of potential murderers and supportive quality improvement should be separate processes, or can be done simultaneously.[2]

We do not know if mortality monitoring in general practice can deter or detect murderers, or detect the non-malicious incompetent, or help raise the quality of care in all practices. The Shipman case demands a response, but the worst of all worlds is an expensive monitoring system that does not work. Developing an effective system or being able to say with certainty that a system cannot serve a particular purpose cannot be achieved through piecemeal local implementation. It needs national commitment, coordination and resources[3] to create a large scale prospective pilot across a number of primary care trust areas, to explicitly compare different monitoring and investigation systems, and with external evaluation to check that mortality monitoring actually does serve its intended purposes without major adverse consequences. If mortality monitoring fails such a real world test, we should abandon it and seek a more suitable alternative.

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Diagnosis and management of patients with bipolar disorder in primary care

Bipolar disorder has previously been reported as having a prevalence of approximately 1%, although there is new data that prevalence rates may actually be as high as 5%.[1] It is therefore likely that GPs will frequently encounter bipolar patients in their practice. New research suggests that up to 30% of patients presenting with depression in primary care may have a primary diagnosis of bipolar disorder.[2] The disorder is characterised by mood fluctuations that include mania, hypomania, depression, and mixed episodes. It is chronic and highly recurrent, and associated with significant distress and disability.[3] The World Health Organisation ranks bipolar disorder as the world's sixth leading cause of disability-adjusted life years among people aged 15–44 years. As many as 25–50% of patients with bipolar disorder attempt suicide during their lifetime.[4]

Bipolar disorder is distinguished from unipolar depression by the presence of a current or past episode of mania or hypomania.[5] Most bipolar patients present with depressive symptoms rather than mania. Active enquiry regarding past mania or hypomania is essential to establish the true diagnosis. The diagnosis may also be blurred by common comorbidities, in particular substance abuse, personality and anxiety disorders. As a consequence, bipolarity is characteristically hard to diagnose in primary care. In one study, only 52% of

sufferers receive a diagnosis by the first or second professional they consult. A diagnosis of bipolar disorder was made in less than 1 year from their first professional contact for only 29% of sufferers, but more than 10 years for 34% of sufferers.[6]

The differentiation into unipolar and bipolar disorder would be semantic if it did not have treatment or prognostic implications. There is clear evidence that the distinction is a therapeutic imperative. Treatments for the two disorders are substantially different and there is increasing evidence that treating patients with bipolar disorder with unipolar therapy algorithms may lead to unfavourable outcomes. This imperative is underlined by studies that suggest that bipolar disorder is among the most treatment responsive and cost-effective disorders to treat among the major disorders in psychiatry.[7]

There are several signs and symptoms that may alert the GP to the possibility that a patient presenting with depression may suffer from bipolar illness. These include a family history of bipolar illness, particularly in a first degree relative.[8] Precipitation of mania or hypomania with antidepressant treatment will confirm a diagnosis of bipolar disorder, although more commonly bipolar disorder sufferers simply fail to respond to antidepressant treatment. Further, where there is failure to respond to three or more antidepressant treatment trials, bipolar disorder should be suspected.[8] The presence of atypical depressive features particularly hypersomnia, should alert clinicians to consider possible bipolarity, as should abrupt onset and offset of episodes and a seasonal pattern. Bipolar disorder has an earlier age of onset than unipolar depression, so it should also be considered in cases where depression appears before the age of 25 years.[8]

Mood stabilisers are the foundation of therapy for bipolar disorder, and current guidelines recommend use of a mood stabiliser in all phases of treatment.[9] Lithium is the most extensively studied mood stabiliser and has been used for both acute,[10–12] and prophylactic[12,13] treatment of bipolar disorder. Lithium has also been found to robustly reduce the risk of suicide.[9,14] Valproate has clear efficacy in the treatment of mania,[10,11] but there is less evidence of its efficacy in bipolar disorder maintenance.[15] Carbamazepine has demonstrated acute antimanic effects,[16] and efficacy as a long-term maintenance agent for sufferers of bipolar disorder.[13,17] Lamotrigine has been found to be efficacious in the acute management of bipolar depression[18] and long-term management of bipolar disorder, especially in delaying depressive recurrence.[19] This antidepressant dominant profile contrasts with the predominantly antimanic activity seen with other mood stabilisers. Lastly, atypical antipsychotics like clozapine, risperidone, ziprasidone and olanzapine are clearly efficacious in acutely manic patients. There is early evidence of efficacy of quetiapine and olanzapine in bipolar depression and evidence for the role of olanzapine in maintenance.

Analysis of marketing data suggests that antidepressants may be more commonly prescribed for use in bipolar disorder than mood stabilisers in some areas.[20] However, increasing data points to the risks of inducing mania, rapid cycling or mixed states.[21] Both rapid cycling, an increase in the number of episodes of illness over time, and mixed states, the occurrence of both manic and depressive symptoms at the same time, are particularly malignant and treatment refractory variants of the illness. While studies have suggested a role for antidepressants in the acute treatment of the depressive phase of bipolar disorder,[22] there is scant evidence for long-term use.[23] Indeed, switching to mania or hypomania may be a cumulative risk in the continuation phase of antidepressant therapy. The field is hampered by the lack of a coherent dataset in this regard.[24]

There is robust evidence suggesting a link between the number of previous episodes experienced by the individual and the risk of future episodes,[25] so relapse prevention strategies are crucial to reduce the morbidity associated with the disorder. The potential of medication to reduce relapse is not always achieved in clinical settings.[26] This may be due at least in part to the problem of non-adherence to prescribed long-term medical treatment in bipolar disorder. Psychosocial interventions that improve medication adherence as well as enhancing overall patient care may serve as a useful adjunct to management in the primary care setting. Various psychosocial interventions including cognitive behavioural therapy,[27] family therapy[28] or Interpersonal and Social Rhythm Therapy[29] involve a psychoeducation component and focus on relapse prevention through increased awareness of illness patterns and prodromes and coping skills to prevent full-blown relapse. These interventions have variously shown improvements in time to relapse, admission rates, length of affective episodes, affective symptomatology and social functioning.

In conclusion, accurate differentiation between unipolar and bipolar disorder is critical. The clinical risk to bipolar patients if they are treated as if they had unipolar depression, is the likelihood that primary treatment will be with antidepressants, rather than mood stabilisers, with the risk of iatrogenic aggravation of the illness. Primary care physicians are often the first clinicians to screen for bipolar disorder and manage its initial manifestations. In many models of care they are also primarily responsible for the long-term management of bipolar patients after specialist stabilisation. They play a pivotal role in detecting, managing and, where necessary, the appropriate referral of patients with bipolar disorder. This role is essential in the management of this highly prevalent and disabling yet treatable condition.

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