In This Issue

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Treatments for Bipolar Depression

Two clinically important findings from the Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD) appear this month. Miklowitz et al. (p. 1340) found that intensive psychosocial intervention improves functioning in patients with bipolar depression. Compared to brief collaborative care, 30 sessions of cognitive behavior therapy, family-focused therapy, or interpersonal and social rhythm therapy produced greater improvements in relationships and life satisfaction, but not work/role performance or recreation. Goldberg et al. (CME, p. 1348) report that adjunctive antidepressant treatment does not improve the likelihood of recovery from bipolar depression with concomitant manic symptoms. Adding an antidepressant to a mood stabilizer for 145 patients resulted in recovery times similar to those for patients not taking an antidepressant, along with more severe manic symptoms at 3 months. Dr. Stephen Strakowski addresses the challenge of treating bipolar depression in an editorial on p. 1301.

Suicidal Behavior in Youth

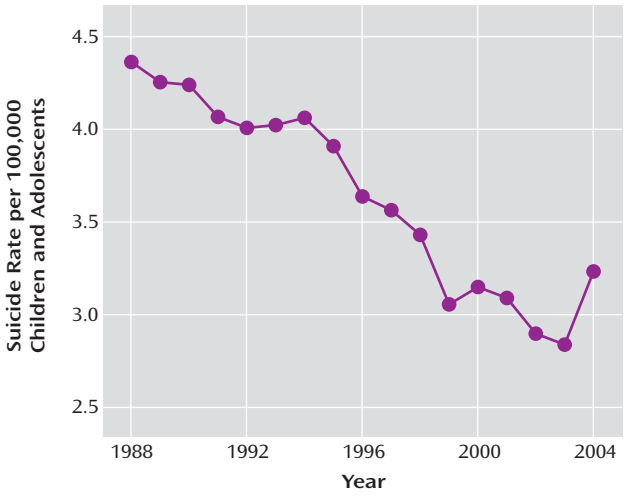
Suicides by children and adolescents increased as antidepressant prescriptions for them decreased after public health warnings in 2003–2004 about possible suicidality in pediatric patients taking selective serotonin reuptake inhibitor antidepressants (SSRIs). Gibbons et al. (p. 1356) demonstrate this inverse relationship in both the United States and the Netherlands. Melhem et al. (p. 1364) identified several precursors of suicidal behavior in the offspring of parents with mood disorders. The offspring began the study at an average age of 20 years old. During the 6-year follow-up, suicide attempts or serious suicidal thoughts were more common among offspring with a mood disorder or impulsive aggression and among those with a parent who had attempted suicide, had been sexually abused, or was depressed. Dr. James Leckman and Dr. Robert King provide a developmental perspective in an editorial on p. 1304.

Heart Disease and Depression

Lack of response to antidepressant treatment in depressed patients with a recent heart attack may signify a high risk of more cardiac events. De Jonge et al. (CME, p. 1371) assessed 70 patients treated for depression after suffering a myocardial infarction. Over 18 months, major heart problems occurred in 26% of the patients whose depression did not respond but only 7% of the responders. Otte et al. (p. 1379) report a possible genetic connection between heart disease and depression. The 5-HTTLPR polymorphism is part of a gene that influences intercellular serotonin transport. Among 557 cardiac patients, those with one or two copies of the 5-HTTLPR short allele had more depression, perceived stress, and urinary norepinephrine excretion than patients with two long alleles. Norepinephrine excretion is believed to reflect activity of the sympathetic nervous system, a possible link between heart disease and depression. Drs. Robert Carney and Kenneth Freedland discuss depression in cardiac patients in an editorial on p. 1307.

Aripiprazole in Schizophrenia

Hyperprolactinemia caused by antipsychotic drugs may respond to the addition of aripiprazole, an antipsychotic with a distinct pharmacological profile. Shim et al. (p. 1404) added aripiprazole to the haloperidol treatment of 26 patients with schizophrenia. Hyperprolactinemia was alleviated in 85%, compared to 4% for placebo. This normalization may be due to aripiprazole's high affinity for dopamine D_2 receptors. Using positron emission tomography, Mamo et al. (p. 1411) measured aripiprazole's binding to D_2 receptors. Therapeutic doses bound to more than 80% of available D_2 receptors in the striatum of patients with schizophrenia or schizoaffective disorder. For most other antipsychotics, occupancy is 60%–65%. The threshold for producing extrapyramidal side effects was 90% for aripiprazole, compared to 80% for other antipsychotics. The clinical pharmacology of aripiprazole is discussed by Dr. Robert Kessler in an editorial on p. 1310.



Youth suicides increased after the 2003 FDA advisory about pediatric SSRI suicidality risk (Gibbons et al., p. 1356)

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