Expert Interview

Depression in Bipolar Illness: An Expert Interview With Sloan Manning, MD

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Editor's Note:
The characteristics of depression in patients with bipolar illness may differ significantly from those of unipolar depression, with therapeutic implications. David Danar, MD, Medscape Internal Medicine, Family Medicine and Rheumatology, interviewed Sloan Manning, MD, of Prime Care - Greensboro, in Greensboro, North Carolina, to discuss the role of the primary care physician in the diagnosis and care of depressed bipolar patients.

Medscape: Why should generalists be aware of bipolar spectrum illness? Does it have an impact on my practice? How?

Dr. Manning: Bipolar illness is often narrowly viewed as consisting of individuals who experience mania. This is far from the truth. Bipolar illness is much broader in its presentation and impact.[1] Most affected individuals never experience syndromal manic episodes. Further, episodes of depression typically *precede* the appearance of manic symptoms and *outnumber* periods of hypomania or mania, causing a greater proportion of dysfunction related to the illness. In short, bipolar illness is usually 1 of significant depression interspersed (or combined) with periods of manic symptoms.

Primary care, traditionally the principal delivery system for mental healthcare, has over the last 15 years become a large source of antidepressant prescriptions. At times, these medications have been prescribed in a rather cavalier fashion, due perhaps, in part, to a perception (albeit inaccurate) that they are relatively innocuous.[2] The importance of bipolar illness in primary care is thus characterized by a predilection for physicians to recognize depressive more than manic features and the tendency of depressed individuals to present first to a generalist. But antidepressants, when used as monotherapy, are unlikely to improve bipolar depressions. In fact, they can lead to a worsening of bipolar illness, both acutely and longitudinally, by inducing manic or mixed manic/depressed states and rapid-cycling illness. Such iatrogenic complications can lead to depressions characterized by energized impulsivity, panic states, erratic behavior, and increased suicidality. Sadly, the underappreciation, misdiagnosis, and mistreatment of bipolar illness can result in disastrous consequences.

Current estimates from direct and indirect investigations suggest that 20% to 30% of depressed or anxious patients in primary care have a bipolar spectrum diagnosis.[3,4] Although not responsible for the majority of patients with mood disorders that we see, bipolar illness may account for a large portion of the difficult-to-treat depressed and anxious patients whom we encounter -- particularly those with multiple antidepressant failures, intolerances, and erratic responses.[5] In day-to-day practice, half of the battle is that of differential diagnosis. Recent information on bipolar spectrum illness and negative consequences of antidepressant monotherapies underscores the fact that accurate diagnosis is the gateway to focused,

efficacious treatment. Further, ongoing reassessment during treatment is a key to good outcomes.

Medscape: How do I differentiate between "unipolar" major depression and bipolar depression or bipolar illness?

Dr. Manning: Differential diagnosis of the illness involves several steps, beginning with an understanding of the prevalence of the illness and an appreciation that although we may define bipolar illness on the basis of manic symptoms, it is bipolar *depression* that will be seen more often. From this, we can suggest essential principles in the clinical assessment of every depressed and anxious patient.

An important principle is to anticipate an ultimate diagnosis of bipolar illness by carefully considering differences in the phenomenology (symptoms), family history, longitudinal course, and treatment response from those of unipolar depression.

A careful look for past or concurrent symptoms of mania is mandatory. Bipolar illness is characterized specifically by the presence or history of manic symptoms. Because depression and mania may occur simultaneously (mixed states), it is wise to review manic symptoms at the same time when depressive symptoms are assessed. Periods of manic symptoms fulfilling the criteria for a *manic episode* yield the diagnosis of bipolar I disorder. Significant manic symptoms that fail to meet the criteria for mania are termed *hypomania*. Recurrent hypomania with a history of major depression is termed bipolar II illness. Recurrent hypomania without a major depression is termed cyclothymic disorder.

Bipolar pedigrees are usually noticeably positive for psychiatric illness, occasionally with formal diagnoses of bipolar disorder. However, substance abuse/dependency, impairing mood disorders, and other features of erratic or impulsive behavior can act as clues -- multiple marriages or extramarital affairs, legal and interpersonal difficulties, etc. By contrast, unipolar depression pedigrees are tamer, even negative.

Bipolar depression and manic symptomatology may appear and disappear abruptly. Many bipolar individuals are recognized as moody, mood-labile, mercurial, and unpredictable. They may describe "switches" in their moods with periods of energy, productivity, elation, or even irritability, giving way suddenly and inexplicably to significant lethargy, pessimism, and depressed mood. Seasonality, often with winter depressions and summer manias, is not uncommon. Unipolar depressions usually begin with 1 or 2 symptoms and escalate slowly to syndromal levels over a period of months.

Bipolar illness most often begins in childhood or adolescence with a period of depression that may be mixed with restlessness or severe irritability. A first mood episode prior to age 25 should arouse suspicion. Unipolar depressions begin later, after the age of 25.

As mentioned before, response to antidepressants alone tends to be negative or erratic, with some individuals switched into hypomanic/manic episodes that can be misinterpreted as recoveries. These "pseudorecoveries," however welcome, are often "too soon to be true" (occurring abruptly during the first 2 weeks of antidepressant treatment) or "too good to be true" in that the levels of increased mood and activity produced may be too intense to bear. They are also short-lived.

Some patients may relate improvement in mood and energy and ask for help with new or worsening insomnia (often with racing thoughts preventing the initiation of sleep) or restlessness. New benzodiazepine prescriptions may be a clue here, as well as the need to increase the dose of an existing medication. Failures to 3 or more antidepressants or any number of antidepressant

combinations should arouse suspicion. Unipolar patients treated successfully with antidepressants usually begin to notice a positive medication effect after the first or second week of treatment at a therapeutic dose, and gradually improve to a sustained response or remission.

Another important principle is to treat every diagnosis as a working diagnosis and nurture a therapeutic alliance to improve the quality of history and follow-up obtained. History is everything, improved by outside sources of information and longitudinal contact.

Medscape: Are there screening instruments available?

Dr. Manning: The Mood Disorder Questionnaire (MDQ) is a patient self-rated instrument that has been validated in psychiatric settings.[6] It consists of 3 questions. In the first question, the patient answers "yes" or "no" to a list of 13 symptoms of mania. In the second question, patients are asked whether the endorsed manic symptoms tend to occur at the same time. In question 3, the patient is asked whether the manic symptoms in question 1 cause significant problems. An endorsement of at least 7 of 13 items in question 1, plus "yes" on question 2, and an answer of at least "moderate problem" to question 3 yields a sensitivity of 70% and specificity of 90% for bipolar I, II, or not otherwise specified (NOS) disorders. It should be noted that screening instruments do not make diagnoses. Instruments, such as the MDQ do, however, offer an opportunity to identify patients likely to have a particular diagnosis and needing more in-depth clinical assessment. The MDQ is available online at www.dbsalliance.org.

Medscape: How might mania present?

Dr. Manning: Manic patients are energetic, excited, and active -- mentally and physically -- and their energy results in noticeable behaviors. The overall mood may be elated or grandiose -- perhaps only self-confident. More often, it is irritable. In fact, the more irritable a patient is, the more likely a manic or hypomanic episode is present. A new mnemonic "DIGFAST"[7] may serve to remind clinicians of manic symptoms that may accompany such a period of abnormally elated, expansive, or predominately irritable mood:

- Distractibility -- jumping from activity to activity;
- Insomnia -- decreased need for sleep or an inability to sleep;
- Grandiosity -- increased self-confidence to delusional grandiosity;
- Flight of ideas -- racing thoughts," "mind moving too fast," or "mind crowded with thoughts";
- Activity -- increased mental or physical activity with ideas, plans, projects, keen insight, etc;
- Speech -- talkative, noticeably more social. In extreme cases, talking too fast to be understood; and
- Thoughtlessness -- decisions made with little or no thought of negative consequences, eg, romantic or financial indiscretions, driving recklessly, traveling impulsively, or with little planning.

Medscape: Must I refer all bipolar patients to a psychiatrist?

Dr. Manning: The need for consultation or referral will vary from clinician to clinician and case to case. Several scenarios may suggest the need:

- Diagnostic dilemma: As discussed, an accurate and complete diagnosis will yield a more focused and successful treatment plan.
- Treatment refractoriness: If several attempts at treatment with efficacious agents have been unsuccessful or only partially successful, consultation and referral may be helpful.

- Issues of severity/complexity: Patients may present so ill as to be a danger to self or others. Assessment for such risk should be made of every patient. Those deemed too sick or too complex for the primary care setting in general or any particular set of practice parameters should be referred to specialty care settings.

Notwithstanding, there are many cases of bipolar disorder in primary care settings that are well within the skill set of the interested generalist who is willing to learn the principles of diagnosis and management, including becoming familiar with medications that have efficacy in various phases of bipolar illness.

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