**Prognosis**

**Patients with early adolescent bipolar disorder had 37.1% recovery and 38.3% relapse rates**


**QUESTION:** In children with a pre-pubertal and early adolescent bipolar disorder phenotype, what are the 1 year recovery and relapse rates?

**Design**
Cohort study with naturalistic follow up at 6 and 12 months.

**Setting**
[A university research unit in St. Louis, Missouri, USA.]*

**Participants**
95 participants (mean age 10.9 y, 57% pre-pubertal) receiving all treatment from their own practitioners in outpatient paediatric and psychiatric sites, who were consecutive new cases diagnosed with a pre-pubertal and early adolescent bipolar disorder phenotype (assessed by the Washington University in St Louis Kiddie Schedule for Affective Disorders and Schizophrenia [WASH-U-KSADS]) defined by elation (90%) and/or grandiosity (85%) as one *DSM-IV* criterion, and with a Children’s Global Assessment Scale (CGAS) score of ≤60 (mean = 43.3). Patients were also assessed for mixed mania (overlapping time periods of mania/hypomania and major depressive disorder) (54%), rapid cycling (4 episodes/y), ultrarapid cycling (>4 and <365 episodes/y), and ultradian cycling (≥365 episodes/y) (87%).

**Assessment of prognostic factors**
Sex, puberty status, presence of mixed mania, psychosis, ultradian rapid cycling, comorbid deficit hyperactivity disorder, comorbid oppositional defiant disorder, and use of antimanic medication (neuroleptics, anticonvulsants, and lithium).

**Main outcome measures**
Recovery (no *DSM-IV* syndromal criteria for mania or hypomania for ≥2 wks) and relapse (*DSM-IV* syndromal criteria for mania or hypomania and a CGAS score of ≤60 for ≥2 wks).

**Main results**
89 participants (96%) were available at follow up. Kaplan-Meier statistic estimates for recovery and relapse rates were 37.1% (95% CI 27 to 47.1) and 38.3% (CI 14.8 to 61.9), respectively. No prognostic factors were significantly associated with recovery or relapse.

**Conclusion**
In participants diagnosed with a pre-pubertal and early adolescent bipolar disorder phenotype, characterised by elation and/or grandiosity, recovery rate was 37.1% and relapse rate was 38.3% at 1 year.

*Information provided by author.

**COMMENTARY**
This study by Geller et al adds to the limited data on recovery and relapse rates of children with pre-pubertal and early adolescent bipolar disorder. An 18 month, naturalistic, prospective follow up study of bipolar adolescents by Strober et al found the relapse rate in patients who discontinued lithium treatment was nearly 3 times greater than patients who continued lithium prophylaxis. Another 5 year, naturalistic, prospective follow up study of 54 adolescents (mean age 16 y) with bipolar I disorder showed that mean recovery time of adolescents with pure manic or mixed index episodes was 9 weeks and 11 weeks, respectively, whereas those with pure depression had a mean recovery time of 26 weeks. Probability of relapse at 5 years among subjects with pure mania, pure depression, and mixed states at entry were 42%, 38%, and 40%, respectively. In a study of adult manics, Winokur and Kadrmas reported an increased vulnerability to multiple relapses among adult patients whose illness started in adolescence.

Children with early onset bipolar disorder have long episode duration; high prevalence of mixed mania, psychosis and rapid cycling; impaired psychosocial functioning; and high risk of substance use disorders and school dropouts. Strober et al reported that 11 (20%) of 54 adolescents with mania attempted suicide by 5 years of follow up. Thus, early recognition of bipolar disorder in children and adolescents and its appropriate treatment is crucial as all studies have found significant impairment at follow up.

The study by Geller et al notes that only 45 children (50.6%) continued to take an antimanic medication from baseline to follow up. Thus, it is not clear whether all children were prescribed medication at baseline, or whether the recovery and relapse rates are similar or different for children who took medication compared with children who did not. Also, it is not reported whether there were higher rates of treatment discontinuation with specific medications due to side effects or lack of efficacy or effectiveness.

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