

Dr Altshuler Replies

To the Editor: We thank Roger Sparhawk, MD, for his letter and concern regarding the use of antidepressants in patients with bipolar disorder. He is specifically concerned that the findings from our study may be uncritically misapplied by physicians in the community, leading to widespread antidepressant prescribing. We want to underscore that our findings do not address whether antidepressants, in conjunction with a mood stabilizer, should be a first-line standard treatment for patients with bipolar disorder. Rather, our study addresses whether an antidepressant should be continued in patients who do not optimally respond to them in the acute treatment phase. In specific response to Dr Sparhawk's comments:

1. A prior retrospective study of ours did, in fact, show that only 15% of bipolar patients treated with antidepressants could tolerate a 6-week antidepressant trial, had a positive response, and did not switch into mania. The patients in our current study involved patients who were first in a prospective double-blind, placebo-controlled trial and had either a partial or a positive antidepressant response in that acute treatment trial.¹ In that study, the positive or partial response rate was less than 50% but greater than the 15% in our prior retrospective study. In both studies, however, it is clear that for many patients with bipolar disorder, antidepressants may not be well tolerated or helpful at treating their depression.
2. We agree that it is important to note that our acute partial responders were less likely to further achieve a full positive antidepressant response with continued coadministration of antidepressants than those who had initially achieved a full positive response. In fact, the conclusion of our study is that patients who do not respond fully acutely may not benefit further from continued antidepressant treatment.
3. All of the patients in our study were, in fact, first treated and did not respond to adequate doses or levels of lithium, divalproex sodium, carbamazepine, or an antipsychotic agent prior to the addition of an antidepressant. We regret that the author believes that this standard is not consistently carried out in clinical practice in his geographic area. Further, while atypical antipsychotics certainly have a place in the treatment of patients with bipolar disorder, our study does not address whether an antipsychotic versus a more "classic" mood stabilizer may be differentially beneficial for patients with bipolar depression.

REFERENCE

1. Post RM, Altshuler LL, Leverich GS, et al. Mood switch in bipolar depression: comparison of adjunctive venlafaxine, bupropion and sertraline. *Br J Psychiatry*. 2006;189(2):124-131.

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