

Patients with bipolar disorder have been found to be at a greater risk for both additional mental health conditions and physical illnesses. The most common co-occurring conditions appear to be anxiety and substance use disorders, and physical illnesses such as cardiovascular disease and obesity.

In particular the NCS-R study found that nearly all of bipolar I and bipolar II patients (97.7% - 95.8%) also met criteria for another lifetime DSM-IV disorder (Merikangas, Akiskal et al. 2007). Anxiety disorders were prevalent in at least 63.1% - 86.7% of patients with bipolar disorder, 56.1% - 71.2% at least one life time impulse control disorder and 35.5% - 60.3% at least one life time comorbid substance use disorder. Impulse control disorders are thought to be part of the obsessive-compulsive spectrum and include disorders such as intermittent explosive disorder, kleptomania, pyromania, gambling and trichotillomania. Of course these are problem behaviours that may occur or even be maintained during symptomatic phases of bipolar disorder, even during sub-syndromal phases that may not be severe enough to require immediate clinical attention. Interestingly enough sub-threshold bipolar disorders in the NCS-R had an almost equally high rate of axis I comorbidity (88.4%) and an examination of the sequence of each disorder revealed bipolar disorders would most likely be secondary. The rates for comorbidities of axis I disorders in Unipolar disorder (Kessler, Berglund et al. 2003) were high but not as high as in bipolar disorder. Fifty nine (59%) had at least a life time anxiety disorder, 31.9% an impulse control disorder, 24% a substance abuse disorder.

Systematic reviews of the epidemiological studies that reported data on bipolar disorder (Pini, de Queiroz et al. 2005) suggest rather equal rates and disorders again, with anxiety disorder to predominate the clinical picture. More specific studies have revealed a higher likelihood of obsessive-compulsive disorder in bipolar I disorder in comparison with unipolar disorder (Goodwin and Jamison, 2007) and panic disorder, and repeated panic attacks especially for the bipolar II sub-type (Angst, 1998).

Of course all the above findings lead to greater disability and overall burden than by simply having bipolar disorder alone, and also highlight the difficulty of having a pure bipolar sample for conducting any relapse or sub-syndromal study in this population. Comorbid conditions are also likely to contribute to the heterogeneity of sub-syndromal symptoms. Hence in order to take into account the role of comorbid conditions in sub-syndromal symptomatology, studies would either need large samples or careful screening at baseline and inclusion of patients free of major comorbidities.

In UK the annual cost of bipolar disorder has been estimated to be £2 billion or £6900 per person with bipolar disorder at the 1999/2000 rates (Das Gupta and Guest, 2002). The unemployment rate was 46% as opposed to 3% of the 1999/2000 general population unemployment rates. Of the bipolar patients who are employed the NCS-R study found out that “presenteeism” as opposed to “absenteeism” was more important in terms of employment costs. “Presenteeism” was operationalised as being at work and underperforming, which most likely is the result of untreated sub-syndromal symptoms, most likely depressive.

Although bipolar disorder does not directly lead to death, the mortality rates of people with bipolar disorder are alarmingly high. Recent studies have found an increased mortality risk of 2.3 times higher than the expected rate in the general population (Goodwin and Jamison, 2007). Earlier mortality studies that combined unipolar and bipolar samples had found a mortality risk of six times higher than the normal population and prior to drug treatments death from manic exhaustion has also been reported (Derby, 1933). The largest prospective follow up study (38 years) of bipolar and Unipolar patients to examine mortality rates (Zurich cohort), (Angst et al., 2002) reported a higher risk of death from cardiovascular disease, suicide, and accidents in the bipolar sample than the Unipolar group. However, the treated bipolar sample had lower risks of death both for suicide and cardiovascular disease than the untreated sample. Goodwin and Jamison (2007) discuss that with proper lithium treatment some studies suggest that the mortality rates of bipolar patients (mainly from suicide risk) becomes almost equal to that of the general population.

### *key references*

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