51 - References

References

Bipolar disorder CHAPTER 2 References

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13. Carvalho AF, et al. Rapid cycling in bipolar disorder: a systematic review. J Clin Psychiatry 2014; 75:e578–e586. Table 2.8 Recommended treatment strategy fo rapid-cycling bipolar disorder. Step Suggested treatment Step 1 Withdraw antidepressants in all patients10,11 (some controversial evidence supports continuation of SSRIs12,13) Step 2 Evaluate possible precipitants e.g. alcohol, thyroid dysfunction (including antithyroid antibodies14), external stressors15 Step 3 Optimise mood stabiliser treatment16–19 (using plasma levels) and Consider combining mood stabilisers e.g. lithium + valproate, lithium +

lamotrigine, valproate + carbamazepine or go to Step 4 Step 4 Consider other (usually adjunctive) treatment options (alphabetical order; preferred treatment options in bold8) Aripiprazole20,21 (15–30mg/day) Clozapine22 (usual doses) ECT23 Lamotrigine24–26 (up to 225mg/day) Levetiracetam27 (up to 2000mg/day) Lurasidone28,29 (40–120mg/day) Nimodipine30–32 (180mg/day) Olanzapine33 (usual doses) Quetiapine34–37 (300–-600mg/day) Risperidone38,39 (up to 6mg/day) Thyroxine40,41 (150–400mcg/day) Topiramate42 (up to 300mg/day) Transcranial magnetic stimulation (rTMS)43,44 The choice of drug is determined by patient factors – there are few comparative efficacy data to guide choice at the time of writing. Quetiapine probably has the best supporting data34–36 but it has similar efficacy to aripiprazole or olanzapine. Supporting data for levetiracetam, nimodipine, thyroxine and topiramate are relatively limited. Clozapine has a clear role in treatment-resistant bipolar disorder,45 a definition that might include rapid cycling, in which it shows some acute and long-term efficacy.22,46

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