Transcript Details

This is a transcript of a continuing medical education (CME) activity. Additional media formats for the activity and full activity details (including sponsor and supporter, disclosures, and instructions for claiming credit) are available by visiting:
https://reachmd.com/programs/cme/bipolar-1-and-2-distilling-the-critical-differences/15292/

Released: 03/31/2023
Valid until: 03/31/2024
Time needed to complete: 1h 46m

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Bipolar 1 and 2: Distilling the Critical Differences

Announcer:
Welcome to CME on ReachMD. This episode is part of our MinuteCME curriculum.

Prior to beginning the activity, please be sure to review the faculty and commercial support disclosure statements as well as the learning objectives.

Dr. Singh:
Hello. My name is Manpreet Singh. I'm at Stanford University, where I do research in bipolar disorders and across the lifespan. Today I'm going to talk to you about Bipolar 1 Disorder, Bipolar 2 Disorder: Distilling the Critical Differences. Our hope here is that we can get into the nuts and bolts of how we make a diagnosis – an accurate one, at that – because misdiagnosis and underdiagnosis are common among patients with bipolar disorder. In fact, if you look at the epidemiology of rates of diagnosis, and also talk to patients in terms of how long it takes them for – to receive an accurate diagnosis, up to 60% of depressed patients with bipolar 2 disorder are initially diagnosed with unipolar depression, and very often it may take upwards of a decade or more, to receive an accurate diagnosis of bipolar disorder. Imagine living 10 years without an accurate diagnosis, and having to struggle with maybe incorrect diagnoses, and the implications of that including inappropriate or inaccurate treatments. Other diagnoses that are commonly misdiagnosed with bipolar disorder, in addition to unipolar depression, are anxiety disorder, schizophrenia, personality disorders, substance use disorders and a smattering of other diagnoses, that can often present with overlapping symptoms, so it becomes very important for a clinician to think very deeply about the differential diagnosis. What are the possible options? What are the key critical symptoms, and how do I make sure that I'm ruling out as well as ruling in?

When you look at the overlap between even bipolar 1 disorder and bipolar 2 disorder, there are a number of factors that might lead us to think a diagnosis of bipolar disorder is pretty difficult to make, because of the continuum between bipolar 1 and bipolar 2, but here are some factors to consider that separate them. So in the Venn diagram here, you see the classic symptoms of mania and hypomania, distractable, impulsive, grandiose, fast thought, increased activity, decreased need for sleep, talkative, or as I like to call T, trouble – any other trouble kind of beha – troublesome behaviors that fall into the category of impulsivity. In both conditions – in bipolar 1 and bipolar 2 – major depressive episodes are – are present and the criteria are the same. The rates of suicide are similar in – in comparison to the general population, but the differences are meaningful because bipolar 1 disorder is a full threshold condition. It is at least a week or more of symptoms. It can involve psychosis at least half of the time. It is hi – disabling and the highs or the euphoric moods, the mania – frank mania – can even lead to hospitalization. Rates are similar among males and females, and the ratios of highs to lows are – are pretty close together, compared to bipolar 2 disorder, which I'll go over in a moment. But in fact, the ratios of lows to highs are in about a 3:1 ratio. So, this diagnosis can be very easy to make and rule out early, if you can understand the criteria for bipolar 1 disorder and make sure that a patient does not have mania that constitutes 50% of the day, every day, of elevated or euphoric mood or irritability plus DIGFAST symptoms lasting at least a week. Bipolar 2 disorder, in contrast, is a little bit less prevalent and in fact, if you ask me, how often do I see it in kids, I can really count on my hand how many times I've diagnosed bipolar 2 disorder in kids, in part because kids typically present classically with bipolar 1 disorder or unspecified bipolar disorder. I often hear, "It's 2-3 days, 2-3 days," never 4 or more, or 4-7 days, which defines bipolar 2 disorder. The highs last at least 4 days, but not 7 days or more. So somewhere between the 4-7 day range is what you're shooting for, in terms of time criteria. And, hypomania is required in combination with 1 or more major

depressive episode. Bipolar 2 disorder is – I guess you could say – a little bit less severe than bipolar 1 disorder, in terms of intensity of the manias, but it's not that they are not disabling. It's that in terms of the impact it has on morbidity and mortality for patients, it's that the highs aren't as disabling and don't lead to hospitalizations. Women, more than men, experience bipolar 2 disorder, and the ratios of lows to highs here is much higher, 39:1, so the prevailing episodes for individuals with bipolar 2 disorder are depressive episodes. So this is another reason why this diagnosis can become very, very difficult to make, because if you're seeing bipolar 2 depression, and the vast majority of the presentation is depression, and you're looking for 4-7 days of hypomania at some point in their lifetime, that can be sometimes a tricky needle to thread.

So, let's go over the diagnostic criteria of bipolar 2 disorder here, in just a little bit more detail so we get this information down, because it's so tricky, is that in order to meet bipolar 2, you've got to have met criteria for at least 1 hypomanic episode and at least 1 major depressive episode. There has never been a manic episode lasting 7 days or more, or required hospitalization. The occurrence of the hypomanic episode and major depressive episode isn't better explained by other conditions. These are the usual rule-outs, in the diagnostic and statistical manuals – schizoaffective disorder, schizophrenia, schizophreniform, delusional disorder or other specified or unspecified schizophrenia spectrum or other psychotic disorders. And the symptoms of depression or the unpredictability caused by frequent alterations between periods of depression and hypomania cause enough significant distress in a patient's life that it – it can impair social, occupational or other areas of functioning. You have to specify whether the most recent or current episode is hypomanic or depressed, and you might also comment on whether or not the patient is currently in remission, fully or partially, or specify how severe the condition is – mild, moderate or severe. There are other opportunities for specifiers here too, in DSM-5, including anxious dis – distress with mixed features, with catatonia, with mood congruent psychotic features, with peripartum onset, seasonal patterns or rapid cycling. The importance of these specifiers is to help people understand that these conditions can coincide with other, maybe subthreshold, conditions that don't meet for a full comorbid condition, but often are very prominent in the condition itself. So, a hypomanic episode is a distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased activity or energy lasting at least 4 consecutive days and present most of the day, nearly every day. I hope this review of the diagnostic criteria for bipolar disorder 2 is helpful to you.

Here are the diagnostic criteria for major depressive disorder – DSM-5. And again, I'm not going to belabor this. Most of us know these diagnostic criteria, so I'm going to have you read them later, but I want to just point to the fact that you must remember, a depressive episode is a distinct period of abnormally and persistently sad or anhedonic mood. It can add irritability to the index mood in kids, lasting at least 2 consecutive weeks, present most of the day, nearly every day, and a mixed episode or bereavement are no longer considered exclusionary for a diagnostic cri – meeting diagnostic criteria for major depressive disorder, and they were in DSM-4. You can have mixed features as a specifier, or you may even include bereavement in your conceptual framework of a major depressive disorder. What that means is that if you've had a recent loss, and you meet criteria for major depressive disorder, then one must treat the major depressive disorder.

We were talking about mixed features, and these are just helpful to know and be aware of. Anxiety, agitation, anger or irritability, attentional disturbance and distractibility as well as anhedonia. These 5 A-symptoms, as – as we like to call them, may indicated mixed features. They're very common when people present with mixed states, so they can be the ones that – these can be part of the chief complaint. I think it's important to understand mixed features and the specifier described in DSM-5, because it can have a significant impact on – on episode presentation, but also helps understand how to effectively treat the – the condition. Mixed features can be present in unipolar depression as well as bipolar depression, and you can see the different distributions of mixed features here.

So, up to 60% of patients with bipolar depression are misdiagnosed with unipolar depression. There are many factors and challenges that contribute to the misdiagnosis of bipolar disorder. Being able to diagnose bipolar disorder with an accurate screening and comprehensive assessment for hypomania and mania will improve outcomes. If you don't ask about mania for every single patient who presents to you for any mood symptoms, you've missed an opportunity to evaluate for bipolar disorder, and I say that – this with an earnest plea for all clinicians, because depression is increasingly presenting in our clinics. It behooves us to also screen for mania at the same time. Thank you so much for your time and attention. I hope this was helpful to you.

Announcer:
You have been listening to CME on ReachMD. This activity is jointly provided by Global Learning Collaborative (GLC) and TotalCME, Inc. and is part of our MinuteCME curriculum.

To receive your free CME credit, or to download this activity, go to ReachMD.com/CME. Thank you for listening.