Conversion from unipolar depression to bipolar depression

Robert K. Schneider MD
James L. Levenson MD

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BACKGROUND
Clinicians, both psychiatrists and non-psychiatrists, underdiagnose bipolar disorder in a substantial proportion of depressed patients. Correct diagnosis is important since the prescription of antidepressants without mood stabilizers may precipitate a switch to mania. In patients presenting with depression, what are the odds they will turn out to really be bipolar? There are few long-term studies looking at the conversion rates from unipolar to bipolar depression. The conversion rates vary across subpopulations of depression. In out-patient depressed patients new-onset bipolar was found in up to 20% of individuals. In depressed adolescents the conversion from unipolar to bipolar ranges from 19% to 37% in follow-up studies. Most depression studies in the 1980s involved patients with the average age in the middle 30s, which would underestimate conversion rates.

AIM
To provide long-term data on the prospective development of mania in a young cohort. To find any clinical features that may be associated with subsequent mania or hypomania. To explore to what extent is antidepressant use longitudinally associated with the induction of mania or hypomania.
METHODS
74 patients, mean age 23 years hospitalized for unipolar depression were followed prospectively for 15 years. Patients were interviewed and records assessed at 2, 5, 8, 11, and 15 years after discharge.

MAIN FINDINGS
By 15 year follow-up, 41% had developed either hypomania or mania (26% hypomania, 15% mania). 80% of the 10 patients who were initially psychotic developed hypomania (4/10) or mania (4/10). In contrast, 34% of the non-psychotically depressed eventually became either manic or hypomaniac (p=0.003). No significant associations were found between gender or substance abuse and polarity. Polarity conversions were similar whether spontaneous or in conjunction with antidepressants (with or without concurrent mood stabilizer).

CONCLUSIONS
Younger patients with unipolar depression especially with psychotic features may be at a particularly high risk for conversion to bipolar depression.

LIMITATIONS
This study started in the early 1980s when the threshold for psychiatric admissions and treatments for depression were different then at present. Also, given that these were psychiatric inpatients, the results are likely an overestimate for primary care practice. This was a naturalistic study and not a treatment intervention study, so differences between treatment regimens may be a confounder.

IMPACT ON INTERNAL MEDICINE
Major depressive disorders are the most common psychiatric disorders seen in primary care, yet history of mania and hypomania is seldom obtained, and mood stabilizers are used even less frequently. Physicians (non-psychiatrists and
psychiatrists) need to be especially vigilant in younger patients with unipolar depression, who may convert to bipolar depression. Patients with bipolar I or II seem to be at particular risk for switching to mania or hypomania when being treated with antidepressants. Bottlender and colleagues found the switch from depression to mania or hypomania occurred in 25% of patients (inpatients with bipolar I) receiving antidepressants. This risk was significantly less when a mood stabilizer was used concurrently.

RELATED REFERENCE: