Evidence that changes the way you practice
Bipolar disorder: mania and depression explained

Outhoff K, MBChB, MFPM(UK)

Senior Lecturer, Department of Pharmacology, University of Pretoria, Pretoria
Correspondence to: Kim Outhoff, e-mail: kim.outhoff@up.ac.za
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Abstract
Bipolar disorder is characterised by alternating discrete episodes of depression and mania. Rational pharmacotherapy necessitates an appreciation of these different phases and of the possible underlying pathophysiology. A greater understanding of the pathogenesis of bipolar disorder has boosted awareness of how anti-bipolar drugs work, and vice versa. This bidirectional relationship has amplified knowledge in both disciplines.

Introduction
Bipolar disorder is characterised by alternating discrete episodes of depression and mania. Rational pharmacotherapy necessitates an appreciation of these different phases and the possible underlying pathophysiology. A greater understanding of the pathogenesis of bipolar disorder has boosted awareness of how anti-bipolar drugs work, and vice versa.1 This bidirectional relationship has amplified knowledge in both disciplines.

Bipolar disorder is highly heritable and genome-wide association studies have uncovered significant insights into the biological mechanisms involved in its development. Potential genetic variants implicated in disease aetiology include CACNA1C, that encodes the alpha subunit of brain L-type voltage-gated calcium ion channels, and ANK3, that encodes an adaptor protein essential for the assembly of voltage-gated sodium channels. Some mood stabilisers, such as lithium, valproate and lamotrigine, stabilise neuronal conduction by modulating these channels.6 In addition, valproate has been shown to enhance neuroinhibitory gamma amino butyric acid effects,5 while possibly attenuating neuroexcitatory glutamate’s effects by upregulating the calcium chaperone protein, glucose-regulated protein (GRP) 78.6

The intracellular actions of lithium and valproate that may also be relevant to their actions in bipolar disorder include stimulating cell survival pathways and increasing levels of neurotrophic factors to improve cellular resiliency.7,8 Both agents inhibit proapoptotic glycogen synthase kinase-3 beta and increase antiapoptotic protein Bcl-2 levels in the frontal cortex, ultimately resulting in downstream regulation of gene expression and neuroprotection.9,10 Recent genome-wide association study results have implicated a risk locus which encodes ADCY2, a protein that is involved in cyclic adenosine monophosphate signal transmission within neurons, and a locus containing MIR2113 and POU3F2, which are thought to play a role in neurodevelopmental processes, lending further support to the importance of neuronal integrity in bipolar disorder.11 Interestingly, valproate has effects on DNA histone acetylation, and may thereby regulate epigenetic phenomena as well.12

Thus, the pathophysiology and treatment model of mood disorders has expanded to include anomalies of neuroplasticity, or the brain’s ability to form new neural connections in response to environmental changes, including injury. Structural and functional neuroimaging studies have re-enforced this neuronal injury hypothesis and have highlighted heritable changes in cortical and corpus callosum volumes, abnormal myelination in several brain regions implicated in bipolar disorder, as well as hippocampal cell damage and loss.14-17 The hypothesis supports the clinical observation that the more episodes that a person experiences, the more he or she will have in the future, underscoring the need for long-term maintenance treatment.18 Besides lithium, valproate or lamotrigine, recommended maintenance monotherapy includes second-generation antipsychotic medications (SGAs); olanzapine, aripiprazole, quetiapine and risperidone long-acting injection.1,19,20

Because serotonin, noradrenaline and dopamine are strongly implicated in the pathophysiology of mania, pharmacological strategies include gradually discontinuing conventional antidepressants and stimulants that increase the levels of any of these neurotransmitters. Agents that antagonise serotonin and dopamine receptors, including olanzapine, aripiprazole, quetiapine, risperidone, paliperidone and ziprasidone, have demonstrated excellent antimanic efficacy when used alone. Lithium or valproate are also valuable first-line options. The combination of either, with one of the above SGAs, confers additive efficacy presumably because different sites are targeted.1,19

There is insufficient evidence for conventional antidepressants in bipolar depression, possibly indicating an aetiology that is sufficiently distinct from major depressive disorder. These agents may also trigger mania.19 Instead, first-line monotherapy options for severe bipolar I depression include the neuronal stabilising and protective agents; lithium, valproate or lamotrigine, and paradoxically, the atypical antipsychotics; quetiapine or olanzapine.19 Their mechanism of antidepressant action is speculative.5 Olanzapine and quetiapine antagonise the 5-hydroxytryptamine (5HT)2a receptors while stimulating the 5HT1a receptors, and this is thought to contribute to their
antidepressant effects. In addition, the prefrontal cortical dopamine levels are indirectly elevated by this SHT1A partial agonistic mechanism. Rapid dissociation of quetiapine from the dopamine D2 receptors, as well as altered expression of glutamate receptor subunits, may also contribute to its antidepressant efficacy in bipolar disorder.6 Incidentally, quetiapine is recommended first line for the milder depression associated with bipolar II.1,3 Based on drug responsiveness studies and a wider appreciation of its pathophysiology, rational second-line options for bipolar I depression include adjunctive risperidone, olanzapine and fluoxetine combinations, or lithium combined with either valproate, lamotrigine or an antidepressant.19

Table I highlights the South African treatment guidelines for bipolar disorder.19

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<thead>
<tr>
<th>Maintenance monotherapy</th>
<th>Acute mania</th>
<th>Bipolar I depression</th>
<th>Bipolar II depression</th>
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<tbody>
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<td>Lithium</td>
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<td>Lithium</td>
<td>Quetiapine</td>
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<table>
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<td>Antidepressants, such as SSRIs and SNRIs alone or with mood stabilisers</td>
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SNRIs: norepinephrine reuptake inhibitors, SSRIs: selective serotonin reuptake inhibitors

*: Bipolar I is characterised by one or more episodes of mania, with or without major depressive episodes, usually leading to severe impairment of social or occupational function

**: Bipolar II disorder is characterised by one or more episodes of hypomania, as well as at least one major depressive episode with no psychotic features, and usually no major impairment of function

References


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