Use of guidelines in acute mania

Bipolar disorder can be misdiagnosed or underdiagnosed as both manic and depressive symptoms frequently occur in other psychiatric conditions.[1] Over the past few years, the range of treatment options available for use in bipolar mania has broadened. Atypical antipsychotics are now among the agents which have an established place in the management of acute mania. But are treatment decisions based on evidence or on traditions? In a survey done in 2007 by Perlis et al., 33% of clinicians reported that they routinely referred to all published guidelines when making decisions on treatment choice for bipolar mania.[2]

The World Federation of Societies of Biological Psychiatry (WFSBP) 2009 guidelines for acute mania is one of the guidelines used for the treatment of bipolar disorder. A literature search was done then reviewed by a team including acknowledged leaders in the field of bipolar disorder. They assigned categories of evidence(CE) to describe the supporting data, with category A requiring the most robust supporting evidence through to D which showed inconsistent results. They added a category E for agents that were not effective, and category F, where no evidence at all existed. Individual agents were given a recommendation grade(RG) based on two factors: the (CE) and the overall benefit/risk ratio. The highest combined RG is Grade 1, meaning an agent supported by CE "A", which also demonstrates a good benefit/risk ratio.[3]

The WFSBP 2009 guidelines recommend choosing monotherapy with a CE "A," and a RG "1" as first choice treatment of mania, in addition to considering the following: symptoms of mania and severity, patient's experience, history and preferences, evidence for efficacy as maintenance treatment if appropriate, modifying medical factors and specific safety profile, route and ease of administration, tolerability and efficacy in continuation therapy if indicated.[3]

Aripiprazole fulfils a CE "A" and a RG "1" for antimanic efficacy, making it one of the first choice options in the management. Subanalyses also supported efficacy in dysphoric/mixed states and psychotic mania.[3]

Without the use of guidelines, medical practice has been shown to vary considerably with some patients receiving substandard or inappropriate care.[4] While there is a need for guidelines to be reviewed and updated regularly as newer agents and more evidence become available, they certainly have a role to play in maintaining standards of care.

Categories of evidence (CE) and grade of recommendation (RG) for antipsychotics used in acute mania

Medication	*Category of evidence (CE)*	*Recommendation Grade (RG)*
Aripiprazole	A	1
Olanzapine	A	2
Quetiapine	A	2
Risperidone	A	1
Ziprasidone	A	1/2

References

1. *Andreasen NC, Black DW. Introductory Textbook of Psychiatry. 4th ed. Washington, DC: American Psychiatric Association; 2006.*
2. *Perlis RH. 2007. Use of treatment guidelines in clinical decision making in bipolar disorder: a pilot survey of clinicians. Curr Med Res Opin 23:467-475.*
3. *Grunze, et al. World Journal of Biological Psychiatry, 2009; 10(2): 85116.*
4. *Shaneyfelt TM et al. Are guidelines following guidelines? The methodological quality of clinical practice guidelines in the peer-reviewed medical literature. JAMA 1999;281:1900-5.*