Bipolar treatment guidelines 2017

Bipolar disorder is a common mental health condition that affects about 1% (in its most severe form) of the world's population (Merikangas et al., 2011). Bipolar disorder affects functioning, employment and physical health and also increases mortality. The application of evidence-based treatment for bipolar disorder may improve outcomes (Kessing et al., 2013). Evidence-based guidelines are therefore important for mental health professionals and patients/carers, as they are one way of formalising what interventions a person should receive. If the evidence is evidence, then interpreting it should certainly lead to the same guidelines around the world. If not, should we be worried? Gordon Parker and colleagues at the Black Dog Institute in Sydney, Australia (Parker et al., 2017) have published a document on Acta Psychiatrica Scandinavica, which checks whether there is an international consensus on evidence-based guidelines for the management of bipolar disorder. They sought to determine the extent to which the guidelines were consistent, at a higher and more subtle level. This new literature review compared a number of evidence-based bipolar disorder guidelines to see how they differ. Methods for the 2005-2015 The results of Eleven guidelines, published in English and described as evidence-based (as opposed to consensus statements), were found. They covered many well-known organisations, including: National Institute of Clinical Excellence (NICE) British Association of Psychopharmacology (BAP) Royal Australian and New Zealand College of Psychiatrists (RANZCP) Canadian Network for Fashion and Anxiety Disorder Treatment (CANMAT) International Society of Bipolar Diseases (ISBD) Japanese Society of Mood Disorders (JSMD) American Psychiatric Association (APA) World Health Organisation (WHO) World Association of Biological Psychiatry Societies (WFSBP) Department of Veterans Affairs (VA). The authors considered the level of agreement in the following areas: Bipolar I and II Disorder Coverage Guidelines offered different definition strategies, e.g. BAP, RANZCP, and NICE used DSM (which uses the terms bipolar I, bipolar II, etc.), while the WHO uses ICD-10 (which does not distinguish between different types of bipolar disorder) Only 3 guidelines offer disorder-specific recommendations for bipolar I and II. Treatment of acute mania NICE recommends the addition of antipsychotics to lithium or valproate if the ineffective RANZCP recommends the adopt of a true-by-truth strategy All but 2 (NICE, VA) in this treatment phase to include benzodiazepines. Treatment of acute hypomania Some guidelines provide recommendations. Guidelines for the treatment of bipolar depression recommend mood stabilizer atypical antipsychotics. Maintenance therapy in all guidelines for bipolar I recommend a mood stabilizer as the first line for bipolar I, but with significant variation in specific substances, including when first-line treatment fails Multiple base bases based on specific clinical characteristics (e.g. dominant polarity) and differences range from which combinations may be most appropriate in different situations. Maintenance therapy with lamotrigine and quetiapine was most commonly recommended in a small number of guidelines that provide specific instructions. Monitoring of lithium guidelines ranged from 1.0 to 1.3 mmol/l in the eye position of lithium. Safety during pregnancy and breastfeeding Most note the potential teratogenic effects of lithium, Valproate and carbamazepine WHO suggest the evidence is not clear Valproate or carbamazepine WHO and APA does not make any recommendations for Lamotrigine while others claim that it is teratogenic lithium generally considered dangerous in breastfeeding in most guidelines Safety recommendations differ compared to carbamazepine breastfeeding. The APA note that it is generally considered safe for the VA, so it is usually without adverse risks in infants, while NICE say it should be avoided. Use of antidepressants in bipolar disorder WfSBP is not recommended due to the risk of transition to mania in most guidelines In most guidelines it is recommended to include antidepressants in mood stabilizers when depression is severe or avoids it if specific symptom profiles are available wfsbp, suggesting that a recommendation cannot be made because efficacy data are inconclusive Some guidelines indicate that this may be a suitable maintenance treatment for bipolar disorder II. Additional psychosocial therapy Psychoeducation either in groups or individually is usually recommended during the care phase and relapse prevention interpersonal and social rhythm therapy, CBT and family-focused therapy are also commonly recommended. Conclusions The authors recommend the main findings are: There is a lower level of agreement than can be expected for evidence-based guidelines, and the guidelines are more distinguished from their differences than from consistency. The position of leadership is largely influenced by the opinions of the Members of the Commission, as they offer their own assessment of the literature and seek consensus. There is a striking minimal emphasis on differential management of bipolar I and II disorders, given that the 2 subtypes are listed in discounted DSM manuals for more than 2 years. The authors suggest that this may be due to the extrapolation model, but contrast it with specific guidelines for type 1 and type 2 diabetes. This review of international guidelines on bipolar disorder shows that evidence-based guidance is more distinguished from their differences than from consistency. Strengths, Limitations and Effects This Study Has a Good Quality Overview of Bipolar Disorder Treatment Guidelines international consistency. Its clinical (and scientific) importance is clear. In recent decades, there has been a wholeheartedly enrolled evidence-based drug (and the guidelines) that have been followed. Some of the contradictions between the different guidelines are rather fine-grained, with differences being shortcomings rather than inconsistencies in the handling of specific stages of mood. However, the difference was important in other areas, such as prescribing the drug to pregnant or breast-feeding women. The decency of the guidelines is likely to result from some inconsistency at the time of writing (e.g. parents and newer ones). Also, as the authors point out, drug recommendations are limited to drugs that are licensed in a country where guidelines are developed. However, this raises the question of whether guideline manufacturers should take a more holistic approach and review data on drugs that are also licensed in other countries. This may be particularly important for bipolar disorder, where various aspects, such as the management of bipolar depression and treatment resistance, are generally underserved areas and where prescribing may be more common than we would like. One issue that would be interesting to explore further is the processes and paradigms that each body use to evaluate the evidence and produce its own guidance. It would be informative to know whether groups are hierarchically structured on the quality of evidence in order to contribute to transparency. As regards paradigms, the WFSBP guidelines use cost-benefit analysis, taking into account both efficacy and safety and tolerability. NICE use cost-effectiveness information, while Parker et al. say all other guidelines appear to be used for the effectiveness of the primary result of interest on which recommendations are made. We could also benefit from knowing how each of the guidelines collects and reviews data, including all requests to pharmaceutical companies for unpublished findings, which can, of course, significantly alter the conclusions of the meta-analysis. These different paradigms suggest one explanation for the paper's findings. The guidelines do not appear to be purely scientific clinical. They have an important social and political response, shaped by the needs, desires and ability (or willingness) of society to pay for health care and can be used as a ratio mechanism. The way in which this framework is established between countries can have one significant impact on the resulting guidelines, even if it has the same evidence base. Questions raised about Parker et al. chime in recent UK public discourse on the validity and recommendations of nice schizophrenia and bipolar disorder guidelines and emphasis or otherwise put individual treatment and make-up decision-making committees. This is often based on discretable results from successive meta-analysis in specific therapeutic areas where apparently largely the same papers have been reviewed. This review shows that and other stakeholders may be forgiven for knowing who to believe or what guidelines (or objectives) they should follow. Should the guidelines be drawn up by scientists who do not have evidence to review? The advantages may be greater objectivity in the review of results, less a basis for criticism of panel members with a perceived legitimate interest (both intellectual and financial) and perhaps more consistency in the evaluation of evidence between different treatment areas. The problem may be that clinical judgee can be invaluable in making small decisions about small differences or when in fact there is little good quality evidence to look at, and it is difficult to understand how patients' voices might be included. Guidelines are necessary, but in general this document stresses that despite the best efforts it can be difficult to take opinions out of guidelines for bipolar disorder (and perhaps other disorders). The evidence to some extent depends on who assesses it and how. Evidence-based or not, it is difficult to take opinions out of the guidelines. Links to Primary Paper Parker GB, Graham RK, Tavella G. (2017) Is there consensus on international evidence-based guidelines for managing bipolar disorder? Acta Psychiatrica Scandinavica Volume 135, Edition 6 June 2017 Pages 515-526 DOI: 10.1111/acps.12717 onlinelibrary.wiley.com.libproxy.ucl.ac.uk/doi/10.1111/acps.12717/full [Abstract] Other references Kessing LV, Hansen HV, Hvenegaard A, Christensen EM, Dam H, Gluud C, Wetterslev J. (2013) Treatment in a special outpatient mood disorder clinic v standard outpatient treatment in the early stages of bipolar disorder: randomized clinical trial. British Journal of Psychiatry, 202, 212-219. Sea fabric KR, Jin R, He J-P, Kessler RC, Lee S, Sampson NA, Viana MC, Andrade LH, Hu C, Karam EG. (2011) Prevalence and correlated bipolar spectrum disorder in the World Mental Health Survey Initiative. General Psychiatry Archive, 68, 241. Photo Credit Photo rawpixel.com On Unsplash Unsplash