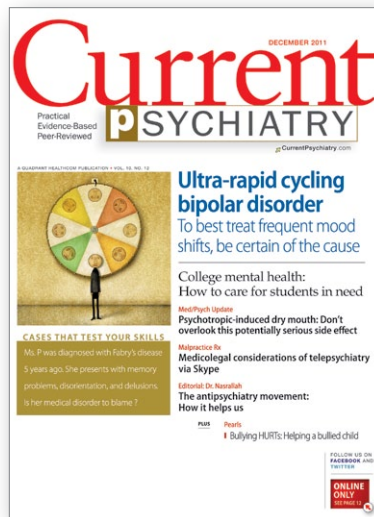


### Ultra-rapid cycling in BD

I feel Dr. Goldberg's article addressing ultra-rapid cycling (URC) bipolar disorder (BD) ("Ultra-rapid cycling bipolar disorder: A critical look," CURRENT PSYCHIATRY, December 2011, p. 42-52), fell short in 2 critical regards. First, I believe evidence would have supported much stronger or less ambiguous conclusions. Although URC clearly is an observable symptomatic phenomenon, it's not a valid construct within the BD spectrum, per se. To include it as such would only detract from the homogeneity that has been achieved with the resolution of that group to date, thereby dissipating the usefulness of the group from both a clinical and research standpoint. Even the Bottom Line stated that URC "has not been validated as a distinct clinical entity," but "careful evaluation" is recommended "to differentiate URC from affective lability seen in other conditions," thus implicitly validating using the term as a diagnostic entity.

Second, I am disturbed by the article's absence of adult attention-deficit/hyperactivity disorder (ADHD), the secondary features of which easily rival BD in accounting for a significant proportion of symptoms commonly attributed to URC, if not the preponderance thereof. Notably, ADHD shares the "trait feature" status the article cites as unique to BD. A commonly cited figure places the prevalence of adult ADHD at 4.4% (using DSM-IV criteria) with 75% to 80% of those patients untreated and undiagnosed.<sup>1</sup> Comorbidities of >50% with generalized anxiety disorder, 25% with cyclothymia, 30% with drug abuse, and 34% with alcohol abuse/dependence have been cited,<sup>2,3</sup> there-



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fore opportunities for misdiagnoses within this cohort abound.

Furthermore, DSM-5 adult ADHD diagnostic criteria may become less restrictive, and 5 years less stringent regarding age of onset, whereas there's no suggestion of including URC—a point which also might have born mention in the discussion.

As a clinician specializing in adult ADHD, I've diagnosed and treated patients previously misdiagnosed with URC and rapid cycling BD, including patients who had been treated unsuccessfully for 15 to 20 years, and switched many from polytherapy (including mood stabilizers) to psychostimulant monotherapy, with life-changing results achieved in 1 day and confirmed over months or years of follow-up.

An omission of this sort does a disservice to the field by contributing to the already well-documented tendency of clinical psychiatrists to miss a significant diagnosis.

**Richard Bunt, MD**  
Private Practice  
Melbourne, FL

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### Mood instability in ADHD

Dr. Goldberg makes an important point that not all mood lability indicates bipolar disorder (BD) in "Ultra-rapid cycling bipolar disorder: A critical look" (CURRENT PSYCHIATRY, December 2011, p. 42-52).

However, there was 1 significant diagnostic omission. Patients with adult attention-deficit/hyperactivity disorder (ADHD) can present with an unremarkable mental status exam, yet can give a history of abrupt episodes of dyscontrol, often in interpersonal situations. As opposed to children manifesting ADHD, where comorbidity with BD is substantial, adults may primarily display impulsivity rather than hyperactivity or inattention. By ignoring this diagnostic consideration, important pharmacotherapeutic options have been discarded, although cognitive-behavioral therapy and dialectical behavior therapy for "borderline" patients are always relevant. Regardless of diagnostic terms and the fate of DSM-5, our treatment approach serves to strengthen prefrontal cortex inhibitory activity and block limbic system reactivity.

**Robert Barris, MD**  
Attending Psychiatrist  
Nassau University Medical Center  
East Meadow, NY



### Dr. Goldberg responds

Drs. Bunt and Barris each raise the clinically and theoretically interesting observation that in patients whose childhood attention-deficit/hyperactivity disorder (ADHD) persists into adulthood, affective instability may be a prominent feature. Consequently, they advise that complaints of frequent mood swings within 1 day should alert clinicians to consider ADHD in their differential diagnosis.

Importantly, emotional dysregulation is not an established criterion for ADHD, although investigators have begun to study impaired emotional processing in adults with ADHD.<sup>1</sup> Because observational research examining emotional dysregulation in adult ADHD is preliminary, I cannot concur with Dr. Bunt's assertion that "an omission of this sort does a disservice to the field."

To the contrary, it would seem premature to counsel practitioners to look for mood instability as a red flag for adult ADHD. In fact, given the nontrivial rates of comorbid mood disorders with ADHD as

cited by Dr. Bunt, it's plausible that mood instability co-occurring with ADHD simply may be the epiphenomenon of a psychiatric comorbidity such as borderline personality disorder,<sup>2</sup> a disruptive behavior disorder,<sup>3</sup> or substance abuse.<sup>3</sup>

Moreover, endophenotype studies suggest that emotional lability and ADHD do not cosegregate in families.<sup>3</sup> Further research is needed to determine whether moment-to-moment mood fluctuations are an intrinsic feature of ADHD that is not better accounted for by another accompanying condition.

Dr. Bunt appears to have misconstrued my use of the term "validation" with respect to ultra-rapid cycling (URC) as if I had been referring to validation of URC as a diagnosis—which I never suggested—rather than as a putative course modifier or specifier in an otherwise-diagnosed bipolar disorder patient—as was the case when researchers empirically validated rapid cycling (RC) as a bipolar course specifier, leading to its inclusion in DSM-IV.<sup>4</sup> To my knowledge there's no movement to

consider URC as a bipolar course specifier in DSM-5, which would be a difficult undertaking in the absence of field trials such as those conducted for bipolar RC.

Drs. Barris, Bunt, and I seem to agree that mood shifts occurring on a daily or more frequent basis constitute a non-pathognomonic phenomenon for which "careful evaluation" is necessary to discern the broader psychopathologic condition and context in which it arises.

Joseph F. Goldberg, MD

Associate Clinical Professor of Psychiatry  
Mt. Sinai School of Medicine  
New York, NY

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