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Commentary Article

A Short Note on Bipolar Disorder

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DESCRIPTION

Bipolar disorder might be characterized by the presence of depression and mania; however its long-term course is quite often dominated by depression rather than manic symptoms. Patients with bipolar disorders are at a significant increase in risk of suicide, especially during depressive episodes. Moreover, in bipolar patients a high level of simultaneous and consecutive comorbidity with other mental problems and physical illness is normal.

Unfortunately, patients with bipolar disorder stay unnoticed by healthcare professionals, untreated or inappropriately treated, which obviously related with a lower life expectancy, a more malignant course and an altogether lower quality of life. A major challenge in the treatment of patients with mood disorders is distinguishing among bipolar and unipolar depression, since these state of mind disorders require different approaches of medication. There is a significant longitudinal risk, presumably more than 10% that underlying unipolar depression in patients ultimately turn out as bipolar depression for longer run.

Symptoms of bipolar disorder vary from individual to individual. Extreme fluctuations in mood and energy levels are the main symptoms of the disease which mainly causes psychological instability.

Bipolar disorder exists in children and adults, but the age at which bipolar disorder can initially be diagnosed remains controversial. Although bipolar-like symptoms might be very regular, dependably characterized bipolar I disorder is rare in pre-pubertal children. The requirement for an increased ability to conduct reliable trails in children and adults is a challenge to whose health care system ought to permit prominent interest and collaboration compared with other regions through clinical networks.

Treatment studies in bipolar depression

Monotherapy trails against placebo remain the highest quality design for determining efficacy in bipolar depression. If efficacy is demonstrated as monotherapy, new compounds might be tried in adjunctive-medicine placebo controlled trails. Adolescents, without long-term medication, might be particularly suitable for clinical trials requiring placebo controls. Switching to mania or hypomania might be the result of active treatment for bipolar depression. A few drugs like the tricyclic antidepressants and venlafaxine might be more likely to switch than others, yet this increased rate of switching may not be seen until around 10 weeks of treatment. Subsequently, 12-week trials against placebo are necessary to decide the risk of switch and to establish continuing effects. Careful assessments up to two months are required to ensure the patients who are failing to respond.

Long-term treatment

Long-term treatment is commonly required in bipolar disorder. Thus, trials should be done in a way where patients are treated in an episode with the medication of interest and afterward randomized to either proceed with the active treatment or with placebo. However, acute withdrawal of active medication after treatment response might artificially enhance effect size due to active drug withdrawal effects. Consequently, long periods of mood stabilization for 90 days might seem desirable, but protocol compliance may then be challenging to accomplish practically and certainly will make studies more difficult an expensive to conduct.

The medications such as mood stabilizers (ex: lithium), anticonvulsant drugs (ex: carbamazepine), antipsychotic drugs are used to treat the effects of bipolar disorder.

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