# FPs Urged to Hone Skill at Diagnosing Bipolar

BY BRUCE K. DIXON
*Chicago Bureau*

CHICAGO — Family physicians can close gaping holes in the safety net for individuals with bipolar disorder by following a few important guidelines, according to Dr. John R. Purvis.

"This is a very complicated illness with complicated treatment, and it's our job as family doctors to diagnose these patients," Dr. Purvis said at the annual meeting of the American Academy of Family Physicians.

Research data suggest that two-thirds of bipolar patients are initially misdiagnosed. In addition, patients see a mean of four physicians before the correct diagnosis is made, and more than one-third wait 10 years or longer for the correct diagnosis (J. Clin. Psychiatry 2003;64:161-74).

"It's estimated that 3%-4% of the population has some sort of bipolar spectrum disorder, and roughly 20% of people who walk into your office with depression have bipolar disorder," said Dr. Purvis, associated director of the family practice residency program at Tallahassee Memorial Healthcare in Florida.

Family physicians should use the Mood Disorder Questionnaire to screen all patients presenting with depression, panic disorder, or anxiety disorder, Dr. Purvis advised.

Because the questionnaire is designed for screening only, its results should be confirmed by the physician's evaluation, and "if you're unsure or uncomfortable managing the patient yourself, get a consultation with a psychiatrist," he added.

A key question to ask patients is, "Do you have racing thoughts?" he said. "This is the most important question. In my experience, it is almost diagnostic, particularly when the racing thoughts keep the patient awake."

Risk is increased in those with first-degree relatives who have bipolar illness or major depression. In addition, seasonal depression, postpartum depression, psychotic depression, and atypical depression should raise suspicion.

There's a common misconception that bipolar I (and II) disease involves regular intervals of mania (or hypomania) and depression separated by periods of euthymia, Dr. Purvis said.

"Even though the diagnosis rests with mania and hypomania, bipolar disease is primarily a disease of depression. Those who are bipolar I spend three times as much of their time depressed as they do manic, and for bipolar II illness the ratio is 1% of the time hypomanic and 50% of the time depressed," he noted.

Comorbid conditions include attention-deficit/hyperactivity disorder, panic attacks, social phobia, and obsessive-compulsive phenomena.

"If you just make the diagnosis of bipolar disorder, you have done the patient a huge service," Dr. Purvis said, explaining that bipolar patients often have chaotic lives, "so it's important to set boundaries, particularly regarding appointments and pain medications."

The goals of treatment are to restore sleep, normalize mood, and maximize executive and cognitive functioning.

"The foundation of treatment of bipolar disorders is behavioral and medication therapy," he said, adding that a good place for the treating physician to start is with the Texas Treatment Guidelines of 2005 (http://www.psycheducation.org/depression/APAguide.htm), which emphasize the importance of mood stabilizers such as lithium, most antiepileptics, and most antipsychotics, but urge caution in the use of antidepressants, which may worsen the condition.

Although some physicians believe that it's acceptable to use antidepressants with mood stabilizers, Dr. Purvis said he believes that mood stabilizers should be used to treat bipolar depression and that antidepressants should be used with caution and for only short periods of time.

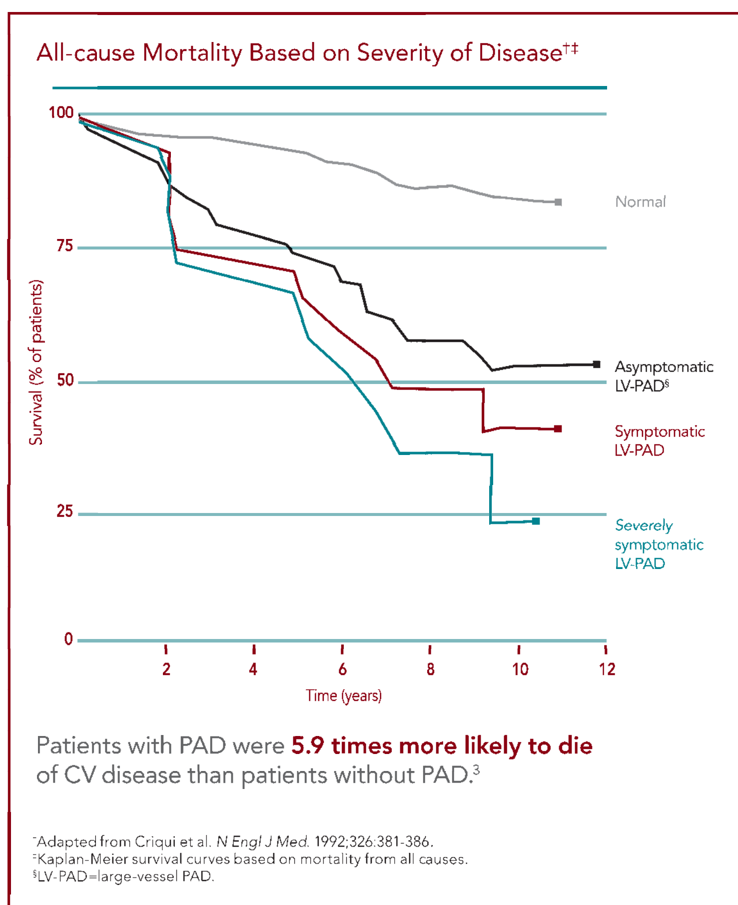
"The one thing that is very clear is that antidepressant monotherapy in bipolar depressed patients is not acceptable," he said in an interview.

Dr. Purvis noted that for some patients, bipolar illness can confer an advantage. "Bipolar illness is sort of like uranium, which can level a city or light a city. Some of the most creative people—including researchers, physicians, CEOs, and actors—are bipolar and can work on several levels at once when they're not in a depressed mood," he said, adding that careful treatment is necessary to keep such patients from self-destructing. ■


## 8 million Americans suffer from PAD[2]

It is estimated that between 12% to 20% of the US population 65 or older have PAD.[2]

## PAD patients face an increased risk of mortality




Patients with PAD were **5.9 times more likely to die** of CV disease than patients without PAD.[3]

†Adapted from Criqui et al. *N Engl J Med.* 1992;326:381-386.
‡Kaplan-Meier survival curves based on mortality from all causes.
§LV-PAD=large-vessel PAD.

## PAD and the Health Care Provider

ACC/AHA PAD guidelines point out that primary care providers are in the best position to detect PAD.[4]

*It is estimated that*

***only 25% of patients diagnosed with PAD are undergoing treatment***[2]

The ACC/AHA PAD Guidelines Class 1 Recommendations for PAD patients include both:

—Symptom relief management for claudication

—CV risk reduction to reduce future events such as MI, stroke, and vascular death

## Find out more about PAD

The Peripheral Arterial Disease (P.A.D.) Coalition, www.padcoalition.org, is an alliance of more than 50 leading health organizations, vascular health professional societies, and government agencies united around a common purpose—to raise public and health professional awareness about lower extremity PAD.

The P.A.D. Coalition offers tools and information to improve the prevention, early detection, treatment, and rehabilitation of people with, or at risk for, PAD.

**Bristol-Myers Squibb/Sanofi Pharmaceuticals Partnership is a proud sponsor of the P.A.D. Coalition.**

**References: 1.** Steg PG, Bhatt DL, Wilson PWF, et al, for the REACH Registry Investigators. One-year cardiovascular event rates in outpatients with atherothrombosis. *JAMA.* 2007;297:1197-1206. **2.** American Heart Association. *Heart Disease and Stroke Statistics—2007 Update.* Dallas, Tex: American Heart Association; 2007. **3.** Criqui MH, Langer RD, Fronek A, et al. Mortality over a period of 10 years in patients with peripheral arterial disease. *N Engl J Med.* 1992;326:381-386. **4.** Hirsch AT, Haskal ZJ, Hertzer NR, et al. ACC/AHA 2005 guidelines for the management of patients with peripheral arterial disease (lower extremity, renal, mesenteric, and abdominal aortic). 2006. http://www.acc.org. Accessed May 4, 2006.

CV=cardiovascular.
PAD=peripheral arterial disease.
CAD=coronary artery disease.
CVD=cerebrovascular disease.
ACC/AHA=American College of Cardiology/American Heart Association.

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