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MONOTHERAPY VS COMBINATION THERAPY IN BIPOLAR DISORDER: WHAT DOES THE EVIDENCE SAY?

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The treatment of bipolar disorder is complex and the overall results of monotherapy are not satisfactory. Combination and add-on studies suggest that in acutely manic patients who are partial responders to lithium, valproate or carbamazepine, a good strategy would be to add haloperidol, risperidone, olanzapine, quetiapine or aripiprazole. Adding oxcarbazepine to lithium is also a choice. For patients with refractory bipolar depression the only positive data concern adding lamotrigine to lithium. During the maintenance phase the combination of quetiapine plus mood stabilizer is superior to monotherapy in the prevention of manic and depressive recurrences in either manic, depressive, or mixed index episode over a period of 2-years. These combination studies appear to be the first to report prevention on both depression and mania regardless of the type of index episode. Discontinuation studies suggest that patients stabilized on combination therapy (olanzapine plus lithium/valproate or mood stabilizer plus ziprasidone) do worse when the antipsychotic is discontinued. The recently published BALANCE could neither reliably confirm nor refute a benefit of combination therapy compared with lithium monotherapy. Add on studies suggest that at least some strategies could be useful in patients with inadequate response to monotherapy. Overall, although there is no compelling data that combination treatment does better than monotherapy, the data suggest that those patients stabilized on combination treatment might do worse if shifted from combination, and patients refractory to monotherapy could benefit with add on treatment with olanzapine, valproate, an antidepressant or lamotrigine, depending on the index acute phase.

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