

Health-Related Quality of Life and Healthcare Resource Use: Comparison of Patients with Bipolar I Disorder and Potentially Misdiagnosed Depression

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Abstract

Background. Bipolar I disorder (BP-I) is associated with a high humanistic and economic burden. Evidence suggests that BP-I is often misdiagnosed as major depressive disorder (MDD), but the unmet needs associated with BP-I misdiagnosis are unknown. This study compares socioeconomic, healthcare-related quality of life (HRQoL), and healthcare resource utilization (HRU) burdens of participants diagnosed with BP-I vs participants who screened as probable for BP-I but were diagnosed only with MDD.

Methods. Using responses to the 2020 National Health and Wellness Survey, respondents were categorized into cohorts of potentially misdiagnosed BP-I (i.e., self-reported physician diagnosis of MDD but screened as probable BP-I [mBP-I]) or BP-I (i.e., self-reported physician diagnosis of BP-I, stratified by BP-I severity). Baseline characteristics were evaluated using bivariate analyses. HRQoL (Short Form-36v2 Health Survey [SF36v2] mental and physical component scores, EuroQol Five-Dimension Visual Analogue Scale [EQ-5D VAS]), HRU, were evaluated using multivariable analyses adjusting for key baseline differences.

Results. There were 302 respondents in the mBP-I cohort and 818 in the BP-I cohort (mild=336, moderate=285, severe=197). Adults with mBP-I were similar in age and level of depression and anxiety to those with moderate and severe BP-I. With respect to HRQoL, the mBP-I cohort had significantly worse SF36v2 mental component scores and EQ-5D VAS scores vs the mild BP-I cohort (31.3 vs 40.3 [$P<.001$] and 60.6 vs 69.4 [$P=.01$], respectively) and statistically similar scores vs the moderate BP-I cohort. SF36v2 physical component scores were statistically similar to those of the mild BP-I cohort. Respondents with mBP-I reported similar rates of provider (5.5 vs 6.1 [$P=.63$]) and ER visits (.34 vs .40 [$P=.59$]) to patients with mild BP-I (but significantly fewer hospitalizations: .08 vs .19 [$P=.03$]).

Conclusions. Respondents with mBP-I exhibited similar HRQoL scores to those with mild to moderate BP-I. As expected for patients without a formal BP-I diagnosis, HRU was lower for mBP-I patients than moderate or severe BP-I, but comparable with mild BP-I. These results suggest that patients with potentially misdiagnosed BP-I may experience considerable HRQoL and HRU burdens akin to those of patients with mild to moderate BP-I.

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Delphi Panel on the Dimensions and Assessment of Functional Recovery in First-Episode and Early-Phase Schizophrenia Patients

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Abstract

Functional recovery is a treatment goal that goes beyond symptomatic remission and encompasses multiple aspects of schizophrenia patients' lives, including quality of life, physical, and mental functioning. There is evidence that long-acting injectable (LAI) treatments promote adherence and reduce rehospitalisation and functional decline, which could facilitate patients' ability to reach functional recovery. Despite this, LAIs are underused in the first-episode (FEP) and early-phase (EP) patient population, due to physician hesitancy and concerns around stigma. A Delphi panel was held to gain expert consensus on an approach to the domains and assessment of functional recovery elements in FEP and EP schizophrenia patients.

A literature review and input from a steering committee of 5 experts in psychiatry informed statements development for a three-round modified Delphi process. Round one was conducted via one-to-one video conference interviews, and the successive rounds were conducted via electronic surveys, which enabled international collaboration. Statements on the different domains and assessment for functional recovery were presented to 17 psychiatrists, practicing in 7 countries (France, Italy, US, Germany, Spain, Denmark, and UK), experienced in the treatment of schizophrenia with LAIs. Several analysis rules determined whether a statement could progress to the next round and specified the level of agreement required to achieve consensus. Measures of central tendency (mode, mean) and variability (interquartile range) were reported back to help panelists look at their previous responses in the context of the overall group.

A consensus was reached (defined a priori as $\geq 80\%$ agreement) on all 27 statements covering the dimensions, assessment, and level of achieved functional recovery for FEP and EP patients. The following domains are important to consider when assessing functional recovery: depression, aggressive behaviour, social