Low Risk for Switch to Mania during Treatment with Sleep Promoting Antidepressants

Introduction

Antidepressive drugs have been widely prescribed in patients with bipolar disorder, despite clinicians’ concern about antidepressant-induced manic switch and the recommendations of practice guidelines. In a recent report on antidepressant use in bipolar disorder, the task force of the International Society of Bipolar Disorders (ISBD) stated that there is striking incongruity between the wide use of antidepressant drugs in bipolar disorder and the weak evidence base for their efficacy and safety. As the frequency and severity of antidepressant-induced manic switch appears to be greater in bipolar I disorder than bipolar II, it is recommended that antidepressants should only be prescribed to bipolar I patients as an adjunct to mood-stabilizing medications [1]. Although the true rate of antidepressant-induced manic switch in bipolar disorder is a controversial issue, there is a consensus that various antidepressants have differing potential for inducing such a switch. Most studies show that such a potential is higher for tricyclic antidepressants (TCAs) and venlafaxine than for selective serotonin reuptake inhibitors (SSRIs) and bupropion [2–5]. However, there is sparse evidence concerning the risk of switching with other antidepressants, such as trazodone, mirtazapine, and agomelatine. These 3 drugs are of special interest because they are used in bipolar patients not only for their antidepressant effect, but also to promote sleep. Low doses of these antidepressants, used for their hypnotic or sedative effects, were observed to cause mania only in patients with other risk factors for switching. There is no evidence for trazodone or mirtazapine and only sparse evidence for agomelatine, claiming that treatment with these antidepressants is related to an increased risk of switching to mania when administered in combination with a mood stabilizer.

Discussion

These findings suggest that low doses of trazodone and mirtazapine are safe in bipolar disorder, and should still be considered important alternatives to hypnotics when long-term pharmacological treatment of insomnia is necessary. It seems that these antidepressants and agomelatine can also be used safely in antidepressant doses when combined with a mood stabilizer.
pharmacological intervention (repetitive transcranial magnetic stimulation, rTMS) added to combined treatment with trazodone (200 mg/day), paroxetine, opipramol, amitriptyline, prazepam and methadone induced a depressive mixed episode in a further patient [21]. In one patient, a switch to hypomania was observed 3 weeks after the discontinuation of trazodone treatment [16]. Additionally, in 2 depressed patients with probable bipolar disorder, who did not respond to trazodone, a switch to mania was described after trazodone was abruptly replaced with imipramine [22]. There are no published cases describing a switch to mania or hypomania in patients who were treated with a mood stabilizer and trazodone as an antidepressant or a sleep-promoting treatment.

The average time until the onset of mania/hypomania after the start of treatment with trazodone was 14.7 days (median 7 days). 9 patients were described as switching to mania, 6 to hypomania, one to hypomania followed by a mixed episode, and one to a mixed depressive episode.

Mirtazapine

Mirtazapine is a noradrenergic and specific serotonergic antidepressant (NaSSA). Its mechanism of action involves noradrenergic alpha2-auto- and hetero-receptor blockade, enhancing noradrenaline (NE) and serotonin (5-HT) release, as well as blockade of serotonergic 5-HT2 and 5-HT3 and histaminergic H1 receptors [23]. The recommended dose of mirtazapine for the treatment of depression is 30–45 mg/day because, in this dose range, mirtazapine acts as an alpha2 antagonist and a 5-HT and NE disinhibitor. However, for the sleep-promoting effect, only the antagonistic action of mirtazapine on histaminergic H1 receptors is necessary. For this effect, low doses of mirtazapine of 3.75–15 mg/day are usually sufficient [6]. Development of a switch to mania or hypomania associated with mirtazapine treatment was described in 10 patients (Table 2).

3 of those patients were treated in monotherapy with the antidepressant dose (≥30 mg/day) of mirtazapine [24–26]. One of those patients may have been at higher risk of switching, because she was an older patient and the treatment with mirtazapine was started without a period of washout from fluoxetine (20 mg/day) [26]. In 2 further patients, treatment with antidepressant dose of mirtazapine was combined with treatment using SSRI [27, 28]. In one patient hypomania was observed after a dose of mirtazapine was increased to 60 mg/day [29]. Mirtazapine doses lower than 30 mg/day were found to be associated with switch to mania or hypomania in only 3 cases [30–32]. In the first of those patients, mirtazapine (15 mg/day) was added to a high dose (250 mg/day) of sertraline [32]. The second patient was an older patient, a 68-year-old woman with organic, post-stroke depression [30], and the third patient was a young patient, a 15-year-old girl [31]. In one older depressed patient, a switch to hypomania was observed 2 days after mirtazapine discontinuation, following 35 days of treatment [33]. There are no published cases that describe a switch to mania or hypomania in patients who were treated with a mood stabilizer and mirtazapine either in antidepressant or in a sleep-promoting dose.

The average time until the onset of mania/hypomania after the start of the treatment or a dose increase of mirtazapine was 15.7 days (median 7 days). 5 patients were described as switching to mania, 4 to hypomania, and one to a mixed depressive episode.
### Table 1  Reports of switching to mania or hypomania during treatment with trazodone.

<table>
<thead>
<tr>
<th>Study</th>
<th>Patient (age/gender/diagnosis)</th>
<th>Dose (mg/day)</th>
<th>Concomitant treatment</th>
<th>Time to switch onset (days)</th>
<th>Affective symptoms</th>
<th>Actions taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Escobar et al. 1980 [12]</td>
<td>middle-aged depressed man</td>
<td>400</td>
<td>none</td>
<td>14</td>
<td>mania</td>
<td>no data</td>
</tr>
<tr>
<td>Warren &amp; Bick 1984 [17]</td>
<td>57-year-old woman, major depression</td>
<td>150</td>
<td>none</td>
<td>7</td>
<td>mania</td>
<td>discontinuation of trazodone, treatment with lithium and thiothixene</td>
</tr>
<tr>
<td>Warren &amp; Bick 1984 [17]</td>
<td>25-year-old depressed woman</td>
<td>400</td>
<td>alprazolam 4 mg/day</td>
<td>28</td>
<td>mania</td>
<td>discontinuation of trazodone, treatment with chlorpromazine</td>
</tr>
<tr>
<td>Arana &amp; Kaplan 1985 [11]</td>
<td>66-year-old man, recurrent depression</td>
<td>100</td>
<td>8 days earlier discontinuation of desipramine 75 mg/day due to switch to mania</td>
<td>4</td>
<td>mania</td>
<td>discontinuation of trazodone</td>
</tr>
<tr>
<td>Arana &amp; Kaplan 1985 [11]</td>
<td>47-year-old depressed woman</td>
<td>400</td>
<td>2 weeks earlier discontinuation of desipramine 125 mg/day due to switch to mania</td>
<td>17</td>
<td>mania</td>
<td>discontinuation of trazodone</td>
</tr>
<tr>
<td>Theilman &amp; Christenbury 1986 [16]</td>
<td>33-year-old woman, major depression</td>
<td>300</td>
<td>none</td>
<td>21</td>
<td>hypomania</td>
<td>treatment with thioridazine and lithium</td>
</tr>
<tr>
<td>Knobler et al. 1986 [14]</td>
<td>82-year-old man, bipolar disorder</td>
<td>100</td>
<td>after 10 days of treatment with maprotiline,</td>
<td>14</td>
<td>mania</td>
<td>discontinuation of trazodone, treatment with haloperidol</td>
</tr>
<tr>
<td>Knobler et al. 1986 [14]</td>
<td>35-year-old woman, bipolar disorder</td>
<td>300</td>
<td>after 6 weeks of treatment with chlorimipramine, up to 250 mg/day, followed by treatment with imipramine, up to 300 mg/day, for another 6 weeks, 5 days of wash out</td>
<td>5</td>
<td>mania</td>
<td>discontinuation of trazodone, treatment with haloperidol</td>
</tr>
<tr>
<td>Knobler et al. 1986 [14]</td>
<td>84-year-old woman, major depression</td>
<td>300</td>
<td>none</td>
<td>56</td>
<td>mania</td>
<td>trazodone dose reduction to 150 mg/day</td>
</tr>
<tr>
<td>Zmitke 1987 [18]</td>
<td>58-year-old woman, major depression</td>
<td>150</td>
<td>none</td>
<td>7</td>
<td>mania</td>
<td>discontinuation of trazodone, treatment with haloperidol</td>
</tr>
<tr>
<td>Lennhoff 1987 [15]</td>
<td>53-year-old man, major depression</td>
<td>150</td>
<td>alcohol detoxification 17 days earlier, treatment doxepin 150 mg/day for 10 days, 3 days of wash out</td>
<td>4</td>
<td>hypomania</td>
<td>trazodone decreased to 50 mg/day, lithium carbonate 900 mg/day</td>
</tr>
<tr>
<td>Jabeen &amp; Fisher 1991 [13]</td>
<td>61-year-old man, severe depression</td>
<td>100</td>
<td>after 7 days of benzodiazepine withdrawal from chlordiazepoxide (7.5 mg/day) and temazepam (20 mg/day)</td>
<td>4</td>
<td>hypomania</td>
<td>discontinuation of trazodone, treatment with lithium, trazodone restarted at 200 mg/day, benzodiazepines were gradually withdrawn</td>
</tr>
<tr>
<td>Jabeen &amp; Fisher 1991 [13]</td>
<td>24-year-old woman, postnatal depression</td>
<td>150</td>
<td>none</td>
<td>4</td>
<td>hypomania</td>
<td>reduction of trazodone dose to 100 mg/day, after 7 days again increased to 150 mg/day</td>
</tr>
<tr>
<td>Jabeen &amp; Fisher 1991 [13]</td>
<td>70-year-old depressed man</td>
<td>100</td>
<td>none</td>
<td>28</td>
<td>transient hypomania</td>
<td>trazodone dose increase to 200 mg/day</td>
</tr>
<tr>
<td>Horiguchi &amp; Sai 2001 [19]</td>
<td>55-year-old man, major depression</td>
<td>50</td>
<td>fluvoxamine 50 mg/day added to stable treatment with trazodone and sulpiride 150 mg/day</td>
<td></td>
<td>hypomania</td>
<td>cessation of fluvoxamine</td>
</tr>
<tr>
<td>Hilleret et al. 2001 [20]</td>
<td>50-year-old man, bipolar disorder, right hemiplegia from birth with persisting motor deficiency</td>
<td>50</td>
<td>venlafaxine 300 mg, CPAP</td>
<td>4 weeks after start of CPAP</td>
<td>hypomania, mixed episode</td>
<td>continuation of CPAP, cessation of venlafaxine and trazodone, 6 days interruption of pharmacological treatment, treatment with valproic acid and levomepromazine</td>
</tr>
<tr>
<td>Rachid et al. 2006 [21]</td>
<td>39-year-old woman, refractory major depression</td>
<td>200</td>
<td>paroxetine 40 mg/day, opipramol 150 mg/day, amitriptyline 50 mg/day, prazepam 100 mg/day, methadone 7.5 mg/day rTMS</td>
<td>second week of rTMS treatment, depressive mixed episode</td>
<td>rTMS treatment was discontinued, treatment with valproic acid</td>
<td></td>
</tr>
</tbody>
</table>

*Not all details given in reports, rTMS = repetitive transcranial magnetic stimulation, CPAP = continuous positive airway pressure*
Table 2  Reports of switching to mania or hypomania during treatment with mirtazapine.

<table>
<thead>
<tr>
<th>Study</th>
<th>Patient (age/gender/diagnosis)</th>
<th>Dose (mg/day)</th>
<th>Concomitant treatment</th>
<th>Time to switch onset (days)</th>
<th>Affective symptoms</th>
<th>Actions taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>Soutullo et al. 1998 [32]</td>
<td>45-year-old, woman, MDE</td>
<td>15</td>
<td>sertraline 250 mg/day</td>
<td>4</td>
<td>hypomania</td>
<td>discontinuation of mirtazapine</td>
</tr>
<tr>
<td>De Leon et al., 1999 [30]</td>
<td>68-year-old, man, poststroke depression</td>
<td>15</td>
<td>after 10 days of washout from paroxetine 60 mg/day</td>
<td>3</td>
<td>hypomania</td>
<td>mirtazapine was discontinued, treatment with carbamazepine and haloperidol</td>
</tr>
<tr>
<td>MacCall &amp; Callender 1999 [33]</td>
<td>65-year-old, woman, MDE</td>
<td>30</td>
<td>none</td>
<td>2, after mirtazapine discontinuation after 35 days of treatment</td>
<td>hypomania</td>
<td>symptoms remitted after 6 weeks</td>
</tr>
<tr>
<td>Bhanji et al. 2002 [29]</td>
<td>43-year-old woman, MDE</td>
<td>60</td>
<td>after washout form venlafaxine 225 mg/day, topiramate 400 mg/day</td>
<td>3</td>
<td>hypomania</td>
<td>mirtazapine dose reduced to 45 mg/day, lithium carbonate 600 mg/day, topiramate 400 mg/day</td>
</tr>
<tr>
<td>Ng 2002 [27]</td>
<td>48-year-old depressed woman</td>
<td>30</td>
<td>fluoxetine 40 mg/day, alprazolam 1 mg/day</td>
<td>35</td>
<td>mania</td>
<td>discontinuation of fluoxetine, dose mirtazapine reduced to 15 mg/day and discontinued, valproate 2000 mg/day and clonazepam 0.5 mg/day at bedtime</td>
</tr>
<tr>
<td>Prost &amp; Abraham 2004 [28]</td>
<td>35-year-old woman, major depression</td>
<td>45</td>
<td>paroxetine 50 mg/day</td>
<td>56</td>
<td>hypomania</td>
<td>mirtazapine discontinued</td>
</tr>
<tr>
<td>Goyal &amp; Sinha 2008 [31]</td>
<td>15-year-old girl, severe depressive episode</td>
<td>22.5</td>
<td>none</td>
<td>14</td>
<td>mania</td>
<td>lithium 900 mg/day after discontinuing mirtazapine, haloperidol 5 mg/day</td>
</tr>
<tr>
<td>Liu et al. 2009 [26]</td>
<td>66-year-old women with late life depression</td>
<td>30</td>
<td>switch from fluoxetine 20 mg/day without a period of tapering-off, washout or cross-titration</td>
<td>3</td>
<td>mania</td>
<td>mirtazapine discontinued, treatment with valproate and low-dose risperidone</td>
</tr>
<tr>
<td>Habermeyer et al. 2010 [25]</td>
<td>51-year-old patient, major depression</td>
<td>45</td>
<td>none</td>
<td>5 after dose increase to 45 mg/day</td>
<td>mixed episode</td>
<td>mirtazapine discontinued, treatment with olanzapine and lithium</td>
</tr>
<tr>
<td>Basavraj et al. 2011 [24]</td>
<td>42-year-old woman, recurrent depressive disorder</td>
<td>30</td>
<td>after tapering down escitalopram 20 mg/day</td>
<td>14</td>
<td>mania</td>
<td>discontinuation of mirtazapine, treatment with lithium 900 mg/day, quetiapine 100 mg/day</td>
</tr>
</tbody>
</table>

MDE – major depressive episode

Agomelatine

Agomelatine is an antidepressant with a novel non-monoaminergic mechanism of action. It is a melatonin agonist at both melatonin receptors MT1 and MT2 and a serotonin antagonist at 5-HT2C receptors. The recommended dose of agomelatine to treat depression is 25–50 mg/day [34]. So far, it is unknown whether lower doses of agomelatine can be used to have only a sleep-promoting effect.

Recently, a switch to hypomania has been described in a 52-year-old female patient with the diagnosis of a recurrent major depressive disorder and comorbid panic disorder. The patient was treated with paroxetine 20 mg/day and trazodone 100 mg/day. As no improvement was observed after 1 month, the patient was admitted to hospital and the paroxetine treatment was shifted to agomelatine 25 mg/day, while 100 mg/day trazodone was maintained. After 4 days, the symptoms of hypomania occurred, and the agomelatine was discontinued 2 days later. One week after stopping the agomelatine treatment, the hypomanic symptoms remitted [35]. In a study that evaluated the efficacy of agomelatine in patients with bipolar I disorder, who were experiencing a major depressive episode during treatment with lithium or valpromide, there were 3 of 13 agomelatine and lithium treated patients who experienced manic or hypomanic episodes during an optional observation period of up to 46 weeks. Only one of those cases was rated as treatment-related [36].

Discussion

The described cases suggest that trazodone, mirtazapine, and agomelatine may induce manic symptoms in some patients. It happens most frequently at an early stage of treatment, which has been already noticed before [37]. The risk of a switch to mania or hypomania during treatment with trazodone or mirtazapine seems to be related, first of all, to the doses recommended for antidepressant treatment, administered without concomitant mood-stabilizer therapy. Low doses of these antidepressants, which can be used for their hypnotic or sedative effects, were observed to cause a switch to mania or hypomania only in patients with other risk factors for switching, such as treatment with other antidepressants, organic origin of the depressive symptoms, and being of an older or very young age. There is no evidence for trazodone and mirtazapine, and only sparse evidence for agomelatine [36], claiming that treatment with these antidepressants is related to an increased risk of
switch to mania when administered in combination with a mood stabilizer. This last finding of our review is supported by results of a recent study based on Swedish national registries, which examined the risk of antidepressant-induced manic switch in patients with bipolar disorder who were being treated either with antidepressant monotherapy or with an antidepressant in conjunction with a mood stabilizer. Although an increased risk of manic switch was found among patients with bipolar disorder on antidepressant monotherapy, the risk of manic episodes was not increased in the short or long term for patients treated with an antidepressant and a concurrent mood stabilizer [38].

To interpret the findings from the case reports reviewed by us, we have to take into account that switching to mania or hypomania related to treatment with trazodone, mirtazapine, or agomelatine may be more common, but underreported. The reason may be, for example, the relatively mild intensity of the hypomanic symptoms. In many described case reports, the described symptoms did not require any other action than stopping or reducing the dose of the administered antidepressant. Some authors even claimed that, in their experience, trazodone-induced hypomanic symptoms may be transient and that immediate withdrawal of trazodone may not always be necessary [13]. In some cases, switching to mania or hypomania may also be considered as resulting from illness progression [39] or stressful life events [40].

However, at least for mirtazapine, the low risk of a switch to mania was also found in studies that analyzed data from clinical trials. In a review of the initial clinical trials, manic symptoms associated with mirtazapine treatment were described in 3 (0.25%) of 1299 patients [41]. In a study that analyzed data from 2 clinical trials in patients with rapid-cycling bipolar disorder, the rate of treatment-derived mania/hypomania was 30.1% for SSRIs (highest for fluoxetine 42.1%, lowest for fluvoxamine 0%), 35.7% for bupropion, 30.6% for venlafaxine, 18.8% for nefazodone (a drug with similar pharmacological action to trazodone), and there were no cases of switching observed for mirtazapine [42].

All of these data suggest that low doses of trazodone and mirtazapine are safe in patients with bipolar disorder and should still be considered as important alternatives to hypnotics when long-term pharmacological treatment of insomnia is necessary. We believe that such a use of sleep-promoting antidepressants can even decrease the risk of switching, because the effective treatment of insomnia in bipolar patients improves the course of the disorder and quality of life. It also seems that trazodone, mirtazapine, and agomelatine can be used safely in antidepressant doses when combined with a mood stabilizer, especially in patients with bipolar II disorder.

Further work should clarify whether doxepin, the only sedative antidepressant approved by the FDA for the treatment of insomnia characterized by difficulty with sleep maintenance, can also be used to treat insomnia in bipolar disorder. Although TCAs are regarded as antidepressants with the highest risk of a switch to mania [43], there is no evidence to claim that low doses (3 and 6 mg) of doxepin, which show only antihistaminergic effects [6,44], are related to treatment-emergent mania or hypomania. Another interesting tricyclic antidepressant worthy of consideration as sleep-promoting drug is trimipramine. Trimipramine is regarded as an atypical antidepressant with antipsychotic and sedative properties. It has been studied in monotherapy in delusional depression [45] and in low dose to treat primary insomnia [46]. In some countries it is frequently used to induce sleep, also as adjuvant therapy to other drugs [47]. It is also noteworthy that the sleep-promoting effect may not be the most relevant feature for estimating the switch risk and choice of an antidepressant. In patients with bipolar disorder without sleep problems a dopaminergic antidepressant bupropion may be a reasonable first-line treatment. Bupropion has lower rates of manic switch than tricyclic and tetracyclic antidepressants and norepinephrine-serotonin reuptake inhibitors [1] and is especially useful, e.g., in bipolar disorder comorbid with attention-deficit/hyperactivity disorder [48].

Conflict of Interest

During last 3 years Adam Wichniak has received speaker honora rio and consultancies, congress and educational grants from Angelini, Lundbeck, Servier. Janusz K. Rybakowski has participated in advisory boards for AstraZeneca, Bristol-Myers Squibb, Eli Lilly, and Sanoﬁ-Aventis and has lectured for Janssen-Cilag, Lundbeck, and Servier.

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