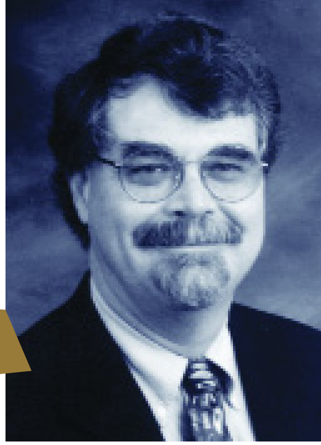
Current Psychiatry



From the editor

Treating bipolar disorder during pregnancy: No time for endless debate

To me, the main difference between MDs and PhDs* is that MDs—at some point—must stop gathering data and make decisions.

I once heard Dr. Albert (Mickey) Stunkard say that when he was a physician fellow at Stanford University's Center for Advanced Studies in the Behavioral Sciences he was at first energized—and a little intimidated—by the scintillating conversations taking place around him. Eventually, though, all the discourse reminded him of those long, philosophical discussions he and his classmates had had in their college dorms ("Well, on one hand you have communism, and on the other hand you have fascism. . . ").

Physicians do not have the luxury of endless debate. At some point, we need to do something or else let our patients die of old age while waiting. One issue about which I have had to make decisions over the years—and which has troubled me the most—is whether to treat pregnant patients with psychotropics. Generally, I try to avoid using drugs in these cases, but sometimes I decide that the mother's need for drug therapy outweighs the potential risks to her offspring.

Dr. Lori Altshuler and colleagues' article in this issue (page 14) is the best summary I have seen of what is known about the risks of using psychotropics in pregnant bipolar women. Each time I treat a woman with bipolar disorder, I will remember this discussion and the algorithm these authors suggest for making therapeutic decisions.

This excellent article may not be the final word on the subject. It can, however, help us with an important clinical decision we often have to make—and that is what CURRENT PSYCHIATRY is all about.

Randy Hillard, MD

* PhD clinical psychologists are probably more like MDs in this regard.