

PREDICTORS OF RESPONSE TO ANTIDEPRESSANT TREATMENT IN BIPOLAR DEPRESSION

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INTRODUCTION

The role of antidepressants (ADs) in the treatment of bipolar depression is highly controversial, both in terms of safety and efficacy. ADs have been associated with hypo/manic or mixed switch [1] and an increased cyclicity in relapses/recurrences. Moreover, recent studies argue against ADs' actual effectiveness in treating bipolar depression, with the doubtful short-term efficacy vanishing at the long-term [2]. Responders to acute AD add-on treatment seem to maintain response with continued treatment, while partial/non-responders fail to reach remission despite continuation treatment.

OBJECTIVE

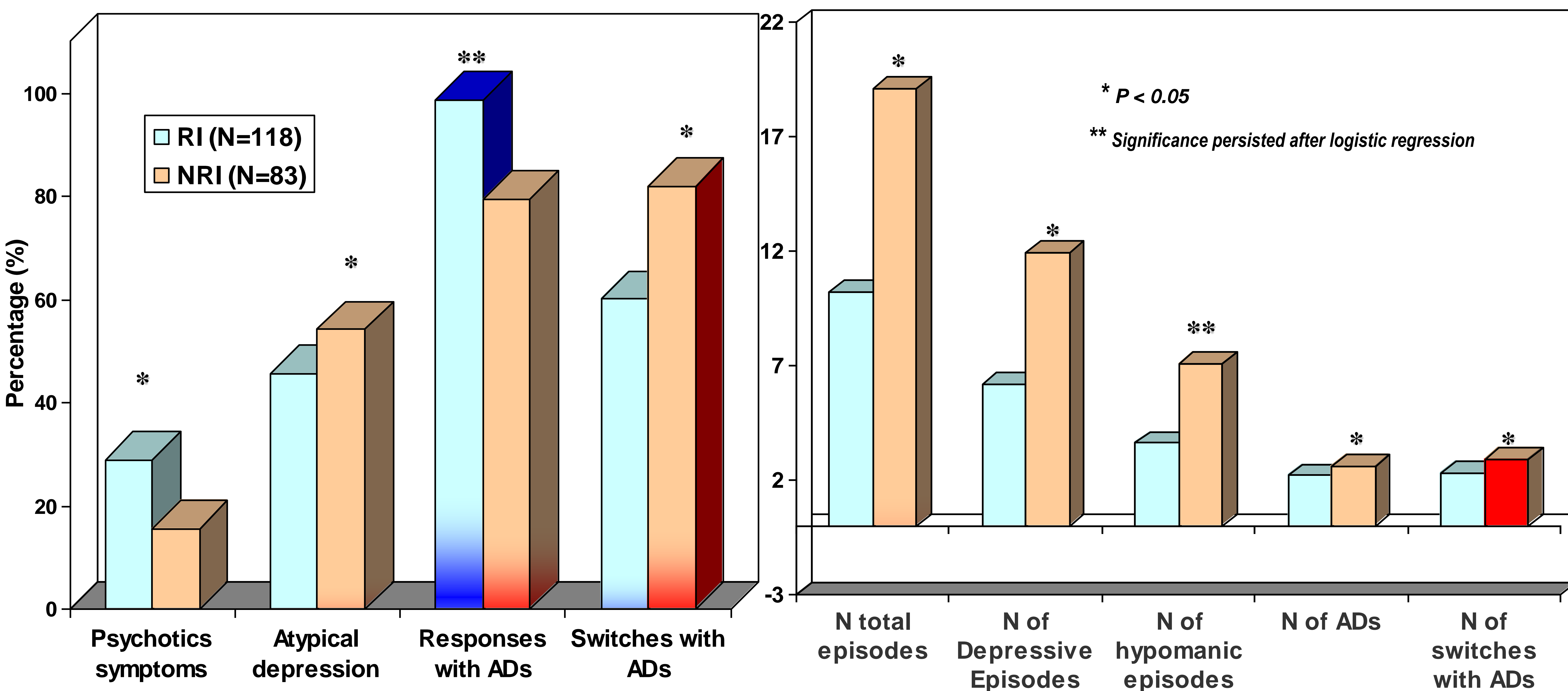
We aimed at identifying response predictors to acute AD addition in bipolar depression in order to optimize treatment choice in bipolar depression and avoid unnecessary AD exposure of people unlikely to respond.

METHODS

Two hundred and twenty-one DSM-IV-TR depressed bipolar –type I and II– patients were treated with AD on an observational study. AD response was defined as an at least 50% drop from baseline of their HDRS17 score after 8 weeks of treatment. One hundred and thirty-eight patients (138, 62.4%) fulfilled response criteria (RI) whilst 83 patients (37.6%) did not (NRI). In all cases AD therapy was on top of previously prescribed stabilizers and/or atypical antipsychotics. RI and NRI groups were compared for clinical and socio-demographic characteristics through ANOVA analysis for continuous variables and the Chi-square test for qualitative variables, as appropriate. Parametric tests were used according to sample distribution. All p values were two-tailed and statistical significance was set at $p < 0.05$. We then performed logistic regression using a backward stepwise model by assuming the initial response to ADs at index episode as the dependent variable and all other variables with p values < 0.1 in univariate analyses as independent factors.

RESULTS

RI patients were more likely to have had previous response to ADs, whereas NRI had a higher number of previous mood switches with ADs during past depressive episodes. Psychotic symptoms were more frequent amongst RI, whilst lifetime history of atypical depression was more frequent amongst NRI. NRI had more total, depressive, and hypomanic, but not manic or mixed, episodes in the past than RI. Analyzed through a logistic regression, higher previous response to ADs and lower rate of past hypomanic episodes in RI were the variables explaining inter-groups (RI vs. NRI) differences.



CONCLUSIONS

Taking into account the proper caution in the use of ADs in bipolar disorder, there is a subgroup of bipolar patients who might benefit from adjunctive ADs. Looking at specific clinical factors during the course of the illness could help physicians in deciding whether to use an antidepressant in a bipolar depressed patient already treated with mood stabilizers. Despite limitations, our results may provide important suggestions for daily clinical practice, namely, adjunctive ADs may benefit patients who had benefited in the past (a learned response?) and had less hypomanic episodes, and the identification of historical predictors points at heterogeneity of BP depression populations, hence suggesting caution when making generalizing statements about efficacy and safety of ADs in BP patients.

REFERENCES

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