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TO WHAT EXTENT ANTIDEPRESSANT MONOTHERAPY STROLL UPON THE PINSTRIPE BETWEEN STANDARD OF CARE AND PSYCHIATRIC MALPRACTICE IN BIPOLAR DEPRESSION?: A COMMENTARY FROM THE VIEWPOINT OF SUICIDE

BİPOLAR DEPRESYONDA ANTİDEPRESAN MONOTERAPİSİ STANDART TEDAVİ İLE PSİKİYATRİK MALPRAKTİS ARASINDAKİ İNCE ÇİZGİDE NEREDE DOLAŞIR?: İNTİHAR BAKIŞ AÇISINDAN BİR AÇIMLAMA

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Abstract

Psychiatry is one of the least facing profession to malpractice claim in medicine. Misevaluation of suicide risk is one of the most frequent issues for litigation in the practice of psychiatry. Psychiatrists are expected to foresee and prevent suicidality by the law, although suicide has an unpredictable diagnostic nature. Bipolar disorder (BPD) is an affective disorder associated with elevated rates of suicidal behaviour, particularly in depressive episodes. Therefore, the main target of standard therapeutic approaches in BPD depression is the reduction of suicide risk. Treatment options ought to be carefully formed by the clinician, in light of the determination of clinical severity and suicidal risk in bipolar depression. This article aimed to discuss to what extent use of antidepressants is appropriate in bipolar depression regarding possible malpractice in line with evidence-based clinical guidelines and actual literature.

Keywords: bipolar disorder; depression; malpractice; suicide

Özet

Tıpta malpraktis iddialarıyla en az karşı karşıya kalan branşlardan biri psikiyatridir. İntihar riskinin değerlendirilmesindeki hatalar psikiyatri uygulamalarında en sık karşılaşılan dava konularındandır. İntiharın tahmin edilmesi güç tanısal doğasına rağmen hukuk, psikiyatristlerden intiharı öngörebilmesini ve önlemesini bekler. Bipolar bozukluk, özellikle depresif hecmedeki yüksek intihar davranış oranlarıyla ilişkili bir affektif bozukluktur. Bu yüzden bipolar depresyonda standart terapötik yaklaşımların ana amacı intihar riskini azaltmaktır. Bipolar depresyonda tedavi seçenekleri klinisyen tarafından hastalığın şiddeti ve intihar riski göz önünde bulundurularak dikkatlice şekillendirilmelidir. Bu yazı, bipolar bozuklukta antidepresan kullanımının olası malpraktis açısından ne ölçüde uygun olduğunu kanıta dayalı klinik kılavuzlar ve güncel literatür ışığında tartışmayı amaçlamıştır.

Anahtar Kelimeler: *bipolar bozukluk; depresyon; intihar; malpraktis*

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Common recognition and the literature indicate that psychiatry is one of the least facing profession to malpractice claim in medicine. Psychiatry ranked 22nd in the number of malpractice charges among 28 medical specialities with a prevalence of 2.6% in a retrospective 15-year follow-up study (Jena, Seabury, Lakdawalla, & Chandra, 2011). Unfavourably, while Turkish literature lacks on actual malpractice statistics, nine of the 931 malpractice claims admitted to the Ministry of Health between 1994 – 1999, were cases of psychiatry; however, the numbers are estimated to be increasing in Turkey (Ertem, Oksel, & Akbıyık, 2009; Ozver et al., 2013). Misevaluation of suicide risk is one of the most frequent issues for litigation in the practice of psychiatry. A comprehensive examination is the sole and essential diagnostic instrument to estimate the risk. Regardless of the physician's appropriate efforts for prevention, patients inevitably commit suicide in some occasions which may result in a lawsuit for psychiatric malpractice. 14% of lawsuits are related to a failure in preventing suicide/homicide (Meyer, 2006). Psychiatric liability regarding suicide includes inexperience, misdiagnosis, erroneous treatment, lack of surveillance and underestimation of the risk (Terranova & Sartore, 2013).

Patients with affective disorders are at a very high risk of death by suicide, approximately 20 times higher than in the general population, particularly when remained untreated. Bipolar disorder (BPD) is a lifelong affective disorder characterized by manic, hypomanic, depressive and euthymic episodes and associated with elevated rates of suicidal behaviour. About a third to a half of bipolar patients attempt suicide at least once in their lifetime, and roughly 15–20% of attempts are completed, particularly patients with depressive predominant polarity or in depressive episode (Grande, Berk, Birmaher, & Vieta, 2016). Due to its episodic nature, treatment options may vary from each episode in BPD. Mood stabilizers, antipsychotics, antidepressants, electroconvulsive therapy and psychotherapy are used in BPD. Nevertheless, the severity of the prognosis in BD is mainly linked to the high rate of suicide, especially in depressive episodes. Hence, treatment of depression in BPD requires more specific and structured medication procedures with strict follow-ups. Mood-stabilizing pharmacotherapy is a cornerstone of BPD treatment. Lithium is strongly recommended lone or in combination with other psychotropic medication, as a first- or second-line pharmacotherapy for the treatment of mania and bipolar depression, as well as a first-line maintenance treatment option for BPD (Toffol et al., 2015). Growing body of evidence has indicated that with lithium reduces the risk of suicide and suicide attempts in patients suffering from affective disorders (Baldessarini & Tondo, 2008). Apart from the fact that lithium has a significant decreasing impact on suicidal attempt risk in BPD, other mood-stabilizers such as valproate are also found to be associated with a reduction of suicide risk (Søndergård, Lopez, Andersen, & Kessing, 2008).

Suicide is a major worldwide public health concern. Almost one million lives are lost each year to suicide, and between 3%–5% of adults attempt suicide at least once in their life. The most powerful predictor, major precursor and risk factor of attempted and completed suicide is a previous suicide attempt (Pompili et al., 2008). A psychiatrist is expected to be able to evaluate the risk on the basis of all available information, including patient responses in a proper psychiatric interview, known risk factors and history. "Foreseeability" is a legal term defines reasonable expectation that some damage is likely to arise from certain acts or omissions, and the law seeks for it in order to conclude a suicide lawsuit as misdiagnosis or negligent treatment (Sher, 2015).

Depression in bipolar disorder is a major therapeutic challenge associated with disability and excess mortality. Prompt and comprehensive assessment and management of suicidal ideation in patients with bipolar depression are needed (Grande et al., 2016). In the presence of suicidal risk in BPD depressive episode, treatment alternatives ought to be paid more attention. Various pharmacotherapeutic interventions are available and published in the literature in BPD depression; however, to avoid legislative acts due to inappropriate medication leading to suicide, physicians should ground their medication on universal evidence-based clinical guidelines. The relative usefulness of standard antidepressants in BPD remains controversial due to their propensity to induce cycling, mania or hypomania, they are often enhanced by a combination with mood-stabilizer in the first line treatment of bipolar depression (Sadock, Sadock, & Ruiz, 2015).

As one of the most recognized, American Psychiatric Association (APA) guideline on BPD suggests lithium and lamotrigine to prevent any mood episode, lamotrigine is an effective preventer for depressive episode. Medications having the strongest evidence for efficacy for acute treatment of depression in patients with bipolar disorder are the olanzapine-fluoxetine combination, quetiapine and lamotrigine. Prescription of antidepressants in the absence of a mood stabilizer is not recommended for bipolar patients according to APA guideline (Hirschfeld, 2005). The National Institute for Health and Care Excellence (NICE) guideline offers lithium as a first-line maintenance therapy in BPD. If lithium is ineffective adding valproate or poorly tolerated switching valproate with or without olanzapine are the alternatives. In BPD depression, NICE guideline suggests checking lithium blood level if the patient is taking lithium, if it is inadequate, increase the dose of lithium; if it is at maximum level, add either fluoxetine combined with olanzapine or quetiapine on its own. If the patient is not taking any mood-stabilizer, guideline suggests olanzapine with/without fluoxetine, or lamotrigine, or quetiapine on its own (NICE, 2014). Canadian Network for Mood and Anxiety Treatments (CANMAT) guideline suggest lithium, lamotrigine, valproate, olanzapine, quetiapine, risperidone or aripiprazole monotherapy in BPD maintenance, antidepressants are not recommended. In BPD depression first-line treatment options are lithium, lamotrigine, quetiapine monotherapy or, lithium/valproate combined with antidepressants, olanzapine combined with antidepressants, lithium - valproate combination. CANMAT guideline considers management of a bipolar depressive episode with antidepressants controversial (Yatham et al., 2013). According to Consensus Group of the British Association for Psychopharmacology (BAP)

guideline, lithium or lamotrigine is recommended as a first-line agent in bipolar depression. Lithium is also considered as a risk-reducing agent for suicide. Quetiapine also suggests convincing efficacy in BPD depression (Goodwin & Psychopharmacology, 2009). Antidepressants are probably effective for treating depression in bipolar disorder; however, should be combined with antimanic agents in order to prevent manic switches. The association between suicidal behaviour and antidepressants are needed to be clarified by the means of further studies. Aforementioned guidelines are based on randomized double-blind clinical trials, systematic reviews and meta-analyses (Table 1).

Tablo 1. Evidence-based clinical guidelines on bipolar depression

Guideline	First-line	Recommended	Not recommended / Controversial
APA	Lithium	Lamotrigine Quetiapine Olanzapine+Fluoxetine	Antidepressants without mood stabilizors
NICE	Lithium	Valproate Olanzapine Quetiapine Olanzapine + Fluoxetine Lamotrigine	-
CANMAT	Lithium Lamotrigine Quetiapine	Lithium + Valproate Lithium/Valproate + antidepressants Olanzapine + Antidepressants	Antidepressants alone
BAP	Lithium	Lamotrigine Quetiapine Olanzapine+Fluoxetine	Antidepressants without mood stabilizors

Despite one can find various treatment options in the literature regarding BPD depression, none of the guidelines encourages antidepressant monotherapy. Any intolerance or side effect of lithium or valproate occurs, substitutional options are available in guidelines. Assesment of suicide risk is a subjective matter that protects psychiatrist facing to legislation; nevertheless, medication preference in ought to be compatible with the evidence-based literature in order to fit standard of care.

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