Many Bipolar Patients Are Also Ailing and Obese

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Pittsburgh — Patients with bipolar disorder have an unexpectedly high prevalence of medical comorbidities, based on findings from a study of 175 patients.

These 175 patients, with an average age of 35, had a high prevalence of gastrointestinal, musculoskeletal, genitourinary, and other medical comorbidities, Ellen Frank, Ph.D., said at the Sixth International Conference on Bipolar Disorder.

The rates were "very high for such a young population. It stunned us," said Dr. Frank, professor of psychiatry and psychology at the University of Pittsburgh, which sponsored the conference.

If physicians focus only on the psychiatric symptoms of patients with bipolar disorder, they "do their patients a disservice because they also have a lot of medical illness . . . associated with poor psychiatric outcomes," she told this newspaper.

The Pittsburgh Study of Maintenance Therapies in Bipolar Disorders was designed to assess the efficacy of a psychosocial therapy as an adjunct to pharmacotherapy. But as part of the study, the participants underwent a thorough medical work-up at baseline.

The initial assessment found large numbers of patients with an active medical illness. For example, 59 of the 175 patients (34%) had active gastrointestinal disease; a total of 97 (55%) had a history of gastrointestinal disease, but the condition was not active in all patients.

Active musculoskeletal or joint disease was found in 56 patients (32%), and a total of 131 (75%) had a history of this comorbidity. A substantial fraction also had active genitourinary disease (43 patients, 25%), headaches or migraines (42 patients, 24%), asthma or respiratory disease (41 patients, 23%), and cardiovascular disease (32 patients, 18%). In addition, 58 patients (33%) were obese.

One analysis of the findings assessed the efficacy of maintenance treatment in patients with four or more active comorbidities, compared with those with fewer comorbidities. The analysis showed that, during 2 years of follow-up, patients with four or more active comorbidities were about twice as likely to have a recurrence of bipolar symptoms as were patients with fewer comorbidities, reported Dr. Frank, who is also director of the depression and manic-depression prevention program at the Western Psychiatric Institute and Clinic in Pittsburgh.

Active Comorbidities in a Study Of 175 Adult Bipolar Patients

Gastrointestinal disease	59
Obesity	58
Musculoskeletal/joint disease	56
Genitourinary disease	43
Headache/migraine	42
Asthma/respiratory disease	41
Cardiovascular disease	32

In the subgroup of patients with a high number of active, medical comorbidities, intensive clinical management was the superior maintenance therapy. The second psychosocial treatment tested—interpersonal and social rhythm therapy—was more effective for patients with fewer medical comorbidities.

The high prevalence of medical comorbidities seen in this study leads to two additional messages on how to best manage patients: First, "some treatments for bipolar disorder may exacerbate medical symptoms," Dr. Frank said. "We need to be careful when treating patients who are at risk" for obesity, cardiovascular disease, and other conditions. "Many bipolar disorder drugs have cardiac effects, so physicians have to be aware of these risk factors."

Since bipolar patients often find it hard to adhere to a healthy diet and exercise plan, they need tools for improving their physical health–related behavior, Dr. Frank said. ■

Bipolar-Specific Psychosocial Therapy Reduces Episodes

Pittsburgh — Psychosocial therapy can be a useful adjunct to drug therapy in patients with bipolar disorder, based on results from a study with 175 patients.

The study's findings also documented the high prevalence of medical comorbidities in patients with bipolar disorder. Identifying comorbidities is an important part of devising an appropriate management strategy for bipolar patients, Ellen Frank, Ph.D., said at the Sixth International Conference on Bipolar Disorder.

"We have enough data to say that adding a bipolar disorder–specific psychosocial therapy is much more likely to have benefit than not. But this does not mean that adding any therapy will [be beneficial]." The psychosocial therapy used needs to be specific for treating bipolar disorder, Dr. Frank said in an interview. "The effect of adding psychosocial therapy to monotherapy with a drug is greater than adding a second drug."

The Pittsburgh Study of Maintenance Therapies in Bipolar Disorder involved 175 patients diagnosed with bipolar disorder, with an average age of 35 years old. All patients were treated with pharmacotherapy. The study was designed to compare the efficacy of interpersonal and social rhythm therapy (IPSRT) with intensive clinical management (ICM) as both acute and maintenance therapies.

IPSRT involved a regularization of daily routines, and psychotherapy that focused on interpersonal problem areas such as grief, role transitions, and role disputes. The psychotherapy was designed as a link between mood changes and life events. The strategy also used a social rhythm measure to monitor changes in the patient.

ICM involved teaching patients about bipolar disorder and the medications used to treat it, as well as educating them about the warning signs of impending bipolar episodes, the use of rescue medication, and the availability of a 24-hour call service.

After adjustment for the effects of marital status, anxiety, and medical burden, patients who were acutely treated with interpersonal and social rhythm therapy went significantly longer without new episodes during 2 years of maintenance therapy, compared with patients treated with intensive clinical management. The advantage of IPSRT was seen regardless of the treatment strategy used during maintenance, reported Dr. Frank, professor of psychiatry and psychology at the University of Pittsburgh, which sponsored the conference.

"For patients without high medical burdens, IPSRT seems to prevent recurrences of mania and depression," she said in an interview. "ICM is also a reasonable strategy. There was a relatively low level of recurrence in both [the IPSRT and ICM] groups. But the modified form of IPSRT works well for bipolar patients with comorbid anxiety or anxiety spectrum conditions."

Psychosocial therapies for bipolar disorder are just starting to be used. "There have now been eight randomized, controlled trials of psychosocial therapies in patients with bipolar disorder, and in seven studies, they produced significant benefits," said Dr. Frank, who is also director of the depression and manic-depression prevention program at the Western Psychiatric Institute and Clinic in Pittsburgh.

The successful studies have also tested other forms of psychosocial interventions, such as cognitive therapy and family-focused therapy. A unifying thread of the successful interventions was that they were modified to be relevant to patients with bipolar disorder, she said.

Spectrum Mania Bridges Gap Between Unipolar and Bipolar

Pittsburgh — About a third of patients with unipolar depression actually have "lifetime spectrum mania," which means they also have symptoms of mania and anxiety disorders, based on results from a study with 148 patients.

Lifetime spectra mania "bridges the gap between bipolar and unipolar depression," Giovanni B, Cassano, M.D., said at the Sixth International Conference on Bipolar Disorder.

These patients meet rigorous criteria for unipolar depression, but their symptoms of mania and hypomania don't meet DSM-IV criteria for bipolar disease, said Ellen Frank, Ph.D., a professor of psychiatry and psychology at the University of Pittsburgh and coinvestigator on the study.

Because this is a recent finding, it's "too soon to say" exactly what it means for patient management, but Dr. Frank offered some possible implications at the conference, sponsored by the university:

▶ These patients are much more scared of psychoactive drugs and more sensitive to the drugs' adverse effects, which means that they need to be started on a lower dose and the dose increased slowly, Dr. Frank told this newspaper. Physicians also need to provide a lot more reassurance to these patients about the adverse effects that appear.

▶ These patients have difficulty identifying their feelings. They may not distinguish irritation, anger, fear, and anxiety, so psychotherapy needs to help patients recognize what they feel and how to communicate it to others.

▶ These patients also tend to be avoiders and procrastinators who need help in engaging with others.

The message for physicians is that when a patient has unipolar depression he or she should determine whether the patient has coexisting mania and anxiety disorder. It's important to make this diagnosis because patients with all of these symptoms tend to be harder to treat, and to require more wide-ranging therapy that's applied for a longer period of time, said Dr. Frank, who is also director of the depression and manic depression prevention program at the Western Psychiatric Institute and Clinic in Pittsburgh.

The study assessed 148 patients with unipolar depression for other psychiatric symptoms. High scores for symptoms of mania, panic, obsessive-compulsive disorder, and social anxiety were seen in 34% of the patients. The remaining 66% had low scores for all of these associated symptoms; their only clear symptom was depression, reported Dr. Cassano, professor and chairman of the department of psychiatry, neurobiology, pharmacology, and biotechnology at the University of Pisa (Italy).

The study was a collaboration between the University of Pisa and the University of Pittsburgh. ■