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UNDER-DIAGNOSIS OF BIPOLAR AFFECTIVE DISORDER IN A BEDFORD CMHT

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SUMMARY

Background: *Bipolar disorder is frequently misdiagnosed or diagnosed late. Misdiagnosis of Bipolar Disorder can have serious implications for prognosis and treatment of this condition.*

Method: *Patients in a Community Mental Health Team were systematically screened for Bipolar Disorder.*

Results: *There was a substantial increase in the number of bipolar patients diagnosed in the Community Mental Health Team.*

Discussion: *The frequent misdiagnosis of Bipolar II disorder frequently leads to the treatment of these patients with anti-depressants only.This leads to the possibility of patients becoming elated in mood, or going into mixed states, which can lead to increased suicidality.*

Conclusion: *Appropriate diagnosis of bipolar II disorder requires skills at present found in secondary care. Such patients should therefore be referred to secondary care. Both Primary and Secondary care should be more aware of this diagnosis and its consequences.*

Key words: *Bipolar Disorder – misdiagnosis - screening*

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Introduction

It is known that bipolar disorder is frequently misdiagnosed or diagnosed late.

Misdiagnosis of Bipolar Disorder can have serious implications for prognosis and treatment of this condition (Agius et al. 2007).

Method

Using an excel database, an audit of the diagnoses of all patients in a CMHT in Bedford was carried out in November 2006.

It was noted that no patients had been diagnosed as having bipolar II disorder, while there was a large number (41) of Bipolar I patients, and a larger number of patients with recurrent depressive disorder (63), mixed anxiety and depression (28), unipolar depression (73), and psychotic depression (12). This was felt to reflect diagnostic practices present at that time in this team and neighbouring teams. It was felt that some bipolar patients were being missed or misdiagnosed.

As a consequence,all patients with recurrent depressive disorder, anxiety and depression, unipolar depression and psychotic depression were reassessed in the outpatient clinic, using a full longitudinal history of their mood changes, a family history, and, when these two tests are positive, the structured mood disorder questionnaire (Hirschfeld et al. 2000).

The new diagnoses are recorded in the Excel Database held by the team.

Results

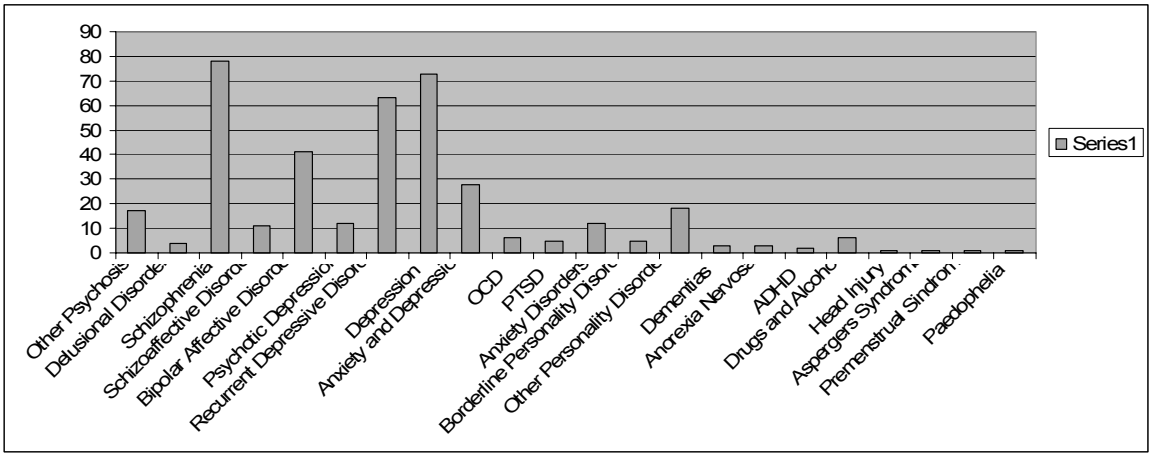

Figure 1. All Patients November 2006

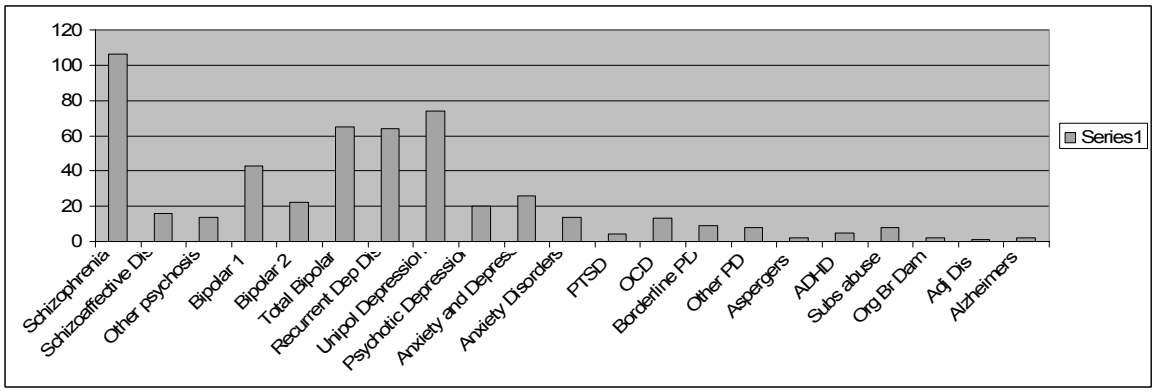

Figure 2. All patients September 2007

This work continues in progress. Already by September 2007, increased awareness of bipolar disorder was leading to a more frequent diagnosis or re-diagnosis of Bipolar II disorder (65), an increase in the number of Bipolar 1 patients diagnosed (43) and total numbers of bipolar patients (22), but little change in the number of unipolar depressed patients (74), recurrent depressive disorder patients (64), patient with depression and anxiety (26) and patients with psychotic depression (20), as well as a consequent change in the proportions of each diagnosis in the sample.

Discussion

The consequence of being more aware of Bipolar disorder, including Bipolar II cases has changed the percentage of bipolar patients in the sample from 8.9% to 14.3%. Studies of previous samples have given similar results (Tavormina et al. 2007, Tavormina et al. 2007). This shift in diagnostic categories was considered substantial, however it did not reach the level reported by others (Tavormina et al. 2007). We considered this to be due to either the difference in the population characteristics, or the difference between the modes of working within a National Health Service Community Mental Health Team and a long term private practice.

The frequent misdiagnosis of Bipolar II disorder frequently leads to the treatment of these patients with anti-depressants only.

This leads to the possibility of patients becoming elated in mood, or going into mixed states, which can lead to increased suicidality. As a consequence of these facts it is suggested that the guidelines for diagnosing and treating unipolar and bipolar disorder in primary care need to be merged, so that the algorithm begins with the proper diagnosis of patients into unipolar and bipolar illness with consequent differences in treatment (Agius 2007).

There needs to be further training of both primary and secondary care staff regarding bipolar affective disorder.

The possibility of bipolar disorder needs to be considered for all cases of recurrent depressive disorder, unipolar depression, including psychotic depression, and resistant depression in CMHT caseloads; these patients are likely to require secondary care supervision because of the tendency of these patients to develop into bipolar disorder.

Caution must be exercised in treating patients with bipolar disorder (including Bipolar II) with anti-depressants.

Mood stabilisers need to be considered as the main treatment once bipolarity is recognised, including bipolar II.

Conclusion

Appropriate diagnosis of bipolar II disorder requires skills at present found in secondary care. Such patients should therefore be referred to secondary care. Both Primary and Secondary care should be more aware of this diagnosis and its consequences.

References

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