Mania is a clearly defined condition that can present in different levels of severity, varying from the mild (hypomanic) to the florid, raging and psychotic. Only the mildest forms can be left untreated without risking harm to either the patient’s welfare, relationships and job, or to the well-being of those who are close to them (relatives, carers and mental health professionals). The milder forms may be accompanied by high levels of energy, productivity and creativity. But even these carry a risk of subsequently switching into a phase of depression and incapacity that might have been avoided by treatment of the preceding hypomania. Severe forms constitute a psychiatric emergency, demanding immediate control, including rapid tranquillisation with medication. Mania is one of the most insightless forms of mental disorder and for treatment to be very useful it must be not only effective but also acceptable to the patient, easy to use and not produce unpleasant side-effects (Cookson, 2007).

Mechanisms of antimanic actions of antipsychotics

It is thought that antipsychotics owe their antimanic effects mainly to blockade dopamine receptors, but additionally to some extent to blockade of noradrenaline at \( \alpha_1 \) receptors (as in the case of haloperidol), and blockade of histamine at \( H_1 \) receptors (causing sedation as in the case of chlorpromazine) (Peroutka & Snyder, 1980; Cookson, 2001). Some atypical antipsychotics (e.g. olanzapine, quetiapine, risperidone) share all these actions as well as being potent blockers of serotonin receptors, but are selective for sub-types of dopamine receptors; others (amisulpride) block only sub-types of dopamine receptors. Blockade of serotonin (5-hydroxytryptamine, 5-HT) at 5-HT\(_{2A}\) receptors is of unclear importance in mania. It cannot be assumed that drugs effective in schizophrenia will be effective in mania or vice versa.

Assessing the evidence

To prove that a drug is efficacious for a psychiatric condition, it is essential to show that it is superior to placebo, by conducting randomised double-blind placebo-controlled trials. The challenges of conducting such trials in mania have been met only in recent years, in the course of developing novel anticonvulsant and atypical antipsychotic treatments in trials since 1994. These trials are therefore providing answers to questions that have long remained unresolved about the treatment of
manic. Analysis of the results of these trials requires attention not only to the statistical significance of differences in special rating scales, but also to the size of the effect, and to the generalisability of results derived from highly selected patients in clinical trials centres to patients with mania in routine practice. It is also important to consider how drop-outs from the studies may have biased the interpretation of results.

### ‘Acute’ or ‘rapid’ tranquillisation

Treatment of mania may begin with control of the agitated patient by ‘acute’ or ‘rapid’ tranquillisation (Cookson, 2006). This involves an antipsychotic or a benzodiazepine or a combination of these, which may have to be given intramuscularly. Two placebo-controlled trials have investigated the response of patients with mania to intramuscular medication. The first showed improvement within 20 min and greater improvement with the antipsychotic (olanzapine 10 mg) than with the benzodiazepine (lorazepam 2 mg) over 2 h (Meehan et al., 2001). The second showed improvement with both lorazepam (2 mg) and aripiprazole (9.75–15 mg) but a trend towards greater improvement with lorazepam (Zimbroff et al., 2007). By contrast, intravenous valproate (20 mg/kg) was not associated with an improvement in mania within 2 h (Phrolov et al., 2004), suggesting a different mechanism of action.

Once calmed, most patients then require treatment over a period of 2–4 weeks with oral medication to achieve a more gradual further improvement.

### Monotherapy comparisons with placebo in mania

Table 1 lists the drugs that have been proved superior to placebo as monotherapy in such trials lasting 3–6 weeks. To grant a licence to market a drug for mania, most authorities, including the European Medicines Agency, require two trials performed at independent centres. Less well-proven, but probably effective, is clozapine (Suppes et al., 1999). In addition, one can conclude from negative trials that certain drugs do not improve mania; these are topiramate, gabapentin and lamotrigine.

### Lithium, valproate or antipsychotics for mania

The first drug to be proved efficacious in such trials was valproate (Pope et al., 1991; Bowden et al., 1994). Although Tables 2 and 3 show that the drug with most trials (not all published) proving efficacy is lithium, this drug is not usually sufficiently rapid in onset to be useful as monotherapy (Bowden et al., 1994). The trials of carbamazepine (Weisler et al., 2004, 2005) and aripiprazole (Sachs et al., 2006) are more recent. Tamoxifen, an anti-oestrogen, widely used for breast cancer, has antimanic properties that were first investigated because this drug shares with lithium and valproate the ability to block the intracellular second messenger system protein kinase-C, through which certain transmitters act (Zarate et al., 2007; Yildiz et al., 2008). Although haloperidol has been the favourite drug of clinicians for treating mania (Chou et al., 1996; Cookson, 2001), it is only in the course of comparative trials with risperidone (Smulevich et al., 2005) and quetiapine (McIntyre et al., 2005), and more recently aripiprazole, that haloperidol has been proved conclusively to be efficacious. Apart from haloperidol, most evidence for efficacy in mania now concerns the atypical antipsychotics olanzapine, risperidone, quetiapine, ziprasidone and aripiprazole. Questions arise about the relative efficacy of these drugs compared with either haloperidol or valproate, and whether they should be used initially as monotherapy or combined with valproate or lithium. Also, since treatment often needs to commence with rapid tranquillisation, and only three atypicals can be given intramuscularly (recently olanzapine and in some countries ziprasidone and aripiprazole), haloperidol remains widely used despite its propensity to cause unpleasant extrapyramidal side-effects.

Randomised placebo-controlled trials of atypical antipsychotics

The published trials are summarised in Table 2, using a ‘number needed to treat’ (NNT) analysis.
Table 2 Monotherapy with atypical antipsychotics in mania: numbers needed to treat (NNTs) in placebo-controlled parallel-group randomised trials

<table>
<thead>
<tr>
<th>Drug, mean daily dose and sample size</th>
<th>Duration (study)¹</th>
<th>Criterion of improvement</th>
<th>Drop-out rate, %</th>
<th>Difference from placebo</th>
<th>NNT (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Olanzapine, 14.9 mg: n=70 Placebo: n=64</td>
<td>3 weeks (Tohen, 1999)</td>
<td>50% reduction YMRS</td>
<td>29 0 49</td>
<td>25</td>
<td>4 (3–10)</td>
</tr>
<tr>
<td>Olanzapine, 16.4 mg: n=55 Placebo: n=60</td>
<td>4 weeks (Tohen, 2000)</td>
<td>50% reduction YMRS</td>
<td>34 4 65</td>
<td>22</td>
<td>5 (3–23)</td>
</tr>
<tr>
<td>Risperidone, 4.1 mg: n=134 Placebo: n=125</td>
<td>3 weeks (Hirschfeld, 2004)</td>
<td>50% reduction YMRS</td>
<td>36 8 43</td>
<td>19</td>
<td>6 (4–13)</td>
</tr>
<tr>
<td>Risperidone, 5.6 mg: n=146 Placebo: n=144</td>
<td>3 weeks (Khanna, 2005)</td>
<td>50% reduction YMRS</td>
<td>10 0.7 73</td>
<td>37</td>
<td>3 (2–4)</td>
</tr>
<tr>
<td>Risperidone, 4.2 mg: n=154 Placebo: n=140 Haloperidol, 8 mg: n=144</td>
<td>3 weeks (Smulevich, 2005)</td>
<td>50% reduction YMRS</td>
<td>7 4 48</td>
<td>15</td>
<td>7 (4–26)</td>
</tr>
<tr>
<td>Quetiapine, 560 mg: n=102 Placebo: n=101 Haloperidol, 5.2 mg: n=99</td>
<td>3 weeks, extended to 12 (McIntyre, 2005)</td>
<td>50% reduction YMRS</td>
<td>41 5 42</td>
<td>7</td>
<td>NSD</td>
</tr>
<tr>
<td>Quetiapine, 586 mg: n=107 Placebo: n=95 Lithium: n=98</td>
<td>3 weeks, extended to 12 (Bowden, 2005)</td>
<td>50% reduction YMRS</td>
<td>26.2 6.5 53.3</td>
<td>25.9</td>
<td>4 (3–8)</td>
</tr>
<tr>
<td>Aripiprazole, 27.7 mg: n=136 Placebo: n=132</td>
<td>3 weeks (Sachs, 2006)</td>
<td>50% reduction YMRS</td>
<td>9 9 53</td>
<td>21</td>
<td>5 (4–11)</td>
</tr>
<tr>
<td>Aripiprazole, 27.9 mg: n=125 Placebo: n=123</td>
<td>3 weeks (Keck, 2003a)</td>
<td>50% reduction YMRS</td>
<td>47 11 40</td>
<td>21</td>
<td>5 (4–11)</td>
</tr>
<tr>
<td>Ziprasidone, 80–160 mg: n=131 Placebo: n=66</td>
<td>3 weeks (Keck, 2003b)</td>
<td>50% reduction MRS</td>
<td>40 6.4 50</td>
<td>15</td>
<td>7 (4–153)</td>
</tr>
<tr>
<td>Ziprasidone, 80–160 mg: n=139 Placebo: n=66</td>
<td>3 weeks (Potkin, 2005)</td>
<td>50% reduction MRS</td>
<td>33 5.8 46</td>
<td>16.8</td>
<td>6 (4–33)</td>
</tr>
</tbody>
</table>

MRS, Mania Rating Scale; NSD, not significantly different; YMRS, Young’s Mania Rating Scale.

1. Studies are identified by first author.

of size of effect. Number needed to treat is calculated by dividing the difference in response rate between active drug and placebo into 100 and correcting to the next highest integer. It represents the number of patients who must be treated for one patient to achieve the defined response as a...
result of the pharmacological effect of the drug. In this instance the response was usually a 50% reduction in score on the 11-item Young’s Mania Rating Scale (YMRS; Young et al., 1978) – a scale that clinicians may find helpful for monitoring the progress of in-patients with mania. The NNT thus provides a measure of the size of effect that can be expected of the drug in a clinical situation, and it may be more clinically meaningful than the statistically more precise measure known as ‘effect size’. For a drug to be useful monotherapy as a first-line treatment in a common and severe disorder such as mania, the NNT for 50% improvement in severity should be in the order of 2–4 (Cookson et al., 2002).

Most studies were of 3 or 4 weeks duration and there was a placebo response rate of 19–43%, reflecting the effects of a variety of possible non-specific factors such as hospitalisation, extra medication with benzodiazepines or chloral allowed during the first 10 days, and bias in the raters. Drop-out rates for inefficacy ranged from 10 to 69% on placebo, and from 7 to 47% on active drug. Drop-out rates for adverse events (including suspected side-effects) ranged from 1.5 to 10% on placebo, and from 0 to 11% on atypical antipsychotic; on haloperidol the drop-out rates for lack of efficacy were 7 and 35%, and for adverse events 3 and 10%. In some studies patients dropped out at their own request with no clear reason. Total drop-out rates ranged from 15 to 79% on placebo, from 11 to 58% on atypical antipsychotic, and were 10 and 45% on haloperidol and 32% on lithium (Table 2). When making comparisons between groups, loss of a participant through drop-out is usually dealt with by carrying forward the rating at the last observed time before drop-out. This method of analysis (‘last observation carried forward’ or LOCF) introduces a bias against any drop-out rates, particularly for lack of efficacy. The mean modal dose was 5.4 mg/day. The rate of response on risperidone was highest in this study and the NNT was impressively low at 3. Extrapyramidal side-effects occurred in 35% of those on risperidone and 6% on placebo.

The study by Smulevich et al. (2005) had a slower dosing schedule, reaching a maximum of 6 mg/day by day 5. It also had a haloperidol comparator group with a mean modal dose of 8 mg/day (see below). Both active drugs were effective compared with placebo from day 7. By day 21 the NNT for 50% improvement was 7 for risperidone and 8 for haloperidol. Side-effects on risperidone included extrapyramidal symptoms (17%, compared with 40% for haloperidol and 95% for placebo).

**Quetiapine**

The two trials of monotherapy excluded patients with mixed mania. Significant efficacy at 3 weeks was observed in one study and in the combined analysis (Vieta et al., 2005). Patients who responded to quetiapine were usually receiving 600 mg/day or more. The dose was increased towards this over 5 days and then to a maximum of 800 mg/day. The most common side-effects were somnolence, dry mouth, weight gain and dizziness.

**Ziprasidone and aripiprazole**

Aripiprazole is the most recent atypical antipsychotic to be licensed in the UK for the treatment of mania. Ziprasidone is not yet licensed for use in the UK. In the studies of aripiprazole and ziprasidone, additional sedation with lorazepam in the relatively high doses of up to 6 and 8 mg/day respectively was permitted for the first 4 days, implying a feared lack of rapid efficacy and control of agitation. For both these drugs the main advantages may be in
long-term treatment when their side-effects on weight gain and metabolism are probably superior to other atypicals.

**Placebo-controlled monotherapy trials of haloperidol in mania**

Two monotherapy studies have included haloperidol as an active comparator (McIntyre et al., 2005; Smulevich et al., 2005) (Table 2). In the former, the haloperidol dose started at 4 mg/day and was adjusted to 2–12 mg/day by day 5. The NNT for 50% improvement by day 21 was 8. This is far larger than one would expect with the most commonly used antimanic drug of the previous decade. This might be because the mean dose of haloperidol was only 8 mg/day, or because the patients in the trial were in some ways not typical of routine clinic patients and more resistant to treatment.

A comparator group on haloperidol (up to 8 mg/day) was also included in the study by McIntyre et al. (2005). At 3 weeks the response rate on haloperidol, on a mean dose of only 5.2 mg/day, was 55% compared with 39% on placebo, giving an NNT of 5. Side-effects in the form of extra-pyramidal symptoms were much more common on haloperidol (59.6%) than on placebo (15.8%); for example, 33.3% of participants on haloperidol but only 5.9% on placebo experienced akathisia. Somnolence occurred more often with haloperidol (9.1%) than placebo (5%).

**Patterns of symptom improvement: sedative, antipsychotic or antimanic?**

It had been suggested that antipsychotics owe their effects in mania either to non-specific sedation (that is making the person drowsy or asleep), or to combating psychotic symptoms. However, this view fails to recognise that non-sedative dopamine-blocking drugs can improve mania (Cookson et al., 1981); these would now include aripiprazole and ziprasidone. In all studies of olanzapine and risperidone and in the combined analysis of quetiapine studies, the improvement in mania occurred in patients with or without psychotic symptoms. When individual items of the YMRS were analysed, drug treatment (with olanzapine, quetiapine and presumably the other antipsychotics) improved the whole range

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### Table 3 Monotherapy with other antimanic drugs in mania: numbers needed to treat (NNTs) in placebo-controlled parallel-group randomised trials

<table>
<thead>
<tr>
<th>Drug, mean daily dose and sample size</th>
<th>Duration (study)</th>
<th>Criterion of improvement</th>
<th>Response, %</th>
<th>Difference from placebo</th>
<th>NNT, mean (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valproate, n=20</td>
<td>3 weeks</td>
<td>50% reduction YMRS</td>
<td>45</td>
<td>9</td>
<td>3 (2–9)</td>
</tr>
<tr>
<td>Placebo, n=23</td>
<td>(Pope, 1991)</td>
<td></td>
<td>36</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Valproate, n=63</td>
<td>3 weeks</td>
<td>50% reduction</td>
<td>48</td>
<td>23</td>
<td>5 (3–14)</td>
</tr>
<tr>
<td>Placebo, n=73</td>
<td>(Bowden, 1994)</td>
<td></td>
<td>25</td>
<td>24</td>
<td>5 (3–22)</td>
</tr>
<tr>
<td>Lithium, n=35</td>
<td>6 weeks</td>
<td>CGI very much or much improved</td>
<td>49</td>
<td>1</td>
<td>NSD</td>
</tr>
<tr>
<td>Placebo, n=77</td>
<td>(Goldsmith, 2003)</td>
<td></td>
<td>48</td>
<td>18</td>
<td>6 (3–37)</td>
</tr>
<tr>
<td>Lithium, n=76</td>
<td>3 weeks</td>
<td>50% reduction YMRS</td>
<td>41.5</td>
<td>19.1</td>
<td>5 (4–16)</td>
</tr>
<tr>
<td>Placebo, n=103</td>
<td>(Weisler, 2004)</td>
<td></td>
<td>22.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carbamazepine ER, 952 mg/day, n=101</td>
<td>3 weeks</td>
<td>50% reduction YMRS</td>
<td>61</td>
<td>32</td>
<td>4 (3–5)</td>
</tr>
<tr>
<td>Placebo, n=115</td>
<td>(Weisler, 2005)</td>
<td></td>
<td>29</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

CGI, Clinical Global Impressions scale; ER, extended release; NNT, number needed to treat; NSD, not significantly different; YMRS, Young’s Mania Rating Scale.

1. Studies are identified by first author.
2. Lithium and valproate were dosed to achieve target blood levels.
3. DSM–IV manic or mixed.
Depression in mania

Depressive symptoms are very common during mania, and if amounting to a major depressive syndrome the condition is classified as mixed mania in DSM–IV (American Psychiatric Association, 1994). However, at least 12 forms of bipolar mixed states have been described and are likely to respond differently to treatments (Cookson & Ghalib, 2005). Some patients develop depressive syndromes after mania has improved (‘post-manic depression’), and this is described as a ‘switch’ into depression.

It has been suggested, but never proved, that classical antipsychotics may worsen or induce depression apart from their obvious extrapyramidal side-effects. For example, the use of perphenazine in mania without an anticholinergic drug has been associated with a high rate of development of depressive symptomatology, with accompanying signs of parkinsonism, particularly akinesia (Zarate & Tohen, 2004). Used in this way for schizophrenia, the older antipsychotics such as haloperidol are known to induce ‘akinetiform depression’, which is best viewed as an extrapyramidal side-effect (van Putten & May, 1978).

In the trials of atypical antipsychotics in mania, changes in symptoms of depression have usually been monitored. Thus, several antipsychotics have been shown to improve depressive symptoms alongside the improvement in mania; these include olanzapine (Tohen et al, 1999, 2000), risperidone (Khanna et al, 2005), quetiapine and aripiprazole. For example, in one study (Smulevich et al, 2005), depression scores (on the Montgomery–Asberg Depression Rating Scale, MADRS) fell more on risperidone than on placebo from week 1, and on haloperidol only from week 2.

Likewise, on both quetiapine and haloperidol, depression scores improved by day 21 more than on placebo (McIntyre et al, 2005). On the other hand, the switch rates into depression over 12 weeks were similar for haloperidol (8.1%) and placebo (8.9%), and tended to be lower for quetiapine (2.9%).

In patients with mixed mania, both depression (MADRS) and mania scores improved with treatment on olanzapine (v. placebo) used either as monotherapy (Baker et al, 2003) or as an adjunct to lithium or valproate (Baker et al, 2004).

Comparative RCTs of antipsychotics in mania without placebo: haloperidol v. atypicals

In a comparative trial in mania, in which additional lorazepam was permitted, risperidone showed similar efficacy to haloperidol or lithium (Segal et al, 1998).

In the largest randomised comparative study of haloperidol (Tohen et al, 2003), it was compared with olanzapine over 6 and 12 weeks. Among patients on haloperidol (up to 15mg/day, at week 6 mean dose 7mg/day), the proportion responding (50% reduction in YMRS score) by 6 weeks was 74%. The proportion showing syndromal remission (according to DSM–IV) was 44%, a figure similar to that found on haloperidol in consecutive admissions for mania by Rifkin et al (1994).

In patients with low levels of depressive symptoms at commencement on haloperidol, a total of 16.8% switched into depression within 12 weeks. However, as there was no placebo group, it is not clear whether this represents the natural history of the patients’ mood cycles, perhaps accelerated by effective treatment of mania, or some additional depressant effect of haloperidol. The switch rate among patients on olanzapine was non-significantly lower at 12 weeks (9.4%), although the switch to depression occurred significantly sooner with haloperidol (Tohen et al, 2003).

Thus, both olanzapine and quetiapine tended to produce a lower rate of switching into depression than did haloperidol. Both drugs (in the doses used) seemed also to lead to slower improvement in mania than did haloperidol. There is also the problem that haloperidol is prescribed in double-blind trials without a prophylactic anticholinergic drug, and is therefore liable to induce ‘akinetiform depression’, as described by van Putten & May (1978) in schizophrenia. When this occurs, some studies allow that an anticholinergic be added; others discontinue the patient from the trial.

These studies confirm the efficacy of haloperidol in reducing the symptoms of mania. None of the newer drugs has been shown to be more effective in this regard. Most (risperidone is the exception) appear to be less effective than haloperidol (Scherk et al, 2007). However, the doses used in the
trials for both the atypical antipsychotics and for haloperidol may be less than sufficient to produce optimal improvement. The clear superiority of the newer antipsychotics is that they produce far fewer extrapyramidal side-effects than haloperidol. For example, the very unpleasant side-effect of akathisia was reported by 30% of patients on haloperidol and 6% on olanzapine.

**Trials of atypical antipsychotics v. valproate in mania**

Olanzapine (Tohen et al, 2002, 2003; Zajecka et al, 2002), quetiapine (Del Bello et al, 2006) and haloperidol (McElroy et al, 1996) have been compared directly with valproate. The improvement was slightly faster and slightly greater with olanzapine (average doses 17.4 and 14.7 mg/day) than with semisodium valproate (1401 and 2115 mg/day). Interestingly, this superiority of olanzapine over valproate was seen only in patients with non-psychotic mania (Tohen et al, 2002). Olanzapine and valproate seemed equally effective in psychotic mania as they did in mixed mania.

A comparison of quetiapine with valproate in adolescents with mania also showed superiority of the antipsychotic (Del Bello et al, 2006).

Apart from speed of action, which is greater with antipsychotics, there are differences in side-effects. Olanzapine produced more somnolence (39% v. 21%, and 47% v. 29%), dry mouth (34% v. 6%), running nose (14% v. 3%), oedema (14% v. 0%), increased appetite (12% v. 2%) and weight gain (12% v. 7.9%, and 25% v. 10%), whereas valproate produced more gastrointestinal disturbance with nausea (29% v. 10%). Other side-effects of valproate and olanzapine occur but are too rare to have been detected in these trials.

The study of psychotic mania by McElroy et al (1996) indicated that if a sufficiently large dose of valproate (as semisodium valproate 20 mg/kg/day) is used from the start, a similar improvement occurs with valproate or haloperidol (0.2 mg/kg/day). However, the generalisability of this finding may be limited, since haloperidol did not show its usual rapid onset of effect. Furthermore, a second study of valproate loading by Hirschfeld et al (1999) showed a delay of about 48 h in onset of the antimanic effect with valproate.

**Monotherapy or combination treatment**

Since lithium and valproate are thought to have mechanisms of action other than receptor blockade, and probably reduce dopamine release, it may be expected that combination of an antipsychotic with lithium or valproate will produce a greater antimanic effect. This has been confirmed in trials in which an antipsychotic or placebo was given in addition to lithium or valproate. The effect is clearest when patients had previously shown only partial response to the lithium or valproate. The antipsychotics for which this added benefit has been shown are olanzapine, risperidone, quetiapine and aripiprazole, but not ziprasidone (Scherk et al, 2007). The contrary situation in which valproate or placebo has been added to an antipsychotic that patients were already receiving has been reported in only one study (Muller-Oerlinghausen et al, 2000).

Two earlier trials found carbamazepine together with a typical antipsychotic more effective than an antipsychotic alone (Klein et al, 1984; Moller et al, 1989). However, more recent trials failed to find a benefit of adding risperidone or olanzapine to carbamazepine (Yatham et al, 2003; Tohen et al, 2008); in the latter trial a high dose of olanzapine was given to counter the increased metabolism due to hepatic enzyme induction on carbamazepine.

**Conclusions**

All the atypical antipsychotics that have been studied in rigorous randomised controlled trials in mania have been shown to be superior to placebo. Of the commonly used drugs, only amisulpride has not been studied in this way.

The clinical trials of atypical antipsychotics in mania, sponsored by the pharmaceutical manufacturers, have answered many important questions about bipolar disorder that had been unresolved for 50 years. In particular, they have shown that antipsychotics generally have specific antimanic properties that are independent of sedation or psychosis. The speed of action and size of effect of antipsychotics makes them especially useful for control of emergent (hypomanic) symptoms and for acute tranquilisation in mania. None of the atypicals is more effective than haloperidol in reducing manic symptoms, but all produce fewer extrapyramidal side-effects than haloperidol and are therefore more acceptable to patients. In addition, some atypicals are associated with less post-manic depression, which can be another manifestation of extrapyramidal effects (akinetic depression). Most current guidelines for the treatment of bipolar disorder (e.g. Cookson, 2005; National Collaborating Centre for Mental Health, 2006) recommend an antipsychotic (preferably an atypical) either alone or as part of first-line treatment of mania.
Declaration of interest

J. C. has provided advice and lectures at meetings sponsored by the manufacturers of several atypical antipsychotics, including those mentioned in this article.

References


Atypical antipsychotics in bipolar disorder

EMIs

1 Theme: antipsychotics

Options
a Haloperidol
b Risperidone
c Olanzapine
d Quetiapine
e Aripiprazole
f Ziprasidone
g Clozapine.

Choose the drug:

i which has not yet been proved superior to placebo as monotherapy for mania
ii which has failed to show superiority to placebo when combined with lithium or valproate for mania
iii which is the most commonly used for acute tranquilisation
iv which showed the lowest NNT for response in mania.

2 Theme: anticonvulsants and lithium

Options
a Lithium
b Valproate
c Lamotrigine
d Carbamazepine
e Topiramate
f Gabapentin.

Choose the drug:

i which, other than lithium and valproate, was efficacious as monotherapy for mania
ii with which olanzapine failed to show efficacy in mania when it was added in combination
iii which, other than lithium, has been proved efficacious in severe (psychotic) mania
iv which has the most randomised placebo-controlled trials showing efficacy in mania.

3 Theme: symptoms and syndromes

Options
a Depressive symptoms
b Post-manic depression
c Akinetic depression
d ‘Switch’ from mania to depression
e The whole range of manic symptoms
f Agitation and psychotic symptoms.

Choose the symptom or syndrome:

i which is rated on the YMRS
ii which in counteracted by anticholinergic medication
iii which is most common during an episode of mania
iv which respond most clearly to olanzapine or quetiapine.
Atypical antipsychotics in bipolar disorder: the treatment of mania

John Cookson


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