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Correspondence on “An algorithm for pharmacological treatment of mania during hospitalisation”

We wish to extend our gratitude to Kessing et al. [1] for their recent contribution in proposing an algorithm for treating mania during hospitalisation. Their work has sparked valuable discussion within our academic circle, which is essential for advancing clinical practices.

The algorithm proposed by Kessing et al. [1] suggests initiating treatment with a combination of lithium and olanzapine for patients hospitalized during a manic episode. As we are deeply involved in developing both national and international guidelines, we are intrigued by the proposal of initiating combination therapy, notably departing from major guidelines that suggest initiating with monotherapy (allowing for an adjunctive benzodiazepine if necessary) and propose combination therapy as a second-line treatment [2]. In addition, there is no evidence from randomised trials conducted in either inpatient or outpatient settings supporting the superiority of initiating therapy with lithium-antipsychotic combination therapy over the antipsychotic alone [3]. Moreover, considering the plethora of drugs accessible for the treatment of mania, demonstrating similar efficacy but having different side effect profiles [4], we regard the proposed substitution of olanzapine with quetiapine in case of intolerability as peculiar since these two antipsychotics have similar side effect profiles, and also share a low binding affinity for the dopaminergic D2-receptor. This proposal could have been juxtaposed with an antipsychotic showing less propensity to induce sedation and metabolic side effects, and exhibiting a higher affinity for the dopaminergic D2-receptor while having a full antagonistic effect, e.g., risperidone. Furthermore, Kessing et al. (1) propose to augment treatment with either electroconvulsive treatment (ECT) or valproate, with the former being prioritised if improvement has not occurred within five days. We agree that ECT should be considered, but we suggest it should be applied only within the first week of treatment in extreme cases.

Considering the challenges with using lithium in hospitalised patients, we advocate for bridging acute and maintenance treatment through a two-phased approach. Accordingly, the treatment is commenced with an antipsychotic and, if necessary, with an adjunctive benzodiazepine, and, in select cases, with valproate to reduce initial symptoms. Not until the patient's condition allows for adequate food and fluid intake and collaboration in lithium monitoring lithium can be initiated.

Algorithm-based treatments have demonstrated efficacy in various mental disorders [5]. However, rather than a rigid, one-size-fit-all algorithm, we propose a more flexible framework that accommodates the diverse array of available treatments and takes into account patient factors like illness severity, comorbidities and patient preferences, albeit within a structure of defined clinical decision points at which symptoms and side-effects should be evaluated and new treatment options considered as necessary.

In conclusion, while we appreciate the contributions of Kessing et al. [1], we advocate for a nuanced approach to treatment algorithms that prioritises patient-centred care and acknowledges the complexities inherent in managing mania during hospitalisation.

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REFERENCES

1. 1. Kessing LV, Christensen EM, Krarup Larsen S. An algorithm for pharmacological treatment of mania during hospitalization. Dan Med J 2024;71(5):A08230525. Doi.10.61409/A08230525
2. 2. Yatham LN, Kennedy SH, Parikh SV et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) and international Society for Bipolar Disorders (ISBD) 2018 guidelines for the management of patients with bipolar disorder. Bipolar Disord. 2018;20(2):97-170. https://doi.org./10.10.1111/bdi.12609.
3. 3. Licht RW. Clinical applicability of results from drug trials in bipolar disorder – an attempt to shed light on a complex issue. In: Tohen M, Bowden C, Nierenberg AA, Geddes, J, eds. Clinical Trial Design Challenges in Mood Disorders. Elsevier; 2015:138-60
4. 4. Kishi T, Ikuta T, Matsuda Y et al. Pharmacological treatment for bipolar mania: a systematic review and network meta-analysis of double-blind randomized controlled trials. Mol Psychiatry. 2022;27(2):1136-44. https://doi.org/10.1038/s41380-021-01334-4
5. 5. Bschor T, Bauer M, Adli M. Chronic and treatment resistant depression: diagnosis and stepwise therapy. Dtsch Arztebl Int. 2014; 111(45):766-75; quiz 775. Doi. https://doi.org/10.3238/arztebl.2014.0766

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