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MRCPsych General Adult Psychiatry

Bipolar 4

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Objectives

To develop an understanding of:

- the course and prognosis of Bipolar disorder.
- risk factors for poor outcomes.

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Expert Led Session

Bipolar Affective Disorder:

Course & Prognosis

- This presentation is based on an APT article:

Saunders KEA, Goodwin GM (2010). The course of bipolar disorder. Advances in Psychiatric Treatment. 16 (5) 318-328.

- The paper summarises dozens of articles which are referenced in the original for personal study.

What constitutes Bipolar?

- This effects how we think about course, treatment and prognosis
    - Studies have generally only dealt with traditional Manic-Depression (Bipolar 1)
    - There is less information about other types

- We must be clear which concept is meant when answering patients/in exam
    - Prevalence is 1% (RCPsych – using conventional concept)

Time course & intensity

- Patients generally have further episodes
    - Only 16% have definitive recovery
    - Relapsing/remitting pattern
    - Length of episodes varies greatly
        - » Mania mean episode average - 6 weeks
        - » Depression - 11 weeks
        - » Mixed affective state - 17 weeks

Time Course & intensity

- x2 frequency over uni-polar
- Time between cycles shortens for first three, then stabilises
- Risk of suicide 1% annually (Baldessarini 2006)
- Polarity of onset may convey prognostic advantages:
    - unipolar mania at presentation = best prognosis.

Lifetime comorbidity of DSM–IV/CIDI bipolar disorder with other DSM–IV/CIDI disorders

	Any bipolar disorder, %	Bipolar I disorder, %	Bipolar II disorder, %	Subthreshold bipolar disorder, %
Any anxiety disorder	74.9	86.7	89.2	63.1
Panic disorder	20.1	29.1	27.2	12.1
Post-traumatic stress disorder	24.2	30.9	34.3	16.5
Generalised anxiety disorder	29.6	38.7	37.0	22.3
Social phobia	37.8	51.6	54.6	24.1
Obsessive–compulsive disorder	13.6	25.3	20.8	4.3
Attention-deficit hyperactivity disorder	31.4	40.6	42.3	23.0
Oppositional defiant disorder	36.8	44.4	38.2	32.8
Conduct disorder	30.3	43.8	18.6	28.9
Alcohol dependence	23.2	38.0	19.0	18.9
Drug dependence	14.0	30.4	8.7	9.5
One comorbid diagnosis	12.7	8.1	7.0	17.1
Two comorbid diagnoses	9.4	3.4	2.9	14.7
Three or more comorbid diagnoses	70.1	86.2	85.8	56.7
CIDI, Composite International Diagnostic Interview.				
Adapted from Merikangas *et al* (2007).				

Types & changes in type

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- 40% depressed on 1st presentation
- Switch to bipolar higher in the young
  - 1% per year >30 y/o
- Conversion from Bipolar II just 7.5% in 10 years
  - Course is similar but without full manic episodes (>4 days, etc)
- Rapid cycling (>4 episodes/yr) affects 12-24%

Treatment response

- Aim is to reduce frequency and intensity
    - Complete remission is unlikely
- 30-50% respond to lithium/anticonvulsant when in the manic phase
    - Similar rate with atypical antipsychotics
- 30% respond to lithium/anticonvulsant in depression
    - 50% with lamotrigine
    - >50% with quetiapine

Inter-episode symptoms

- Sub-syndromal 15% of the time and minor symptoms for a further 20% of the time

- Cognitive functioning can be deficient
    - Reduced general quality of life

Physical comorbidities

- Poor glucose regulation more common
- Up to 35% obese
- Thyroid disorders 9% (even in lithium naïve)
- Migraine more common

Pregnancy

- Relapse generally said to be 50%
    - 27% of women with bipolar admitted in 1st year post-partum
- Non-concordance increases relapse

Mortality

- SMR overall = 1.6
- For suicide risk in bipolar SMR = 12.28
- Medication reduces mortality
- Lithium shown to decrease suicide

Key Points

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- Age at onset is late teens to twenties on average
- 40% of individuals are initially diagnosed with unipolar depression
- Bipolar I disorder remains a relatively rare, frequently psychotic disorder: significant inter-episode cognitive impairment may exist in the absence of an affective episode
- Bipolar II disorder is a stable diagnosis, now made more frequently and associated with a chronic course in which depression is usually the predominant polarity

Key Points 2

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- Bipolar-spectrum diagnoses reflect the prevalence of mild elated states **but** carry uncertain implications for treatment
- Long treatment delays are common (1/3 wait 10 years)
- Childbirth is associated with high rates of relapse

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Questions or Comments?

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MCQs

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MCQs

1. Using the broadest definition, prevalence of bipolar spectrum disorders in the general population has been estimated as high as:

   A. 0.8%
   B. 1.2%
   C. 3.9%
   D. 8.3%
   E. 10.4%

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MCQs

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MCQs

2. Age at onset of bipolar disorder:

   A. Has little prognostic relevance
   B. Is not a heritable trait
   C. Has been observed to be higher in more recent studies
   D. Is higher in women than men
   E. Has implications for clinical course

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MCQs

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3. Individuals with bipolar disorder:

   A. Rarely receive a diagnosis of unipolar depression
   B. Have longer episodes of mania than depression
   C. Commonly have psychiatric co-morbidities
   D. Have fewer depressive episodes than those with unipolar depression
   E. Show poorer prognosis if they have predominantly manic episodes

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4. When compared with bipolar I disorder, bipolar II disorder:

   A. Is associated with better inter-episode functioning
   B. Is similar and frequently develops into bipolar I disorder
   C. Is associated with fewer affective episodes overall
   D. Has a less chronic course
   E. Has a significantly higher age at onset

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4. When compared with bipolar I disorder, bipolar II disorder:

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5. Regarding the treatment of bipolar disorder:

   A. Delays in initiating treatment are rare
   B. The vast majority of patients respond to lithium or an anticonvulsant treatment when in a manic phase
   C. Quetiapine leads to remission in over 50% of patients in the depressive phase
   D. There are a number of well-tolerated treatments that are effective in all phases of the illness
   E. The majority of patients are maintained on monotherapies

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5. Regarding the treatment of bipolar disorder:

A. Delays in initiating treatment are rare
B. The vast majority of patients respond to lithium or an anticonvulsant treatment when in a manic phase
C. Quetiapine leads to remission in over 50% of patients in the depressive phase
D. There are a number of well-tolerated treatments that are effective in all phases of the illness
E. The majority of patients are maintained on monotherapies

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Any Questions?

Thank you