The burden of bipolar disorder in the UK

Bipolar disorder is complex and challenging to diagnose. As a result the disorder is under-recognised and undertreated, commented Professor Allan Young, Chair of Psychiatry at Imperial College London, speaking at a satellite meeting organised by AstraZeneca during the Latest Advances in Psychiatry Symposium XI in March. A more holistic approach to managing bipolar disorder and recognition that the illness is probably more common than official statistics suggest could lessen the burden considerably. Steve Titmarsh reports.

Professor Young told colleagues that the way bipolar disorder is classified and diagnosed means the condition can be mistaken for depression or psychosis and contributes to the underestimation of the true prevalence of the disorder.

For example, the 2 per cent attributed to bipolar disorder in World Health Organization (WHO) data on the burden of disease (see Figure 1)\(^1\) is probably bipolar I; bipolar II and bipolar spectrum are probably subsumed into major depression. Major depression is such a mixed bag of disorders that it is difficult to split signal from noise, Professor Young commented. That may to some extent account for drugs failing at late stage to separate significantly from placebo, he suggested.

Clinical data give some insight into the real prevalence of bipolar disorder. For example, Hantouche et al. found that among patients with a major depressive episode the percentage of patients with bipolar II disorder almost doubled (from 22 per cent to 40 per cent; n=250) when the hypomania checklist was applied around four weeks after first diagnosis.\(^2\) The BRIDGE study examined 5635 patients with a major depressive episode. Researchers applied four definitions of bipolar disorder – DSM-IV, modified DSM-IV, Angst’s bipolarity diagnostic specifier (Angst’s best guess as to what the correct diagnostic criteria should be) and people who scored positive (14 or more) on the hypomania checklist.\(^3\) The results show that broader sets of diagnostic criteria are no less valid than the narrower DSM criteria and that 40-50 per cent of patients who see psychiatrists would fit into this broad group of bipolar disorders. ‘This is really a game changer in the way we think about affective disorders. Affective disorders are not just mostly depression with a small component of bipolar – bipolar is much more common than we have previously believed,’ Professor Young said.

**Disease characteristics**

The difficulty of recognising bipolar disorder is just one reason why many people with bipolar disorder do not receive optimal care. Morbidity and mortality associated with bipolar disorder place a significant burden on those with it and the society they live in which, in Professor Young’s opinion, might be reduced with a more holistic approach.
Although bipolar disorder is defined by episodes of mania or hypomania and depression, depression is the predominant symptom cluster over the course of the illness. Bipolar I consists of manic and mixed manic episodes almost always interspersed with episodes of depression. There is a small group of unipolar manic who seem to experience only manic episodes but they can only be identified over a long period of follow-up; they seem quite distinct and are associated with less morbidity than those who experience depressive episodes. There is some symptom overlap in first episodes particularly with psychosis, which can lead to misdiagnosis.

Bipolar II disorder is often confused with major depression. A history of hypomania can be difficult to ascertain even with screening tools such as the hypomania checklist – patients can under-report it and family members may think it is just a normal part of the person’s personality. There is also confusion about hypomania – subthreshold symptoms are common in adolescence and do not usually powerfully predict bipolar disorder unless there are other factors such as depression and substance abuse, including smoking. Then there are a number of important subtypes such as rapid cycling – defined as four distinct episodes in a year or four switches between symptoms of depression and mania. Once this threshold is reached, the immediate prognosis is worse.

Bipolar II has been called ‘bipolar light’, but in Professor Young’s view that was an unfortunate term referring to hypomania and ignoring the fact that the depression, which characterises the condition, is the more toxic and impairing aspect of the illness. About 24 per cent of patients with bipolar II disorder attempt suicide during their illness compared with 17 per cent of patients with bipolar I disorder.4

Bipolar disorder is a lifelong illness even though patients may feel relatively well for significant periods of time. Judd et al. found that patients were symptom-free for about half the time over a 30-year follow-up.5,6 Nevertheless, the likelihood of relapse among bipolar patients remains constant over decades as does the increased rate of suicide. Merikangas et al. found a 4.4 per cent mean lifetime prevalence of any bipolar disorder among 9282 adults in the USA, of whom 50 per cent or more were not receiving medication.7 A sample of 60 000 adults in the community showed a lifetime prevalence worldwide of 0.6 per cent (0.4 per cent 12-month prevalence) for bipolar I, 0.4 per cent (0.3 per cent) for bipolar II, and 1.4 per cent (0.8 per cent) for bipolar disorder not otherwise specified, and found that only 45 per cent were receiving metal health care.8 So it is common across the world and undertreated.

**Cost**

Das Gupta and Guest estimated that the annual social and economic cost of bipolar disorders to the UK was £2 billion at 1999/2000 prices.9 Around 10 per cent of this (about £200m) was attributable to NHS resource use, of which 35 per cent was attributable to hospital admissions. McCrone et al. estimated that the total socioeconomic cost for bipolar disorder and related conditions in 2007 was £5.2 billion, £1.6 billion of which was comprised of total service costs, which included not only health care services but also social care, criminal justice services, informal care from family members and costs associated with lost employment.10 However, McCrone’s figures relied on US data so are likely to be at the top end, Professor Young commented.

**Holistic future**

Bipolar disorder is fascinating in that it is one of the few illnesses that can present with an apparent opposite symptomatic picture during different episodes. However, these episodes tend to be viewed, and so treated, in isolation, which can lead to patients being subjected to the ‘revolving door’ syndrome where they are readmitted for each episode and are seen by a different team each time. Professor Young felt there was a case for specialist secondary care bipolar teams that treated the illness holistically. He felt such an approach would reduce the number of readmissions and thus save the NHS resources and money.

**References**