchent jusqu'à 30% des patients qui présentent de l'anxiété ou de la dépression.
- Il arrive souvent que l'hypomanie ne soit pas détectée parce qu'elle se présente subtilement. Des dépistages réguliers, des entrevues semi-structurées et des renseignements obtenus de la famille peuvent améliorer le taux de diagnostic. Les médecins de famille devraient envisager cette possibilité chez les patients souffrant de dépression atypique ou qui ne répondent pas bien aux traitements antidépresseurs habituels.
- La thérapie commence habituellement par des psychorégulateurs auxquels s'ajoutent, au besoin, des antidépresseurs (habituellement de manière transitoire) ou les plus récents psychorégulateurs. Tous les antidépresseurs pourraient déclencher chez les patients l'hypomanie ou la manie, mais il semble qu'il y ait moins de risques que cela se produise avec les plus nouveaux inhibiteurs de recapture de la sérotonine.



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