Surveillance of Paediatric Bipolar I Disorder in the UK & ROI
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Background
There is considerable uncertainty about the presentation and epidemiology of bipolar disorder in under 18s (Youngstrom et al. 2006). The prevalence of BD in children and adolescents has been reported to vary between 0.1% and 2% (Kessler et al. 1994; Lewisohn et al. 1995; Costello et al. 1996; Weissman et al. 1996; Johnson et al. 2000; Stringaris et al. 2010). Notwithstanding the controversies that remain regarding the presentation, epidemiology and clinical features in early onset BD (Youngstrom et al. 2006) the rates of diagnosis of Early Onset BD in under 18s in USA have increased by 4000% between 1995 and 2005 (Moreno et al. 2007). What remains unclear is whether these high rates are due to better identification of BD in under 18s, increased incidence or over diagnosis of BD (Chang 2009). There is very limited data regarding the epidemiology of bipolar I disorder from the UK. Previous UK studies have used self report and parent report questionnaires from a representative sample to estimate prevalence of mania like symptoms in under 18s (Stringaris et al. 2010). These studies have advanced the field; however might not have been the best technique to estimate incidence in a rare disorder for which surveillance epidemiology case ascertainment would be a better method.

Aims
Primary Aim
To estimate the incidence of first time diagnosis of Bipolar I Disorder in children and adolescents under 16 years of age.
Secondary Aim
1. Symptom and diagnostic profile at presentation
2. Frequency of co-morbid conditions, associated genetic and psychosocial factors
3. Short term and intermediate management strategies
4. Clinical outcome after 1 year

Method
The study used the CAPSS (Child and Adolescent Psychiatry Surveillance System) methodology and received a favourable opinion from NHS REC and NIGB approval. All Consultants in Child and Adolescent Psychiatry in UK and Republic of Ireland were contacted by CAPSS monthly for 13 months using the CAPSS yellow cards asking them to report if they had given a first time diagnosis of narrow phenotype ‘Bipolar I Disorder’ (presenting with elated mood; not just irritable mood) in a child or adolescent under age 16 years. If a consultant confirmed that they had done so, their contact details were sent to our research team so that we could send them an initial questionnaire.

Results
Case ascertainment phase: 151 cases of narrow phenotype Bipolar I Disorder were reported over the first year. Of these 33 cases met the analytical research definition. The age range at diagnosis was 10-15 with median age at diagnosis being 15 years. About 50% cases had had previous mood episodes with the majority having had depressive episodes. 48% of patients required admission to hospital for the management of this index episode. 52% of cases had an additional mental health/developmental disorder co-morbidity. More than half cases received atypical antipsychotics to help manage the index episode

Follow up phase at 1 year: 90% of consultants returned follow up questionnaires (30 of 33). 17 of the 30 cases had a subsequent mood episode in the follow up phase of 1 year. There was a low rate of substance use disorders.

Bibliography


