BRIEF COMMUNICATION

What can we learn from the Canadian Network for Mood and Anxiety Treatments (CANMAT) Guidelines?

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Abstract

Bipolar Mood Disorder (BMD) is one of the most common, severe, and persistent mental illnesses. The Malaysian Consensus Statement for the Treatment of Bipolar Mood Disorder, published in 2007 is still the major reference for managing the condition in this country. However, recently the Canadian Network for Mood and Anxiety Treatments (CANMAT) guidelines was revised and at the moment, this contains the most up-to-date recommendations. This paper reviewed and compared both documents to establish the latest information on managing Bipolar Mood Disorder.

Keywords: Bipolar mood disorder, acute phase management, Malaysian Consensus, CANMAT

Introduction

Bipolar disorder, or manic-depressive illness (MDI), is one of the most common, severe, and persistent mental illness. It is characterized by periods of deep, prolonged, and profound depression which alternates between periods of an excessively elevated and/or irritable mood known as mania. Between these highs and lows, patients usually experience periods of higher functionality and can lead a productive life. Bipolar disorder is a serious lifelong struggle.

Bipolar disorder constitutes one pole of a spectrum of mood disorders including bipolar I (BPI), bipolar II (BPII), cyclothymia (oscillating high and low moods), and major depression. Bipolar I disorder is also referred to as classic manic-depression, characterized by distinct episodes of major depression contrasting intensely with episodes of mania, which lead to severe impairment of function. In comparison, bipolar II disorder is a milder disorder consisting of depression alternating with periods of hypomania. Hypomania may be thought of as a less severe form of mania that does not include psychotic symptoms or lead to major impairment of social or occupational function.

According to the Malaysian consensus for bipolar mood disorder, the 1st line agents for treatment of mania is monotherapy including either lithium or Na Valproate or atypical antipsychotic (AAP)[1]. Although current consensus stated that the addition of AAP as a co-therapy is more effective than

monotherapy alone[2], the AAP is reserved for severe form of acute manic phase. This is antihistamine. Among AAP used are include ziprasidone, quetiapine, risperidone, aripiprazole, olanzapine, and asenapine.[1] Second line treatment will be given when patient is not responding to initial treatment. The regime includes the combination of Lithium or Na Valproate with AAP or Carbamazepine. Study has shown that Carbamazepine might be comparable to lithium in terms of efficacy and safety, and therefore a valuable option in the treatment of both manic and maintenance phases.[3] It is also said that the AAP is superior or preferred than typical antipsychotics. Sometimes electroconvulsive therapy (ECT) is used for severe cases that needs urgent treatment, i.e those who has high tendency for harming others and suicidal ideation. For those who had refractory manic phase, meaning that the patient is not responding to all the treatments, on consultant opinion, Clozapine might be given despite the notorious side effect of agranulocytosis. This is off-label.[1]

According to another guideline, Canadian Network for Mood and Anxiety Treatments (CANMAT) and International Society for Bipolar Disorders (ISBD) collaborative update of CANMAT guidelines for the management of patients with bipolar disorder (update 2009), stated that the agitation symptom must be treated first[4]. Regarding the emergency management, there are randomized controlled trial (RCT) data to support the use of IM Aripiprazole, which can now be considered as a first choice in the treatment of acute agitation[5]. In a large RCT (n = 301), IM Aripiprazole was as effective as IM Lorazepam and more effective than IM placebo within 45–60 minutes for the treatment of agitation in patients with Bipolar I manic or mixed episodes. Additional data support the use of due to the side effects of AAP such as metabolic syndrome, anticholinergic and IM Olanzapine for severely agitated in-patients with acute mania. In a one-week, observational study, patients exhibited mild calmness and significantly reduced agitation within two hours of administration of IM Olanzapine[6]. Over 90% of the patients received only one injection in the first 24 hours and 50% had a categorical response within 30 minutes.[4] The pharmacological treatment regarding acute manic phase has 5 steps.

This includes;
Step 1: Review general principles and assess medication status,
Step 2: First-line therapies,
Step 3: Add-on or switch therapy (alternate first line therapies),
Step 4: Add-on or switch therapy (second- and third-line therapies) and
Step 5: Add-on novel or experimental agents.

In addition to the information, extensive RCT data supported the efficacy of atypical antipsychotic monotherapy with olanzapine, risperidone, quetiapine, ziprasidone, and aripiprazole for the first-line treatment of acute mania.[7] There was also four-week RCT conducted in China suggested that olanzapine was significantly more effective than lithium in the acute treatment of 140 patients with a manic or mixed episode.[8] The incidence of adverse events, including weight gain, was greater with olanzapine. A Cochrane database systematic review, including six trials (n = 1343) of risperidone as monotherapy or as adjunct to lithium or an anticonvulsant for the treatment of acute mania, confirmed that risperidone was as effective as haloperidol.[9] A three-week RCT (n = 329) found that olanzapine and risperidone were equally effective on most

measures of manic and depressive symptoms.[10]

This is summarized in the diagram below; [4]

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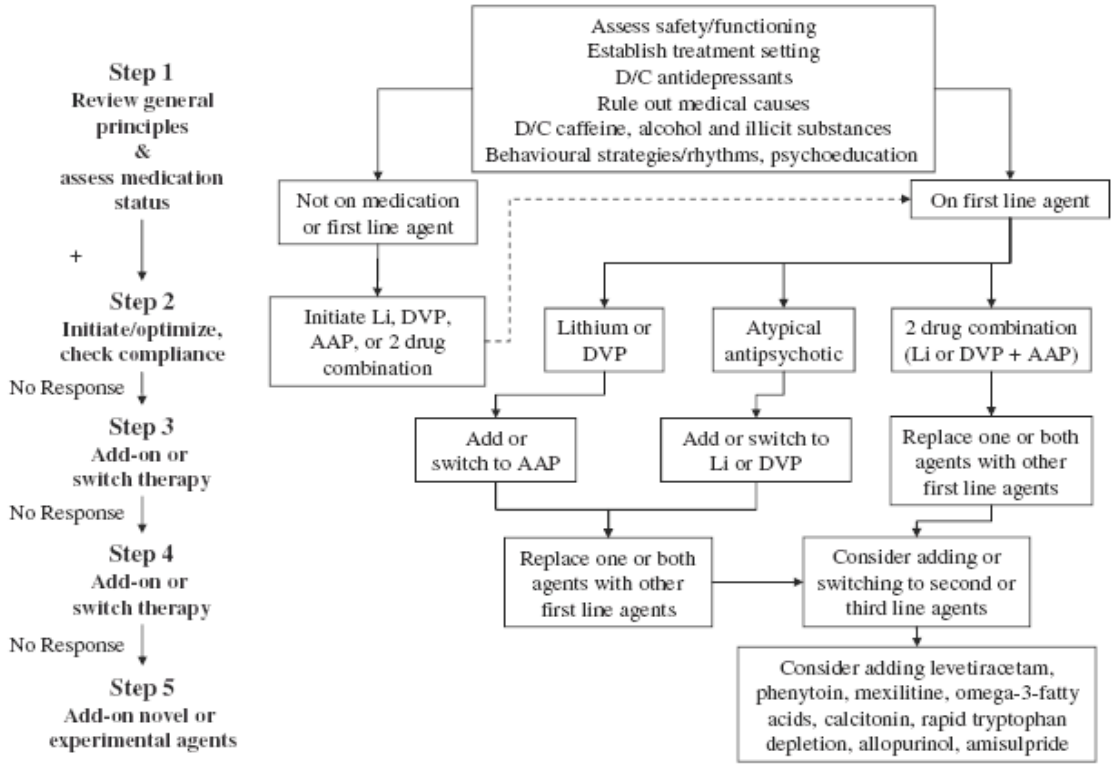

Fig. 3.1. Treatment algorithm for acute mania.
D/C = discontinue; Li = lithium; DVP = divalproex; AAP = atypical antipsychotic.

In conclusion, the Malaysian Consensus and CANMAT are comparable with each other in the sense that it recommends the use of similar medications under similar circumstances. However, CANMAT introduces the 5 steps approach to treating bipolar disorder, which includes the use of novel agents. As more research are done in this field, it is hoped that we can be better in treating our patients, guided by the best evidence available.

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