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Debate section

Letter to the editor

General indicators confounding Kraepelin: predictive indicators of misdiagnosing borderline as bipolar

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In their article titled 'Bipolar or borderline: a clinical overview', Ghaemi and colleagues found the two illnesses to be similar with regard to the nosological validators of mood lability and impulsivity (1). The authors conclusion that such a similarity often leads to misdiagnosis despite the two conditions being seen as different clinical entities is consistent with previous research (2).

We recently reviewed data obtained from a clinical assessment tool used by the Division of Psychosomatic Medicine at Robert Wood Johnson University Hospital in New Brunswick, New Jersey. The tool (GICK) consists of pooled questions from the routine History, Physical and Mental Status Examination included in medical students' orientation packets at the commencement of their third-year clerkship in psychiatry. We looked at 83 consecutive new patient consults requested over a 1-month period and found that 12 patients had a pre-admission diagnosis of bipolar affective disorder (BAD). We chose to exclude patients with a co-occurring substance use disorder ($n = 3$). Of the nine patients identified, 3 were re-evaluated as having a primary diagnosis of borderline personality disorder. While all three patients were also diagnosed with post-traumatic stress disorder (PTSD), none ruled-in for bipolar affective disorder or schizoaffective disorder. Items in the patient's history that demonstrated predictive value of misdiagnosis included (i) a history of physical or sexual trauma, (ii) female gender, (iii) a positive screen to the question, 'Do you consider yourself a nervous person?,' and (iv) a pattern of antipsychotic use characterized by initial efficacy, followed by a loss of effect. Patients with such a pattern may also have related aspects in their history including extrapyramidal side-effects (EPS) and use of benztropine or similar acting anticholinergic medication. While we did find that past sexual abuse was correlated, our study did not find the genetic validator of a bipolar family history being predictive of misdiagnosis. This may have been due to our extremely small sample size.

While ours was a clinical performance improvement project that reviewed data routinely obtained by medical students during a core clerkship, we did find that 3.6% of patients with a pre-admission diagnosis of BAD were misdiagnosed and instead afflicted with borderline personality disorder and PTSD. We plan on applying the identified predictive variables to a larger database of patients with diagnoses of schizophrenia, schizoaffective disorder, and bipolar affective disorder to test their statistical and clinical significance. Such a study would further clarify the role specific indicators in patients' histories play in the accurate diagnosis and treatment planning of individuals who present with mood lability and impulsivity (3, 4).

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Misdiagnosis: Predictive value versus sensitivity

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Reply

In this analysis, 3 of 9 patients previously diagnosed with bipolar illness were felt to be misdiagnosed as having borderline personality disorder (BPD), using DSM criteria (1). I will note that the DSM criteria for BPD are very broad, exclude sexual trauma as a criterion, and list self-harm as one of nine criteria, of which five are sufficient to make that diagnosis. Thus, if my view is correct that sexual trauma and self-harm are central to the borderline personality concept, then the DSM definition of BPD, as used in most research, may not be scientifically valid.

With that proviso, these data reflect predictive values, and not sensitivity, of the bipolar diagnosis. In this case, the positive predictive value (PPV) of bipolar illness was 67% (6/9).