# Letters

## Treatment of bipolar depression

**To the Editor:** We were interested to read the MJA Open supplement *Difficult-to-treat depression: a guide to management in primary care*, and in particular the article on treatment of bipolar depression.[1] However, we were surprised that nowhere in the supplement was there any mention of the importance of diagnosing bipolar II disorder, and that there was no emphasis on the need to recognise that bipolar depression requires different treatment to non-bipolar depression to be effective.

In a recent study of patients in a rural setting referred largely by general practitioners for psychiatric assessment, we found that 113 of 559 newly referred patients (20%) were diagnosed with bipolar II disorder and, of these, the diagnosis was made for the first time in 69 patients (61%).[2]

Our findings suggest that the most common cause of difficult-to-treat depression is a failure to diagnose bipolar II depression — or, when it is diagnosed, a failure to know that bipolar depression requires different treatment to be effective.

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1 Berk M, Berk L, Davey CG, et al. Treatment of bipolar depression. *MJA Open* 2012; 1 Suppl 4: 32-35. doi: 10.5694/mjao12.10611.

2 Robertson A, de Moore G, Boyce P. Bipolar II disorder in rural New South Wales. *Australas Psychiatry* 2012; 20: 203-207. ❑

***In reply:*** Robertson and colleagues highlight that bipolar depression must be treated differently from unipolar depression. It is true that the depressive phase of bipolar II disorder is often mistaken for unipolar depression, with consequent treatment implications, and that correct diagnosis is the first necessary step for correct treatment.

We did not cover bipolar II disorder specifically in our article,[1] as there is little quality evidence to suggest that the depressive phases of bipolar II and bipolar I disorder should be treated substantially differently.[2] Most data derive from examinations of subgroups of people with bipolar II disorder in broader bipolar cohorts. Differences may exist, including possibly lower rates of switching from depression to mania or hypomania, and greater potential utility of antidepressants in those with bipolar II disorder. However, these data are methodologically limited and thus controversial.[3]

The 2013 update of the Canadian Network for Mood and Anxiety Treatments (CANMAT) guidelines[4] suggests first-line options for managing bipolar II depression include lithium, lamotrigine, valproate, lithium plus valproate, lithium or valproate plus antidepressants, and the combination of atypical antipsychotics and antidepressants. Second-line options include antidepressant monotherapy for those with infrequent hypomania, quetiapine plus lamotrigine, adjunctive electroconvulsive therapy, adjunctive *N*-acetylcysteine or adjunctive triiodothyronine. With the exception of greater latitude for antidepressant therapy, these recommendations differ minimally from those for bipolar I disorder.

Quality studies examining the treatment of this important subgroup are underway, and their results are eagerly awaited.

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1 Berk M, Berk L, Davey CG, et al. Treatment of bipolar depression. *MJA Open* 2012; 1 Suppl 4: 32-35. doi: 10.5694/mjao12.10611.

2 Bond DJ, Noronha MM, Kauer-Sant'Anna M, et al. Antidepressant-associated mood elevations in bipolar II disorder compared with bipolar I disorder and major depressive disorder: a systematic review and meta-analysis. *J Clin Psychiatry* 2008; 69: 1589-1601.

3 Amsterdam JD, Shults J. Efficacy and mood conversion rate of short-term fluoxetine monotherapy of bipolar II major depressive episode. *J Clin Psychopharmacol* 2010; 30: 306-311.

4 Yatham LN, Kennedy SH, Parikh SV, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) and International Society for Bipolar Disorders (ISBD) collaborative update of CANMAT guidelines for the management of patients with bipolar disorder: update 2013. *Bipolar Disord* 2012; Dec 12 [Epub ahead of print]. doi: 10.1111/bdi.12025. ❑