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Treatment guidelines for acute mania

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Nowadays, psychiatrists have a wide range of treatment choices to treat acute mania. Introduction of atypical antipsychotics in the last decade has increased the range of available treatments. A good number of double-blind randomized clinical trials have supported the efficacy of several atypicals, (aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone) both as monotherapy and in combination with lithium or valproate. I.m. formulations of aripiprazole and olanzapine have also shown efficacy in agitated patients suffering acute mania. More recently, asenapine (both as monotherapy or combination) and paliperidone (only monotherapy so far) have shown positive results and may deserve a second-line option according to the most recent clinical guidelines. Atypicals are recommended over typical antipsychotics due to a better short-term side-effect profile. Although not yet proved in meta-analysis, several trials show that atypicals also have a lower risk of switch to depression.

More "classical" mood-stabilizers, such as lithium, valproate, and carbamazepine also share evidence-based antimanic properties. However, some data show lithium being slightly slower in his action, and carbamazepine not being advisable in combination (negative results with risperidone and olanzapine, and not tested with other atypicals). Clinical guidelines usually recommend monotherapy with an antimanic agent to treat mild or moderate mania, and combination treatment (usually with lithium or valproate plus an atypical antipsychotic) for more severe mania. However, combination treatment is usually the rule in clinical practice, especially when the patient is already taking a mood-stabilizer with antimanic action, taking for granted adherence has been demonstrated. Pros and cons of these different approaches will be discussed, as well as differences among antimanic treatment combinations. The use of benzodiazepines in the short-term, for managament of insomnia and psychomotor agitation is also a recommended strategy in most guidelines. For treatment resistant mania, there is some evidence supporting the use of clozapine, and ECT may also be a good option. Novel treatments, such as tamoxifen, with four small positive randomized clinical trials, suggest new mechanisms of action that could be further understood in next years.

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