

Expert Panel Discussion and Recommendations

Selected clinical issues - bipolar disorder

There has been a large increase in the rate of diagnosis of bipolar disorder in children and adolescents over the past eight years. With the increased rate of diagnosis of bipolar disorder has come an increase in polypharmacy and the use of anticonvulsant medications as mood stabilizers. Many of the common practices do not have good data to support their efficacy and some have potentially dangerous adverse effects. This break-out group will address the following issues:

- 1) What is the appropriate first line of treatment for mania? Mixed mania?
- 2) What is the role of antidepressants in the management of bipolar disorder? At what point in the treatment are antidepressants introduced?
- 3) What is the role of stimulants in the management of co-morbid bipolar disorder and ADHD? At which point should stimulants introduced?
- 4) What is the role of atomoxetine, a selective norepinephrine reuptake inhibitor with antidepressant properties in the treatment of ADHD in patients with bipolar disorder?
- 5) What are the indications for lamotrigine?
- 6) Are the AACAP Treatment Guidelines appropriate for the treatment of bipolar disorder in this population?
- 7) Under what circumstances is it warranted to deviate from the AACAP Treatment Guidelines?

Panel Report

The panel spent a great deal of time discussing the assessment and diagnosis of bipolar disorder in children and adolescents. The panel spoke of the diagnosis of bipolar disorder vs. a symptom complex. One of the most difficult differential diagnoses to make is the diagnosis of bipolar disorder vs. ADHD. There is a significant overlap in symptoms between the two diagnoses. The panel listed several symptoms that distinguish between and bipolar disorder ADHD, including hypersexuality, grandiosity, elevated mood, and decreased need for sleep. In establishing the diagnosis the panel addressed the impact on the child psychosocial functioning and the need for interventions other than polypharmacy. In designing a medication intervention they emphasized the need for clearly identifying target symptoms and monitoring their response to treatment. In addition, they addressed the need to reassess the pharmacotherapy if the diagnosis of bipolar disorder is not supported.

- 1) The first line of treatment for pediatric bipolar disorder is either a mood stabilizer or a second generation antipsychotic. LiCO₃ and divalproex sodium were specifically listed as a first line mood stabilizer by the panel. A specific second generation antipsychotic was not identified. For psychosis or particularly acute presentations of mania the combination of a mood stabilizer and a second generation antipsychotic was recommended.

- 2) The panel felt that there was, indeed, a role for antidepressants in the treatment of depression in bipolar disorder. Fluoxetine was specifically listed as an adjunct. The panel recommended a small dose of fluoxetine.
- 3) Psychostimulants play a major role in the treatment of ADHD in patients with pediatric onset bipolar disorder. The stimulant would be a first line treatment if the ADHD was the primary diagnosis and would be added as an adjunct after the mood disorders was stabilized by a mood stabilizers and/or a second generation antipsychotic when the mood disorder diagnosis was primary.
- 4) The panel felt that atomoxetine had little role in treating co-morbid bipolar disorder and ADHD.
- 5) There are good data to support the use of lamotrigine in bipolar depression, a mixed picture, and for maintenance pharmacotherapy. There are no data to support the use of lamotrigine in the treatment of acute mania. The panel recommended that the medication be started at a low dose and titrated slowly (~ 12.5 mg/wk).
- 6) The panelists felt that the AACAP Treatment Guidelines¹ were appropriate for the treatment of bipolar disorder in children and adolescents and felt that the AACAP Practice Parameters should be used when published.
- 7) The panelists did not make specific recommendations, stating that deviations from the AACAP Treatment Guidelines are acceptable if they are rational and based on high quality data published in a peer-reviewed journal.

¹ Kowatch et al. and the Child Psychiatric Workgroup on Bipolar Disorder. Treatment guidelines for children and adolescents with bipolar disorder. *Journal of the American Academy of Child & Adolescent Psychiatry*, 44(3):213-35, 2005.