

Psychopharmacology for the Clinician

The information in this column is not intended as a definitive treatment strategy but as a suggested approach for clinicians treating patients with similar histories. Individual cases may vary and should be evaluated carefully before treatment is provided.

The overdiagnosis of bipolar disorder

An 18-year-old female student was referred to a mood disorders clinic by her psychiatrist with a diagnosis of bipolar disorder, type II, characterized by prominent “mood swings” for which she had been started on quetiapine (900 mg/day).

Her “up” swings consisted of periods lasting up to 2 hours when she felt “happy, positive and more outgoing.” Her friends agreed that she was happy during these times but not out of the usual. She also had episodes lasting less than 1 hour of anger, frustration, irritability and occasional yelling; these episodes were always triggered by routine interpersonal interactions, such as difficulties with customer representatives and fights with her boyfriend. She had never been physically abusive but had occasionally been verbally abusive. She denied doing things she regretted during these times. Further inquiry yielded no more “manic or hypomanic” symptoms. In particular, she had no decreased need for sleep or increased energy or grandiosity.

The patient’s “down” swings consisted of several months of sadness and anhedonia after moving provinces for her studies. She denied neurovegetative symptoms, but she had occasional, fleeting thoughts of suicide but no attempts. She remained functional in school and tried to make new friends.

She was raised by a single mother who was not supportive, and her angry outbursts since childhood received no attention. Her maternal grandmother had a history of depression.

This case exemplifies 2 disturbing trends in bipolar disorder diagnosis and treatment. First, there are reports

in the medical and psychiatric community about bipolar disorder that have created the impression of a rise in its incidence and prevalence, particularly in the pediatric and young adult populations.^{1,2} The serious implication of this potential (over)diagnosis has led to a second disturbing trend: the use of monotherapy atypical antipsychotics for the initial treatment of bipolar disorder³ in the absence of adequate trials of mainstay mood stabilizers.^{4,5}

As is the case for all psychiatric disorders, bipolar disorder lacks pathophysiologic indicators or tests that provide a gold standard for diagnosis. Its diagnosis, therefore, remains predominantly clinical. The increased awareness of bipolar disorder in the medical and public realms can influence the tendency to diagnose — and potentially overdiagnose — bipolar disorder.⁶ Additionally, the diagnostic criteria of bipolar disorder and its categorical distinction (v. schizophrenia spectrum disorders) are being disputed by growing evidence from longitudinal and family/genetic studies that challenge their validity.^{7,8} To address potential overdiagnosis, clinicians should carefully and systematically collect diagnostic criteria and other symptoms in the individual context of the patient. They should observe, pinpoint and document the origin and fluctuation of symptoms. In this patient, the diagnosis of bipolar disorder was not retained because her “mood swings” were of a short duration, of a severity within the normal range, in keeping with the context of difficulties of daily life and were not associated with impairment. No DSM-IV diagnosis was given.

With respect to the increasing use of

monotherapy atypical antipsychotics, this may originate from several sources: the ease of dosing and monitoring (i.e., no mg/kg initial loading, no blood levels required for titration, no narrow therapeutic windows for toxicity, less baseline work-up, availability of depot formulations for non-compliance); more sedative effects to control manic irritability and disruptive activity; updates from practice guidelines regarding trials with their use,^{9–11} and popularization of their use through pharmaceutical promotion.¹²

It thus becomes understandable that these drugs are being more commonly used and as first-line therapy. However, given their strong association with cardiovascular morbidity risk factors (obesity, diabetes, hyperlipidemia, metabolic syndrome^{13,14}), clinicians may be trading the work of prescribing traditional mood stabilizers for managing other diseases that compete with bipolar disorder at the levels of chronicity, impairment and disability. Our patient was instructed to discontinue quetiapine and to start psychotherapy to help with her anger.

As gatekeepers to diagnosis and experts responsible for treatment, clinicians should remain stable and vigilant about the potential for overdiagnosis and be judicious and cautious prescribers of medication that has been clearly associated with other chronic disorders.

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Psychopharmacology for the Clinician columns are usually based on a case report that illustrates a point of interest in clinical psychopharmacology. They are about 500–650 words long and do not include references. Columns can include a bibliography which will be available only at the journal website and can be accessed through a link at the bottom of the column.

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