

Functional recovery is limited in people with bipolar disorder

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Q What is the prognosis for people hospitalised with first episode bipolar disorder?

METHODS

-  **Design:** Prospective cohort study, part of the larger decade long McLean-Harvard First-Episode Project.
-  **Setting:** Inpatient units at McLean Division of Massachusetts General Hospital; 1989 to 1996.
-  **Population:** 173 people (mean age 33 years, 55% male) were consecutively recruited within 72 hours of psychiatric hospitalisation for manic (75%) or mixed (25%) episode bipolar disorder (DSM-IV criteria). Exclusions: current substance withdrawal, delirium, previous psychiatric hospitalisation unless for detoxification only, documented IQ <70, ill for >1 year, previous treatment with a mood stabiliser or antipsychotic for >3 months in total.
-  **Prognostic factors:** Participants were assessed weekly until discharge. Semistructured telephone interviews were conducted at 6, 12, 24, 26, and 48 months by experienced assessors. Information obtained included symptoms, occupational status, residential status, current treatment, and determination of syndromal, symptomatic, and functional recovery.
-  **Outcomes:** Likelihood of syndromal, symptomatic, and functional recovery (according to occupational and residential status); risks of first relapse or recurrence.
-  **Follow up period:** Average 4.86 years, 87% followed for ≥2 years.

MAIN RESULTS

Syndromal recovery: 98% experienced syndromal recovery at 2 years. Predictors of earlier syndromal recovery were shorter initial hospitalisations (HR 1.99, 95% CI 1.36 to 2.93, $p < 0.001$), female sex (HR 1.72, 95% CI 1.16 to 2.56, $p = 0.008$), and below median initial depression ratings (HR 1.65, 95% CI 1.14 to 2.39, $p = 0.008$). **Symptomatic recovery:** 72% had symptomatic recovery at 2 years. **Functional recovery:** at 2 years, 43% had functional recovery. Predictors of functional recovery were age ≥30 years (OR 3.28, 95% CI 1.58 to 6.82, $p = 0.006$) and shorter initial hospitalisations (OR 2.82, 95% CI 1.36 to 5.88, $p = 0.006$). **First relapse or recurrence:** 20% had new episodes of mania, 20% new episodes of depression and 19% switched phases without recovery within 2 years (see <http://www.ebmentalhealth.com/supplemental> for table). Predictors of mania were initial mood-congruent psychotic features (HR 2.79, 95% CI 1.31 to 5.91, $p = 0.05$); low premorbid occupational status (HR 2.53, 95% CI 1.15 to 5.55, $p = 0.02$), and initial manic versus mixed state (HR 3.38, 95% CI 1.00 to 11.5 $p = 0.05$). Predictors of depression were higher premorbid occupational status (HR 5.08, 95% CI 2.16 to 11.90, $p < 0.0001$); initial mixed presentation (HR 4.52, 95%

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CI 2.23 to 9.16, $p < 0.0001$); and any comorbidity (HR 2.60, 95% CI 1.20 to 5.66 $p = 0.02$).

CONCLUSIONS

Among people with bipolar disorder who require hospitalisation, many have relapses, switches, and limited functional recovery.

Commentary

The classical description of affective disorders as episodic illnesses with full symptomatic and functional recovery between episodes is no longer valid. Kraepelin's conceptualisation of functional decline as being pathognomonic of schizophrenia, and not affective disorders, no longer holds true.¹ Many people with mood disorders, whether their symptoms persist or not, never return to their premorbid level of functioning after becoming ill.²⁻³ Even with adequate care, the long term course of bipolar I disorder appears to be one of chronicity, with recurrent or subsyndromal symptoms of mania or depression frequently present.⁴

By monitoring changes in functioning, Tohen *et al* have found that in spite of syndromal recovery following hospitalisation for a manic or mixed episode, many patients continue to exhibit subsyndromal symptoms (especially depression) and functional decline. Even when euthymic, compared with people without mood disorders, people with bipolar disorder have cognitive impairment, with the greatest impairment found in verbal and visual-spatial memory.⁵ This may in part explain why previously able people decline in their functioning.⁶

Advances in psychopharmacological treatments of acute bipolar mood episodes have come swiftly, and this study underscores the near term success of those agents in reducing mood symptoms. Successes at obtaining complete euthymia and at preventing relapse to new episodes have been fewer.⁴ Importantly, symptomatic recovery does not guarantee return of functioning, and newer agents have not yet had a positive impact on this problem.² Because the rate of psychosis in this study (87%) is higher than expected, the participants in this study may be somewhat more ill than the average bipolar I patient.

Although 69% of subjects in this study were discharged from inpatient treatment on lithium, only 39% remained on that drug at two year follow up. Although antipsychotic and anticonvulsant use was less frequent at the time of the study, the use of those drugs remained more stable over the first two years of follow up. The difference may be due not only to effectiveness, but to tolerability. As the adverse cognitive effects of lithium and valproate are well known, it will be interesting to note whether newer drugs will have an impact on the likelihood of return to functioning.

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