

### Is bipolar disorder overdiagnosed?

I note with some dismay an increasing trend in CURRENT PSYCHIATRY to identify almost any mood disorder as bipolar disorder. I found the clinical logic expressed in the supplement “Diagnosing and managing psychotic and mood disorders” (CURRENT PSYCHIATRY, December 2008, p. S1-S31) especially confounding.

In the case “Bipolar depression and anxiety,” a clinician is implicitly criticized for “focusing on symptoms without giving due consideration to a patient’s history and family history (leading) to a snap misjudgment and inappropriate treatment.” These are harsh words. However, the only possible bipolar symptoms reported in the case study are “feeling overstimulated and ... tremendously irritable.” There also is a family history that “suggested” bipolar disorder. Although this history in the context of a poorly responsive, agitated depression certainly makes bipolar disorder a reasonable diagnosis, assuming that a patient is bipolar and starting mood stabilizers from treatment onset given the data seems like a leap of faith. If I diagnosed bipolar disorder in all my irritable, depressed patients with a vague family history of possible bipolar illness, then my rate of unipolar depression would drop to around 5%.

In addition, Dr. Henry Nasrallah’s suggestion that the chronically and severely psychotic man in “Treatment-resistant psychosis and schizophrenia” has bipolar disorder seems dubious. There is no history of lack of need for sleep, excessive psychomotor activity, grandiosity, or a stated



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episodic nature to his disturbance. Yes, he has been severely ill, psychotic, and violent, but all these factors are consistent with severe schizophrenia. Finally, to suggest that his tardive dyskinesia adds credibility to the bipolar argument is illogical. Almost all cats have fur but this does not mean that because a newly discovered species is furry, it must be a cat.

One would wonder if clinical judgment has been influenced in any way by the large number of pharmaceutical grants received by the expert panel.

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#### Dr. Nasrallah responds

I thank Dr. Zimmerman for his letter regarding the December 2008 supplement to CURRENT PSYCHIATRY, which was based on a roundtable discussion of 4 cases from the 4 participating faculty’s clinical practices. Both diagnostic and treatment issues were discussed in a spontaneous and unrehearsed manner. The faculty submitted their challenging cases before they knew who sponsored the CME activity, so it is not fair to assume the cli-

nicians were influenced by pharmaceutical industry involvement.

Whether or not you agree, studies have shown that bipolar depression is frequently misdiagnosed as unipolar depression if a patient has never had a manic episode.<sup>1,2</sup> This is an important diagnostic issue because antidepressants—all approved by the FDA for unipolar depression only—may cause a switch to hypomania, mania, mixed states, or rapid cycling when used as monotherapy in some patients. The faculty agreed that the patient with bipolar depression and anxiety was 1 of those misdiagnosed bipolar depression cases that switched to a mixed state (irritable depression) when given venlafaxine, which was shown in a recent meta-analysis to have the highest switching rate among antidepressants.<sup>3</sup>

It would be an egregious oversight if a psychiatrist did not have a high index of suspicion about the possibility of a bipolar depression in a patient who presented with:

- early-onset depression (in her early 20s in this case)
- a first-degree family member diagnosed with bipolar disorder (her father)
- a description of her depressed mood as “tremendously irritable.”

Also, there is a high rate of anxiety/obsessive-compulsive disorder comorbidity in bipolar depression when there is a history of high functioning prior to the onset of depression, as was the case in this patient.

I also would add that about a dozen published, controlled studies report significant improvement with the addition of lithium in “treatment-resistant depression” after numerous failures or worsening with antidepressants. Many of those

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## Comments & Controversies

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*cases likely are bipolar depression that worsened with antidepressant monotherapy because a mood stabilizer was needed.*

*As for the second case of "Treatment-resistant psychosis and schizophrenia," numerous clues in the patient's history point to severe psychotic bipolar disorder:*

- initial psychotic symptoms appeared in high school after age 17, but he completed his college degree, which is more typical of bipolar disorder than schizophrenia*
- very frequent hospitalizations (>50 admissions), which is consistent with bipolar cyclicity*
- assaultiveness, which is more consistent with irritable mania than schizophrenia*
- past and current treatment with mood stabilizers, which suggests that his psychiatrist noted manic symptoms*
- ability to get married early in his illness even after hospitalization*
- advanced vocabulary, which is characteristic of mania rather than schizophrenia*
- history of episodic depression and suicidal ideas*
- episodes of excitement, rapid speech, hypersexuality, and grandiose delusions, which can be found in schizophrenia but are consistent with psychotic mania in the context of these other bipolar disorder features.*

*Finally, I brought up the issue of tardive dyskinesia being consistent with bipolar disorder based on my many years researching tardive dyskinesia and extrapyramidal symptoms. I found a higher occurrence of movement disorders in patients with bipolar disorder than in those with schizophrenia.*

*I welcome Dr. Zimmerman's disagreement on diagnostic issues and hope that he sees that the faculty's diagnostic formulations were driven by the historical facts in the presented cases as well as research findings, not due to any other reason or motive. All of the participants would have given the same diagnostic discussion to our medical students and residents on any morning rounds.*

**Henry A. Nasrallah, MD**  
Editor-in-Chief

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