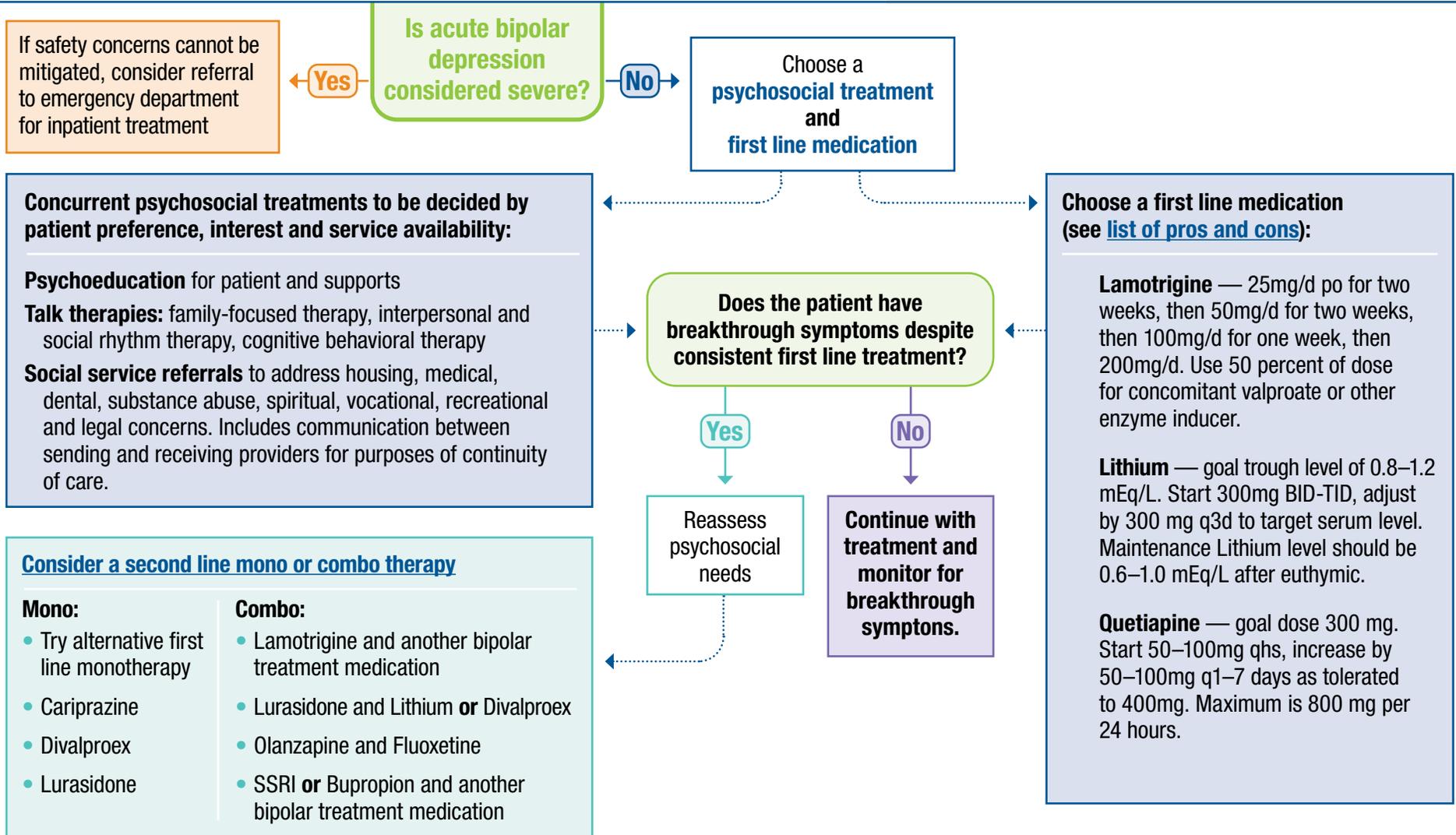


Acute Bipolar Depression Algorithm

Call the Oregon Psychiatric Access Line (OPAL) for clinical consultation at any point in treatment: 503-346-1000



For the treatment of acute bipolar depression *avoid*:

- **Aripiprazole** (evidence of ineffectiveness)
- **Antidepressant monotherapy** (ineffective and runs the risk of triggering a manic or mixed episode)

Picking a second-line bipolar depression treatment

There is little evidence to guide decision making among the multiple options suggested here as second line, co-equal options. Determining factors for a given patient are:

- Patient preference
- Patient bipolar illness history
- Psychiatric and physical health co-morbidities, and
- Symptom severity.

Here are some general principles to keep in mind:

Combination mood stabilizing treatments

- Lurasidone + Lithium or Divalproex
- Lamotrigine + another mood stabilizing medication

May be most appropriate for persons with:

- Severe depressive symptoms, or
- A history of non-response to appropriate monotherapy trials.

Second-generation antipsychotic monotherapy

- Lurasidone
- Cariprazine

May be most appropriate for persons who:

- Have not tolerated or not benefited from Lithium or Lamotrigine, and
- Quetiapine has failed or is not an option.

Also, appropriate when an antipsychotic medication with lower metabolic syndrome risk is a very high treatment priority.

Selective serotonin reuptake inhibitors (SSRI) antidepressant agents

- Olanzapine-fluoxetine
- Adding an SSRI or Bupropion to another mood stabilizing medication

Adding an SSRI may be most appropriate if a patient deals with:

- A co-morbid anxiety disorder, or
- PTSD.

This is particularly true, if:

- They have a personal experience of benefiting from SSRI treatment, and
- Have not been restarted due to symptoms of mania.

Bupropion

- Added to another mood stabilizing medication

May be most appropriate when:

- Depression is insufficiently responding to mood stabilizing treatment, and
- Selecting a weight neutral medication has a high priority.

Note: Bupropion is unlikely to help with anxiety disorders (as compared to SSRIs). For some patients it may worsen anxiety.

Regimen	Selection pearls
Lurasidone + Lithium/Divalproex Lamotrigine + other med	<ul style="list-style-type: none">• Good for severe depressive symptoms• If no response to other monotherapy
SGA monotherapy: Lurasidone, Cariprazine	<ul style="list-style-type: none">• If no response to Lithium or lamotrigine and quetiapine won't work.• Low metabolic syndrome risk
SSRI + other bipolar med	<ul style="list-style-type: none">• With co-morbid Anxiety or PTSD, especially if it helped in past
Bupropion	<ul style="list-style-type: none">• Can help with depressive symptoms, not anxiety• Weight neutral

Medications pros and cons

	Pros	Cons
Lamotrigine	<ul style="list-style-type: none"> • Lowest overall side effect profile • Lowest risk of weight gain • Safer in pregnancy 	<ul style="list-style-type: none"> • Slow titration over 6+ weeks • Consistent adherence essential • Rare risk of Stevens-Johnson Syndrome
Lithium	<ul style="list-style-type: none"> • Decreased suicidality (*though caution as it is dangerous in overdose) • Simpler dose titration than quetiapine • Strong evidence of support 	<ul style="list-style-type: none"> • Narrow dose window • Extreme caution when used during pregnancy • Renal, thyroid toxicity • Medication interactions
Quetiapine	<ul style="list-style-type: none"> • May see mood benefits more rapidly • Sedating properties can be helpful for anxiety, insomnia • Safer in pregnancy • Wider dose window 	<ul style="list-style-type: none"> • Moderate risk metabolic syndrome; highest risk weight gain amongst these options • Can be sedating, risk orthostatic hypotension