Commentary

Rapid cycling, and its sibling mixed states, is a clinically significant and understudied variant of bipolar disorder. There is nevertheless controversy regarding the definition of rapid cycling.[1] The importance of rapid cycling reflects the differences in clinical features, course, and outcome, extensively covered in this review. It is a more severe variant, with greater morbidity and is often more treatment refractory. There is evidence that cycle length shortens with increasing number of episodes.[2] Furthermore, the authors cover data suggesting antidepressants, especially if used without mood stabiliser cover, can shorten cycle length[3] and induce rapid cycling. However the association of antidepressants with rapid cycling has been argued to reflect the depressive predominance in rapid cycling.[4 5] Opinion has swung to reflect greater caution with regard to the role of antidepressants. Rapid cycling can therefore be seen at least in part as a consequence of misdiagnosis and mistreatment. This suggests that shortening the latency to appropriate therapy can reduce the incidence of rapid cycling. The authors furthermore present the limited available data on differential response to therapy in this subgroup, particularly the lower rates of lithium response. Combination mood stabiliser strategies are widely used in practice, despite the absence of controlled efficacy data. Placebo controlled long term data is however currently restricted to lamotrigine.[6] There is a clear need for further prospective data on other potential agents such as the atypical agents[7 8] and combination strategies in this indication. This paper emphasises the importance of the recognition of rapid cycling, and highlights many significant clinical, prognostic, and therapeutic differentiators.

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