All That Wheezes Is Not Asthma: Bipolar Disorder in Primary Care 1997–2007

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It has been 10 years since our University of Tennessee Department of Family Medicine group reported a significant presence of bipolar disorders in primary care. In that study,[1] close examination of a consecutive cohort of primarily depressive and anxious patients found 26% had bipolar disorders—usually bipolar II disorder. Two years later, in the inaugural issue of the *Companion*, we reported on a group of patients with difficult-to-treat depression seen in our mood disorders clinics.[2] We found that 39% of those patients had a bipolar disorder and speculated that undiagnosed bipolar disorders might be prevalent in samples of primary care depressed patients who are more impaired or refractory to treatment. Hirschfeld et al.[3] and Das et al.[4] have confirmed bipolar disorder to be a significant and undiagnosed condition in primary care. In each of these investigations, patients with confirmed or likely bipolar disorder were found to be significantly more ill than their nonbipolar counterparts on a number of measures.[3,4]

In the previous issue of the *Companion*, Stang et al.[5] added to the literature on bipolar patients in the areas of social adjustment and work ability, with 76% of bipolar patients studied reporting marked work impairment. For nearly half of these patients, the work impairment was most or all of the time. Absenteeism was a problem, usually during a depressive episode of the illness. Nearly half of the study subjects felt that their illness impaired their productivity when compared with their peers. Suicidality was pervasive, with 66% of patients at elevated risk.[5]

Also notable in this sample of patients treated in a psychiatry service is that antidepressant monotherapy was employed as treatment for nearly 23%—in stark contrast to the recommendations of current treatment guidelines.[5] This finding is regrettable and arguably tragic, but consistent with other studies of the treatment of bipolar patients. Baldessarini et al.,[6] in a recent study using a national pharmacy database for the years 2002 through 2003, found that antidepressant monotherapy was the initial treatment for bipolar disorder 50% of the time! This matter is a public health concern. The U.S. Food and Drug Administration in 2004 in a public health advisory[7] recommended screening all depressed patients for bipolar disorder prior to the administration of antidepressant therapy. This matter is also a health care quality concern. The National Quality Forum,[8] whose recommendations form the basis for national performance measures and quality indicators, calls for an assessment for the presence of prior or current symptoms and/or behaviors associated with mania or hypomania prior to the initiation of antidepressant treatment. In both recommendations, antidepressant monotherapy in bipolar patients is emphasized as ineffective and capable of worsening the illness. Most often, bipolar patients present in the depressed phase of the disorder (largely in primary care settings) and, unrecognized as bipolar, receive repeated trials of antidepressants without the potential protection of mood stabilizers. These unfocused treatments may well be responsible for the iatrogenic deterioration of the acute and chronic course of the illness in a significant number of patients. In some cases, increased suicidality or switches into a manic or mixed state may occur. The ancient axiom *primum non nocere* ("First, do no harm") cannot be overemphasized in this regard.

Are primary care clinicians more aware today than a decade ago about the differential diagnosis conundrum regarding bipolar disorder and major depression? It's impossible to say with certainty. There has, however, been a concerted effort to inform and educate the primary care setting of recent findings in this important area of clinical practice. Unfortunately, old habits die hard, and there are always skeptics. In 1990 during the dawn of the serotonin reuptake inhibitor antidepressant era in primary care, many primary care clinicians swore never to have seen a depressed patient. Now primary care is the source of the majority of prescriptions written for this class of agent. Likewise today, many primary care clinicians swear never to see bipolar depression, but the research is incontrovertible—if you treat depression, you are treating bipolar depression, for 20% to 30% of primary care de-

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pression is bipolar. The operative question remaining is, "How skillfully are you treating bipolar depression?"

This kind of problem has been seen in other areas of practice, too. It took years to get practitioners to give aspirin, an ancient and inelegant remedy, for acute coronary syndrome with any regularity in the emergency room. Hydrochlorothiazide, cheap and plentiful, is still underutilized in the management of hypertension in spite of the seventh Joint National Committee guidelines.

We are learners always, and repetition is an important part of enduring memory and learning. So I remain, in spite of the current state of affairs, hopeful about the future, because I intend to keep on repeating myself. One day we will all believe that we have always known that depression itself is not a diagnosis, and that bipolar disorder is most often manifested as depression, and that differentiating bipolar depression from other forms of depression is a critical decision point in the treatment of patients presenting with depressed mood. And we will believe that we have always known that families with the most problematic psychiatric histories usually point to bipolar disorder, and that depression in children and adolescents is very often bipolar depression, and that antidepressant switches into hypomanic/manic or mixed states are indicative of bipolar disorder, and that mood stabilizers with antidepressant efficacy are the drugs of first choice in bipolar depression.

And then I shall retire.

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