Letters

ADHD OR BIPOLAR, BUT NOT BOTH

"What's the best treatment for comorbid ADHD/bipolar mania?" by Drs. Nick C. Patel and Floyd R. Sallee (CURRENT PSYCHIATRY, April 2005, p. 27-37) was well-written and offers excellent treatment guidelines. However, the idea that patients can have comorbid bipolar disorder and attention-deficit/hyperactivity disorder (ADHD) is a fallacy.

I challenge any colleague, from the leading expert to the most recent graduate, to present a bona fide case of "comorbid" ADHD/bipolar disorder. I can prove that only one diagnosis is correct because:

- Bipolar disorder is more heritable than other psychiatric illnesses. Many patients labeled as having "comorbid" bipolar disorder and ADHD have parents with bipolar disorder or schizophrenia or are in foster care and their biological parents' histories are unknown.
- I've seen hundreds of patients enter full-blown psychosis after another clinician put them on amphetamines or antidepressants while being treated for ADHD.
- Bipolar disorder can explain any so-called ADHD symptom.
- ADHD does not include moodiness or predatory aggression.

Over 10 years, I have diagnosed three or four patients as having comorbid bipolar disorder and ADHD. After a few years and inpatient treatments, these patients proved the second diagnosis wrong. We can decrease costs and avoid patients' suffering by refining diagnostic criteria.

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Drs. Patel and Sallee respond

Dr. Mota-Castillo's argument is most often stated from the opposite point of view that bipolar symptoms, particularly in patients age <10, are almost indistinguishable from those of ADHD. Our article did not—and cannot—address this controversy.

Because the evidence has been inconclusive, it is unclear if comorbid bipolar disorder and ADHD result from overlapping DSM-IV-TR diagnostic criteria, or whether two concurrent disorders exist. Suffice it to say that ADHD and bipolar disorder have many phenotypes and are both highly—but distinctly—heritable.

Overlapping symptoms may confound clinical diagnosis and result in "false positives" but may not account for most bipolar youths with comorbid ADHD. In one study,[1] 56% of subjects with both disorders maintained a bipolar disorder diagnosis when overlapping ADHD symptoms were subtracted.

Combination pharmacotherapy is needed because mood stabilizers do not treat attention and neurocognitive problems associated with ADHD. Therefore, a psychostimulant trial may help euthymic bipolar children and adolescents. In a recent placebo-controlled study by Scheffer et al,[2] ADHD symptoms—as measured with the Clinical Global Impression of Improvement scale and based upon Conners' Teachers and Parent Ratings—significantly improved among divalproex sodium responders receiving mixed amphetamine salts.

Dr. Mota-Castillo, however, brings up two important questions:

- Are childhood symptoms that result in ADHD diagnosis a prodromal manifestation of

bipolar disorder in some patients? Data from the first 1,000 STEP-BD participants suggest that ADHD may be part of the developmental phenotype of bipolar disorder comorbidity. Participants with mood symptom onset before age 13 had higher rates of comorbid ADHD than did those whose mood symptoms surfaced later on.[3]

• Do psychostimulants hasten mood disorder onset in a child diagnosed with ADHD who has a high familial risk of a mood disorder? How these agents influence the course of bipolar disorder is unclear. DelBello et al[4] reported that psychostimulant exposure may be a stressor in youths at risk for bipolar disorder, may progressively worsen affective symptoms over time, and may lead to earlier mood symptom onset.

Both questions need further exploration as the implications for clinical practice may be tremendous.

Results from numerous independent studies consistently suggest that patients can be diagnosed with comorbid bipolar disorder and ADHD. More research is needed, however, to solve this diagnostic conundrum.

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References

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2. Scheffer RE, Kowatch RA, Carmody T, Rush AJ. Randomized, placebo-controlled trial of mixed amphetamine salts for symptoms of comorbid ADHD in pediatric bipolar disorder after mood stabilization with divalproex sodium. *Am J Psychiatry* 2005;162:58-64.
3. Perlis RH, Miyahara S, Marangell LB, et al, for the STEP-BD Investigators. Long-term implications of early onset in bipolar disorder: data from the first 1,000 participants in the systematic treatment enhancement program for bipolar disorder (STEP-BD). *Biol Psychiatry* 2004;55:875-81.
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MEDICATIONS FOR INDIGENT PATIENTS

Dr. Shelley Sellinger's article "Helping indigent patients obtain medications" (Pearls, CURRENT PSYCHIATRY, April 2005, p. 103) is helpful for psychiatrists working with patients who lack pharmacy benefits. Not having the information handy or believing the process is too cumbersome may deter some clinicians from using patient assistance programs.

We also suggest the following services:

• **www.needymeds.com** lists thousands of medications alphabetically (by brand or generic name). Each listing provides complete assistance program information, including the phone number, eligibility criteria, and application form.

• **GlaxoSmithKline (GSK) patient assistance program.** Simply obtain a brief application by calling 1-866-PATIENT (728-4368) or logging onto www.bridgestoaccess.gsk.com. Fill out the form, then call 1-866-PATIENT to activate the attached coupon. Give the patient the coupon and a 60-day prescription for a GSK medication. The patient can fill the prescription at any pharmacy for a $10 co-payment. GSK then mails you 3-month supplies of the medication for 1 year.

Requests through most patient assistance programs generally take 4 to 6 weeks to process, so fill out the request form for the next batch of medication at the time you hand the newly obtained batch to the patient. This will ensure an uninterrupted medication supply.

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