

key points

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Bipolar disorder is a complex, recurrent, severe and potentially lifelong mental illness. The peak age of onset is 15-19 years, with most cases developing before the age of 30. The lifetime prevalence of bipolar I disorder (mania and depression) and bipolar II disorder (hypomania and depression) is estimated to be 1.0% and 1.1% of the adult population, respectively. The risk of recurrence is high: 60% of people presenting for the first time with mania will experience a further affective episode within two years. The risk of suicide is up to 20 times higher than in the general population.

A period of ten years from onset of symptoms to diagnosis is unexceptional. Up to 60% of patients initially present with depression, without any clinical evidence of a prior manic/hypomanic episode. Once a diagnosis of bipolar disorder is made, depressive symptoms typically dominate the clinical picture. In bipolar I, the time spent with depressive symptoms outnumbers that with (hypo)manic symptoms by a ratio of 3:1; in bipolar II the ratio is 39:1.

Useful screening tools for detecting bipolar disorder in primary care are not available. NICE advises that, when assessing depression, GPs should enquire about previous episodes of overactivity or disinhibited behaviour; if these have lasted for more than four days the patient should be referred to secondary care. Other pointers to bipolar depression are: frequent or severe episodes of depression, a family history of bipolar disorder, treatment resistance, young age, and atypical features (e.g. hypersomnia, hyperphagia or racing thoughts).

The distinction between bipolar I and II is based on the duration and severity of (hypo)manic episodes. Bipolar II is not simply 'less severe' bipolar disorder: though episodes of mood elevation may be less extreme, patients probably spend more time unwell than in type I and suicide attempts and completed suicide are at least as common. In addition to these diagnoses, many more patients have subthreshold bipolar symptoms. Cyclothymia refers to a chronic mood disturbance, lasting at least two years, with depressive and hypomanic symptoms that do not meet diagnostic criteria for major depression or hypomania. In a nationally representative sample of US adults diagnosed with depression, 40% of participants also had a history of subthreshold hypomanic symptoms.

Treatment of (hypo)mania will normally be initiated by the psychiatric team and generally involves stopping antidepressants, starting an antipsychotic and, once elevated mood has settled, adding a 'mood stabiliser'. It is crucial to distinguish bipolar from unipolar depression not only as an essential starting point for appropriate treatment and risk management, but also to avoid antidepressant monotherapy, which can exacerbate the frequency and severity of mood symptoms and cause resistance to appropriate medications.