Letters

Bipolar disorder: One name doesn't fit all

I commend Drs. Lake and Hurwitz for their out-of-the-box thinking about bipolar disorder (CURRENT PSYCHIATRY, March 2006, p. 42-60), but their argument is the weakest I have seen in a scholarly article. One misdiagnosis does not prove that every patient labeled as schizophrenic has been misdiagnosed.

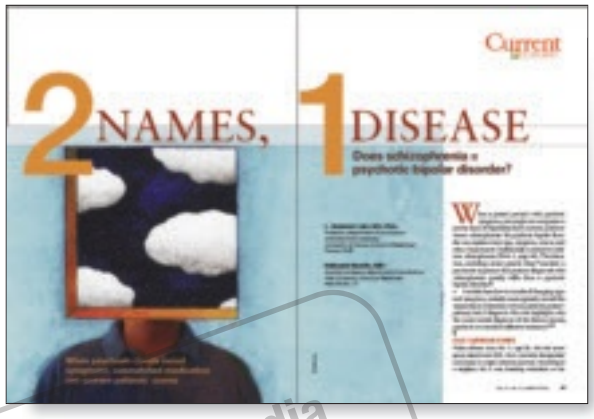
The authors describe Mr. C's initial presentation but offer few details on his behavior and symptoms, saying only, "within 2 weeks, Mr. C. switches from depression to a mixed, dysphoric mania." What does that mean? What signs and symptoms were present?

The only evidence the authors present to support their conclusion is Pope and Lipinski's 1978 paper.[1] Drs. Lake and Hurwitz barely address the controversy surrounding these findings, saying, "We concur … that psychotic bipolar disorder includes patient populations typically diagnosed as having schizophrenia and schizoaffective disorder."

Note that the authors did not write, "We believe that these findings indicate that patients who meet DSM-IV-TR criteria for schizophrenia really have a form of bipolar disorder." This reversal is merely sleight of hand.

Worse, Drs. Lake and Hurwitz fail to note that a set of diagnostic labels and criteria such as DSM-IV-TR facilitates communication among clinicians and researchers. This way, when a new patient's chart indicates a schizophrenia diagnosis, you know what to expect (psychotic symptoms, auditory hallucinations, downward spiral, etc.).

In practice, however, I have seen patients with nearly every psychiatric disorder who have been misdiagnosed with bipolar disorder, usually with little or no evidence of past hypomania or mania. One provider closed his clinic and referred his patients to me; each came with an (incorrect) bipolar disorder diagnosis.



I no longer know what to expect when I see a patient who has been labeled as "bipolar," "manic," or "mixed manic." The diagnosis has been distorted to the point of clinical uselessness.

Lumping schizophrenia into this rubric would further cloud bipolar disorder diagnosis. Should we next lump in panic disorder? Social phobia? Vascular dementia? Cocaine dependence? While these suggestions are patently ridiculous, I have seen patients with each of these diagnoses labeled by another clinician as "bipolar."

Maybe DSM-V should list a separate axis for mood dysfunction, which would fit the construct of a "bipolar spectrum."

Mark P. Snyder, MD
Pinehurst, NC

Reference

1. Pope HG, Lipinski JF. Diagnosis in schizophrenia and manic-depressive illness: a reassessment of the specificity of 'schizophrenic' symptoms in the light of current research. *Arch Gen Psychiatry* 1978;35:811-28.

Schizophrenia: no mood disorder

Bipolar disorder and schizophrenia are two distinct disorders. True, many bipolar patients are misdiagnosed as having schizophrenia, and some patients have overlapping symptoms of both disorders. Many patients with schizophrenia, however, have chronic persistent psychosis and negative symptoms with no mood disorder.

Also, how can the authors say that misdiagnosing bipolar disorder as schizophrenia would

unnecessarily expose patients to antipsychotics instead of needed mood stabilizers? Many atypical antipsychotics work as mood stabilizers, sometimes more effectively than lithium, divalproex, or other old standards. It sounded like the authors were turning back the clock to when many bipolar patients were misdiagnosed with schizophrenia and placed on long-term haloperidol or another conventional antipsychotic.

Anthony Green, MD
Aberdeen, NJ

Sample patient was clearly bipolar

Drs. Lake and Hurwitz' sample patient's symptoms were clearly consistent with bipolar illness, with evidence of catatonia more commonly seen in bipolar illness. Many patients with schizophrenia, however, present with no evidence of current or past affective components. Dissecting such a case would have been more helpful. It is also unclear where the authors got their data regarding increased risk of suicide with neuroleptics.

Blindly diagnosing schizophrenia based on Bleuler's and Kraepelin's early 1900s descriptions is not the standard of care. We can thus remind ourselves that psychiatry is an evolving art and science, and that we have much to learn about the dynamics of behavior, mood, and thinking.

Danielle Skirchak, MD
Department of Psychiatry and Behavioral Sciences
University of Kansas School of Medicine, Kansas City

Drs. Lake and Hurwitz respond

Dr. Henry Nasrallah is correct that the "2 names, 1 disease" concept is polarizing (Commentary, CURRENT PSYCHIATRY, March 2006, p. 67-8). Schizophrenia, conceived almost 100 years ago, has been so widely accepted and has accumulated such a "massive body of evidence" that we keep endorsing it without question.

Schizophrenia is defined by hallucinations, delusions, and a chronic, deteriorating course, but these supposedly disease-specific features readily occur in psychotic mood disorders.[1,2] Classic bipolar patients can suffer chronic, deteriorating courses without remission, and severe psychotic symptoms can obscure mood symptoms.[1,2] The idea that "interepisode phenomenology," "chronic persistent psychosis," and "between-episode interpersonal skills" differentiate schizophrenia from severe mood disorder is obsolete.[1,2]

More-recent phenotypic and genotypic similarities—and overlap from basic science, neuroradiologic, epidemiologic, and genetic studies—support the "one disease" hypothesis.[3,4] Moreover, 8 of 11 susceptibility loci identified for schizophrenia and bipolar overlap.[4]

In his table, Dr. Nasrallah presents the traditional justifications for considering schizophrenia a separate disorder: that auditory hallucinations, negative symptoms, and the most bizarre delusions are "more common" in schizophrenia, and that paranoia is "more systematized."

However, nearly **all** severely manic patients have these features as well as "disorganized and derailed thoughts." **All** patients with severe depression have "negative symptoms" that can lack "affective cyclicity." The "racing thoughts and flight of ideas," specific to mania, actually derail and disorganize thoughts and behavior.

Continuing to consider schizophrenia a separate disease based on "a massive body of evidence," and on certain symptoms being "more common" or "more severe" in schizophrenia than in bipolar disorder, puts psychiatry in the category of "art," not science, and opens us for criticism from antipsychiatry groups such as the Scientologists.

The broad spectrum of symptoms and chronicity of course, initially unrecognized in psychotic mood, might account for differences in comparative studies. This spectrum likely encompasses other variances across mood disorders that have been cited as evidence for a separate disorder. Further, the longstanding tradition of separating

continued on page 11

Letters

continued from page 3

bipolar disorder and schizophrenia may influence interpretation of comparative studies.

Concerning Dr. Skirchak's remarks, psychotic major depressive disorder misdiagnosed as schizophrenia and treated only with neuroleptics explains "a risk of suicide with neuroleptics." Also, continued use of neuroleptics in remitted, misdiagnosed manic patients can increase cycling, typically to a depressed episode.[5]

Regarding the queries of Drs. Green and Skirchak, our sample patient presented "without evident current or past mood symptoms." No mood symptoms were obvious or elicited at presentation because attention focused on psychotic symptoms and not mood symptoms, leading to misdiagnosis and mistreatment. A temporary diagnosis of psychotic disorder NOS is appropriate in some cases while obscure mood and organic causes are explored.

Should the "one disease" concept prevail, Kraepelin would rest easily because his later concept was accurate; Bleuler—who could have renamed and promoted manic-depressive insanity instead of dementia praecox—and those invested in schizophrenia—clinicians, professors, researchers, grantees, editors, and some in the pharmaceutical industry—would incur discomfort.

C. Raymond Lake, MD, PhD
University of Kansas School of Medicine, Kansas City

Nathaniel Hurwitz, MD
Yale University School of Medicine, New Haven, CT

References

1. Pope HG, Lipinski JF. Diagnosis in schizophrenia and manic-depressive illness, a reassessment of the specificity of "schizophrenic" symptoms in the light of current research. *Arch Gen Psychiatry* 1978;35:811-28.
2. Post RM. Transduction of psychosocial stress into the neurobiology of recurrent affective disorder. *Am J Psychiatry* 1992;149:999-1010.
3. Schulze TG, Ohlraun S, Czerski P, et al. Genotype-phenotype studies in bipolar disorder showing association between the DAOA/G30 locus and persecutory delusions: a first step toward a molecular genetic classification of psychiatric phenotypes. *Am J Psychiatry* 2005;162:2101-8.
4. Fawcett J. What do we know for sure about bipolar disorder? *Am J Psychiatry* 2005;162:1-2.
5. Zarate CA, Tohen M. Double-blind comparison of the continued use of antipsychotic treatment versus its discontinuation in remitted manic patients. *Am J Psychiatry* 2004;161:169-71.

continued

Letters

continued from page 11

'Fuzzy' diagnostic boundaries

Kudos to Drs. Lake and Hurwitz for bringing to the fore an issue that deserves much more attention than it gets in psychiatry's academic circles. Their opinion remains in the minority not because their argument is invalid, but because:

1) We find it difficult to accept that the boundaries between psychiatric disorders are much fuzzier than what DSM-IV-TR suggests. We fear that doing so will cost us our hard-earned ostensive legitimacy as a medical discipline.

2) As most atypical antipsychotics are indicated for both schizophrenia and bipolar disorder, one can justify use of any atypical for either disorder, even if the diagnosis is not entirely accurate.

Questioning the validity of a diagnostic construct (not a disease) should not be considered a "scientific transgression," as Dr. Nasrallah puts it. After all, we still have not reached an international consensus on how long symptoms must be present before we diagnose schizophrenia (DSM-IV-TR says 6 months, ICD-10 says 1 month).

Jatinder P. Babbar, MD
Carilion University of Virginia
Roanoke Valley Program, University of Virginia
Salem, VA

'Wrong-headed nosology'

Interepisode phenomenology of bipolar disorder and schizophrenia are qualitatively different. Printing Drs. Lake and Hurwitz' wrong-headed nosology disserves patients because impressionable residents and students reading about it might take it as truth and adopt it unexamined.

Correction

In the figure that accompanied "Out of the Pipeline: Intramuscular naltrexone" (CURRENT PSYCHIATRY, March 2006, p. 107), median heavy drinking days per month should have been listed without percent signs.

I also fear that the authors have been swayed by the idea that DSM-IV-TR is necessarily valid. DSM-IV ensures that all disorders are called by the same names but may or may not represent valid conceptions of mental life and its disorders.

I do agree in part with rejecting the notion of "schizoaffective disorder," as the term is grossly overused. I think "schizoaffective" is often an easy shorthand for "bad mental illness" and is too frequently used without considering the psychopathologic phenomenology evident over the course of the patient's life.

Mark Mollenhauer, MD
Mental Illness—Substance Abuse Program
Johns Hopkins Bayview Medical Center, Baltimore, MD

Schizophrenia: a diagnosis of exclusion

There are two ways to diagnose a disorder: List the symptoms and history, or observe response to treatment. If the patient appears to have schizophrenia but responds exceptionally well to lithium, we would naturally suspect bipolar disorder.

I once proposed studying patients who appear to have schizophrenia—as defined by the leading researchers of the disorder—while treating them with anything but a neuroleptic. The study, if successful, would show similar remission rates (without neuroleptics) among patients with schizophrenia or bipolar disorder. A certain number of patients with bipolar disorder require neuroleptics for stability.

In any case, I believe that true schizophrenia is quite rare and should be considered a diagnosis of exclusion. Most patients diagnosed with schizophrenia have some combination of bipolar disorder, obsessive-compulsive disorder, attention-deficit disorder, panic disorder, and/or seizure disorder. Treating these patients correctly requires much sophistication and creativity while considering all psychotropics with or without neuroleptics.

David Corwin, MD
Paramus, NJ