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Back to basics- a UK perspective on "Make lithium great again" Malhi et al

Joel Winstanley[1], Allan H Young[2], Sameer Jauhar[2]

1: South London and Maudsley National Health Service Foundation Trust, Bethlem Royal Hospital, London, United Kingdom

2: Department of Psychological Medicine, Centre for Affective Disorders, Institute of Psychiatry, Psychology and Neuroscience, King's College London, London, United Kingdom

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Corresponding Author; Sameer Jauhar Sameer.jauhar@kcl.ac.uk

Back to basics- a UK perspective

We agree in general with Malhi et al's forthright Editorial "Make Lithium Great Again", where they reiterate that, despite its clear efficacy and effectiveness, lithium remains under-utilised in the treatment of bipolar disorder. Possible reasons they give for this include prescription of second generation antipsychotics (SGAs), which may appear easier to prescribe, are marketed better, and may appear to require less monitoring. They also make the most pertinent point about clinical expertise being required for lithium prescribing.[1] We concur with these views and wish to add a UK perspective in addition to how this problem may be tackled-at least at the psychiatry trainee level.

In the UK, lithium monotherapy is recommended as first line long-term pharmacological therapy for bipolar disorder by the British Association for Psychopharmacology Guidelines.[2] Despite this, prescribing of lithium in the UK appears to be decreasing. A recent national (Scottish) linkage study found only 5.90% of patients on long-term pharmacological therapy for bipolar disorder received lithium monotherapy between 2009 and 2016. Prescription of lithium decreased each year and lithium was the fifth most prescribed medication for bipolar disorder after antidepressant monotherapy, antipsychotic monotherapy, hypnotic/anxiolytics and combined treatment with antidepressants & antipsychotics.[3] Most antidepressants have been off patent for a number of years and are not licensed by the European Medicines Agency (EMA) as treatments for bipolar disorder. They are thus unlikely to have been significantly marketed by pharmaceutical companies for this (non)indication. Furthermore, concerns regarding under-use of lithium predate the rise of SGAs for treatment of bipolar disorder. Ronald Fieve raised concerns regarding decreased lithium prescription in 1999.[4] This was prior to any SGAs gaining EMA approval for bipolar disorder. At that time there were concerns regarding marketing and promotion of antiepileptic medications, in a similar manner to how Malhi et al comment on SGAs.

Psychiatry training

A possible underlying factor that warrants consideration in the UK is psychiatry training. Concern has been raised previously regarding the lack of prominence of psychopharmacology in UK training.[5] It has been argued that psychiatric trainees need to follow up the care of people with bipolar disorder for at least 8-12 months, preferably more, and receive expert training from a psychopharmacology or lithium expert to be adequately trained in using lithium.[4] This is not possible in the current UK training scheme, where trainees typically work 6-month attachments before rotating. Lack of experience can lead to underuse of lithium as a first line treatment. This has the potential to compound itself as trainees who may not have gained sufficient experience with lithium during training and therefore prescribe it rarely, become Consultants responsible for the supervision and training of the next generation.

A way forward

Suggestions for improving UK psychiatry trainees' experience of psychopharmacology are not new.[5] UK trainees are required to complete a "long case" as part of psychotherapy competencies, where one patient must be seen for a minimum of 20 sessions under supervision by a specialist psychotherapist. Similar "psychopharmacology long cases" should be established. Trainees would follow patients prescribed medications such as lithium for a number of months under the supervision of an expert psychopharmacologist. This could be a way to increase psychopharmacology knowledge and better equip trainees to prescribe medications perceived as being complicated, such as lithium, more confidently and effectively. With adequate knowledge and experience it would be expected that prescription

of lithium in the UK would increase to better reflect its undoubted efficacy in bipolar disorder.

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Declaration of interests

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Conflict of interest

JW has no conflict of interest to report.

Back to basics- a UK perspective

AHY reports paid lectures and advisory boards for the following companies with drugs used in affective and related disorders: AstraZeneca (AZ), Eli Lilly, Lundbeck, Sunovion, Servier, LivaNova, and Janssen. No shareholdings in pharmaceutical companies. Lead Investigator for Embolden Study (AZ), BCI Neuroplasticity study and Aripiprazole Mania Study. Investigator initiated studies from AZ, Eli Lilly, Lundbeck, Wyeth, Janssen.

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