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Your Patient Is Depressed: Could It Be Bipolar Disorder?

Announcer:
This is ReachMD. Welcome to this Medical Industry Feature titled, “Your Patient is Depressed: Could it Be Bipolar Disorder?" This program was sponsored by Allergan prior to its acquisition by AbbVie and is intended for healthcare professionals. Your host is Dr. Jennifer Caudle.

Dr. Caudle:
Two studies published in 2005 reported that approximately a quarter of patients with depression in a primary care setting may actually have bipolar disorder.[1,2] Also, a significant number of patients with bipolar disorder are receiving a misdiagnosis of unipolar depression.[3] Nationally, approximately 43% of family physicians are providing mental health care;[4] therefore the need for faster recognition and more accurate management of patients with bipolar depression is absolutely critical.

This is ReachMD and I am your host, Dr. Jennifer Caudle. And here with me today is Dr. Roger McIntyre, Professor of Psychiatry and Pharmacology at the University of Toronto and Head of the Mood Disorders Psychopharmacology Unit at the University Health Network. Dr. McIntyre is the lead author of a recently published article in the journal Current Medical Research and Opinion, entitled “Bipolar Depression: The Clinical Characteristics and Unmet Needs of a Complex Disorder.” This topic will be the focus of our discussion today. Dr. McIntyre, welcome to the program.

Dr. McIntyre:
Thank you for having me, Dr. Caudle. Nice to be here.

Dr. Caudle:
So, Dr. McIntyre, let’s start with a clear understanding of the factors behind the misdiagnosis of bipolar disorder. So, first off, how often is this happening, and why?

Dr. McIntyre:
Well, misdiagnosis is the rule rather than the exception, and I like to remind colleagues of the rule of 25%, that about 25% of people who present with depression in primary care actually have bipolar.[1,2] It’s approximately 25%. And there are many, many reasons why we miss the diagnosis, particularly at the first visit, and those reasons can be summarized really, in fact, as follows. Firstly, bipolar disorder is an illness wherein depressive symptoms and episodes not only predominate, but they’re also the initial presentation of the illness.[5] So, the clinician meeting with the patient meets with the patient when they’re depressed, and so that often, in fact, biases the clinician towards nonbipolar diagnoses.

Secondly, which is also worth noting, is that many individuals who have bipolar disorder also have other concurrent conditions, both other mental disorders and medical disorders.[6,7]

For example, it’s not uncommon for someone with depression to visit the healthcare provider who also has symptoms of anxiety disorders or substance use disorders, or attention deficit hyperactivity, just to name a few.[6] Moreover, these disorders often co-occur with other well-known medical disorders like obesity,[8] like migraine[9] and cardiovascular disease,[10] and taken together, these concurrent conditions often obscure the underlying diagnosis of bipolar.[11] The takeaway is that for every person we see who has depression, no matter what clinical setting we’re in, we have to be thinking about possibilities of bipolar disorder, given the extraordinary rate of misdiagnosis taking place.

Dr. Caudle:
And what kinds of impacts could a delayed diagnosis or even an ongoing misdiagnosis have on patients?

Dr. McIntyre:
There are many implications for the person who's been affected by the condition. First of all, bipolar disorder is a highly impairing condition, and what we've learned is that the depressive symptoms and episodes disproportionately account for the morbidity and reduction in overall function that's associated with bipolar disorder.[12-20] In other words, the person has ongoing symptoms that are propagating their decreased quality of life and function. Second, we know that individuals who are not appropriately diagnosed are at increased risk of suicide.[21] Bipolar disorder, in many studies, has one of the highest rates of suicide in all of psychiatry, and we know that suicidal behavior and completion disproportionately occurs when people are experiencing depressive symptoms.[22,23]

Dr. Caudle, what I've seen so often in clinical practice, and I see it weekly in my office, is too often patients are misdiagnosed as having, for example, major depression, and they're prescribed conventional antidepressants.

Not only are conventional antidepressants not FDA approved for bipolar disorder, but in many cases, conventional antidepressants, especially as monotherapy, actually could be hazardous to some persons with bipolar and can contribute to greater instability of their illness.[24-26] So, taking together the overall illness burden, the morbidity, the risk for mortality, as well as really misadventures with antidepressants, remains very high in people who have, in fact, not been diagnosed accurately or timely.

Dr. Caudle:
So, given the fact that a timely and accurate diagnosis is essential for these patients, what are some of the common characteristics that primary care physicians should look for? And what tools or strategies can we use to help get us there?

Dr. McIntyre:
Clinicians, when meeting with individuals who have presented to them with depressive symptoms, should, in fact, begin the process of screening for bipolar disorder. One of the best-known self-screening instruments for bipolar is noted as the Mood Disorder Questionnaire, this screener has modest sensitivity but reasonably good specificity.[3,27] Translating that – what that means is if the person is screening negative, you've got a pretty good level of confidence they likely don't have bipolar disorder.

If they're screening positive, that doesn't diagnose bipolar – that invites the need to take a careful history, and what I'm paying close attention to, Dr. Caudle, in these types of situations, is what's the age at onset of this patient? How many episodes of illness have they had? What's the phenomenology? Is the patient experiencing more increase in appetite and sleep – hyperphagia, hypersomnia respectively? What's the family history? Is there family loading, if you will, for mental disorders?

Why I'm asking these questions is that the adult who has bipolar disorder, who's in my office presenting with depression, is more likely to report earlier age at onset relative to major depression,[28] more episodes,[28] more hyperphagia,[28] more hypersomnia,[28] and particularly, a higher family history of mental illness.[28] Let's not forget their history with antidepressants, going back to what I said a moment ago, it's very common for persons to report to us that have been exposed to multiple conventional antidepressants and they just haven't been sufficient.[29] That's another factor that suggests possibly this person has bipolar disorder.

So, take a very, very careful history following an appropriate screening. Be also vigilant for what I call diagnostic transition or conversion. In other words, remember a moment ago, Dr. Caudle, I mentioned that depressive symptoms and episodes, they really herald the onset of this illness, and many patients have not had mania at this point in time.[5] So, always be vigilant for the possibility of bipolar, even in those patients you've got a high level of confidence the diagnosis is major depression, especially when they start to not respond to antidepressants or have reactions like worsening of anxiety, irritability, or agitation when taking an antidepressant.

Dr. Caudle:
For those of you who are just joining us, you're listening to Reach MD and I'm your host, Dr. Jennifer Caudle. Today, I'm speaking with Dr. Roger McIntyre about the importance of considering bipolar disorder among patients who present with depressive episodes in the primary care setting. So, Dr. McIntyre, now that we've covered some key diagnostic considerations, let's shift over to the therapeutic landscape for bipolar depression. What treatment options are currently available for bipolar disorder to address both the manic and depressive symptoms?

Dr. McIntyre:
I would encourage my colleagues who are really tuning into this program to consult an evidence-based guideline. For example, the most recent updated version of the Florida Medicaid Guidelines provides up-to-date guidance as to the evidence-based treatments for both mania and depression in the acute and the maintenance phase.[26] The therapeutic options for bipolar disorder are varied and

include a long list of treatments, frankly, that are approved by the FDA for acute mania, but relatively few treatments are approved for bipolar depression. We have even fewer agents that are approved for both mania and depression, and clinicians should familiarize themselves with what those agents are. Moreover, clinicians should familiarize themselves with the tolerability profiles of medications as some are more likely than others to be associated with side effects like weight gain and metabolic problems, particularly problematic in this population. But, again, I would encourage my colleagues to consult the Florida Medicaid Guidelines, or what's listed on the FDA website.[26,30]

Dr. Caudle:
And what can we as clinicians do to improve outcomes and treatment adherence for these patients? Are there some insights that help you guide clinicians towards best practices here?

Dr. McIntyre:
It's a wonderful question and it's such an important part of the art of managing bipolar disorder.

Throughout my history of having the privilege of meeting families and people who are affected by bipolar, I've learned that there's no more powerful ingredient than forming a robust, therapeutic alliance with patients. That sets the groundwork, if you will, for psychoeducation, not just around the diagnosis, but its treatment. The provision of accurate information is desperately needed to improve patients' both diagnostic and therapeutic literacy. The other part is I think we need to have a candid conversation about what's reasonable and consensually agreed-upon therapeutic objectives. It's important we articulate what those objectives are in the short-term and the long-term and work with patients collaboratively to achieve those objectives. It's essential to pick treatments that are evidence-based, FDA-approved, and recommended by best practices and guidelines, and this is important because too often patients receive treatments that are discordant with best practices.

Finally, I really, really think it's important to measure patients' outcomes, measure their symptoms, measure their outcomes, and let's not forget about health below the neck. In other words, taking good care of their physical health, not just their mental health. This means paying close attention to their body mass index, their weight, their diet, their lifestyle, et cetera. It's all part of taking good care of our patients. I would like to end that, if I could, by just articulating that too often – and part of this is an access and availability issue – patients are not, in fact, receiving manual-based psychotherapy, and we've learned that in many cases, psychotherapy, like cognitive therapy or mindfulness, can help some patients improve their overall level of function and well-being.[31-34] So, as you can hear, it's a very multidimensional, eclectic mix of treatments, and in many cases these treatments are offered for multiple years, if not lifetime, for many of our patients we encounter.

Dr. Caudle:
So, Dr. McIntyre, before we wrap up today's discussion, can you summarize a few takeaways on how we can better manage our patients with bipolar depression?

Dr. McIntyre:
Key takeaways of this are that clinicians should be aware that approximately 25% of patients with depression in primary care are, in fact, experiencing bipolar.[1,2] These are patients who are presenting with depression. Secondly, be aware of the fact that too often bipolar disorder's misdiagnosed.[3] Persons with a diagnosis often wait many years before the correct diagnosis is provided,[11] and too often, these patients are experiencing multiple episodes, causing terrible distress, impairment, and leaving them at risk of mortality. Finally, the importance of diagnostic timeliness and accuracy is underscored by the fact that too often patients are not diagnosed appropriately and receive antidepressants as monotherapy, often to their peril, not benefitting them, and in many cases could worsen their overall outcome.[24-26] So, thinking about bipolar, be aware of misdiagnosis risks and be very cautious with the treatments that are provided.

Dr. Caudle:
Well that is a great set of considerations for us to think on as we come to the end of today's program, and I want to thank you, Dr. McIntyre, for joining me to share key insights from the article you recently co-authored on bipolar depression. It was wonderful having you on today's program.

Dr. McIntyre:
Thank you so much for having me and covering this very interesting topic. I appreciate it.

Announcer:
This program was sponsored by Allergan prior to its acquisition by AbbVie. For access to this and other episodes identifying characteristics and discussing unmet needs of bipolar depression visit ReachMD.com. And to find the complete publication of Dr. Roger

McIntyre's co-authored article, visit the online journal, *Current Medical Research and Opinion*. This is ReachMD: Be Part of the Knowledge. Thank you for listening.

References

1. Hirschfeld RMA, Cass AR, Holt DCL, et al. *J Am Board Fam Pract*. 2005;18(4):233–239.
2. Olfson M, Das AK, Gameroff MJ, et al. *Am J Psychiatry*. 2005;162:2146–2151.
3. Hirschfeld RMA, Lewis L, Vornik LA. *J Clin Psychiatry*. 2003;64:161–174.
4. Xierali IM, Tong ST, Petterson SM, et al. *J Am Board Fam Pract*. 2013;26(2):114–115.
5. Mitchell PB, Goodwin GM, Johnson GF, et al. *Bipolar Disord*. 2008;10:144–152.
6. Merikangas KR, Akiskal HS, Angst J, et al. *Arch Gen Psychiatry*. 2007;64: 543–552.
7. Roshanaei-Moghaddam B, Katon W. *Psychiatr Serv*. 2009;60:147–156.
8. Goldstein BI, Liu SM, Zivkovic N, et al. *Bipolar Disorder*. 2011;13(4):387–395.
9. McIntyre RS, Konarski JZ, Soczynska JK, et al. *Psychiatr Serv*. 2006;57:1140–1144.
10. Fiedorowicz JG, Palagummi NM, Forman-Hoffman VL, et al. *Ann Clin Psychiatry*. 2008;20: 131–137.
11. Berk M, Hallam K, Lucas N, et al. *Med J Aust*. 2007;187:S11–4.
12. Baldessarini RJ, Salvatore P, Khalsa H-MK, et al. *J Affect Disord*. 2009;126(1–2):299–302.
13. Judd LL, Akiskal HS, Schettler PJ, et al. *Arch Gen Psychiatry*. 2002;59:530–7.
14. Post RM, Denicoff KD, Leverich GS, et al. *J Clin Psychiatry*. 2003;64:680–90.
15. Joffe RT, MacQueen GM, Marriott M, Young TL. *Bipolar Disord*. 2004;6:62–6.
16. Paykel ES, Abbott R, Morriss R, Hayhurst H, Scott J. *Br J Psychiatry*. 2006;189:118–23.
17. Kupka RW, Altshuler LL, Nolen WA, et al. *Bipolar Disord*. 2007;9:531–5.
18. Forty L, Jones L, Jones I, et al. *Bipolar Disord*. 2009;11:82–8.
19. Baldessarini RJ, Salvatore P, Khalsa H-MK, et al. *Bipolar Disord*. 2010;1293):264–70.
20. Altshuler LL, Gitlin MJ, Mintz J, Leight KL, Frye MA. *J Clin Psychiatry*. 2002;63:807–11.
21. Berk M, Dodd S. *Med Hypotheses*. 2005;65:39–43.
22. Miller S, Dell'Osso B, Ketter TA. *J Affect Disord*. 2014;169(Suppl 1):S3–S11.
23. Valtonen HM, Suominen K, Mantere O, et al. *J Affect Disord*. 2007;97:101–107.
24. Pacchiarotti I, Bond DJ, Baldessarini RJ, et al. *Am J Psychiatry*. 2013;170:1249–62.
25. Viktorin A, Lichtenstein P, Thase ME, et al. *Am J Psychiatry*. 2014;171:1067–1073
26. McIntrye RS. 2019-20 Florida Best Practice Psychotherapeutic Medication Guidelines for Adults. Available from: http://www.medicaidmentalhealth.org/ Accessed 14 February 2020.
27. Hirschfeld RMA, Williams JB, Spitzer RL, et al. *Am J Psychiatry*. 2000;157:1873–1875.
28. Moreno C, Hasin DS, Arango C, et al. *Bipolar Disord*. 2012;14(3):271–282.
29. Hirschfeld RMA. *J of Affect Disord*. 2014;169(S1):S12–S16.
30. Butler M, Urosevic S, Desai P, et al. *Comparative Effectiveness Review No. 208*. Rockville, MD: Agency for Healthcare Research and Quality (US); 2018.

31. Colom F, Vieta E, Martinez-Aran A, et al. *Arch Gen Psychiatry*. 2003;60:402–407.
32. Colom F, Vieta E, Sánchez-Moreno J, et al. *Br J Psychiatry*. 2009;194:260–65.
33. Scott J, Paykel E, Morriss R, et al. *Br J Psychiatry*. 2006;188:313–20.
34. Frank E, Kupfer DJ, Wagner EF, et al. *Arch Gen Psychiatry*. 1991;48: 1053–59.
35. Viktorin A, Lichtenstein P, Thase ME, et al. *Am J Psychiatry*. 2014;171:1067–1073