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Pain in primary care patients with bipolar disorder^{★,★★}

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To the Editor

Birgenheir et al [1] found that a chart diagnosis of a chronic pain condition occurred approximately two times as often in veterans with a documented diagnosis of bipolar disorder compared to those without bipolar disorder. These findings are important for addressing the overall health of patients with bipolar disorder [1]. The authors noted that the veteran population was a limitation of their study. In an effort to expand the authors' findings, we will describe our previously unreported findings on pain in primary care patients with bipolar disorder.

We identified 740 primary care patients with bipolar disorder receiving care between January 2008 and December 2011 in the Washington State Mental Health Integration Program (MHIP), a state wide clinical program serving patients with co-occurring medical and mental health needs in over 140 community health centers [2]. Cases of bipolar disorder were defined as having both the presence of a semi-structured Composite International Diagnostic Interview Version 3.0 [3] consistent with bipolar disorder and a clinician-documented bipolar disorder diagnosis. All patients enrolled in MHIP are assessed with baseline symptom questions, including a question about pain phrased as, "*Is the patient being treated for a chronic pain condition, or does s/he describe pain that happens regularly and that interferes with daily functioning?*". We defined the presence of pain as answering

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“yes” to this question. Additional details of MHIP and of primary care patients with bipolar disorder treated in MHIP are described elsewhere [4].

The mean age of patients with bipolar disorder in MHIP was 39 years (S.D. 10.6), and 44% ($n=326$) were women. 641 of the 740 (87%) patients with bipolar disorder responded to the pain question. Almost half of the total patients with bipolar disorder ($n=338$, 46%) endorsed either current treatment for a pain condition or regular pain interfering with daily functioning. Other findings included a mean Patient Health Questionnaire 9 (PHQ-9) score of 18.1 (SD 5.9), suicidal ideation based on a score of 1 or more on item 9 of the PHQ-9 in 58% of patients, and significant psychosocial impairment, such as lack of a support person, in many patients with bipolar disorder [4].

We found that a high percentage of primary care patients with bipolar disorder enrolled in a collaborative care treatment program endorsed current pain symptoms or functional impairment related to pain. A previous report on patients enrolled in MHIP prior to October 31, 2010, showed that chronic pain was significantly associated with suicidal ideation measured by the PHQ-9 in univariate, but not multivariate, analyses [5]. Suicidal ideation was common in our sample of patients with bipolar disorder, which may have also been related to the severity of depression in many patients, in addition to commonly occurring pain [5]. As Birgenheir et al. reported, the presence of depressive symptoms may influence the experience and/ or reporting of pain [1,6,7], which may partially account for the high frequency of pain in our sample. We did not have data on co-occurring medical problems, which may also account for pain as Birgenheir et al. noted [1]. The clinical question in MHIP only assessed current pain symptoms and patient reported functioning related to pain. Questioning about prior pain symptoms and treatment in addition to current pain may have revealed an even higher percentage of patients with bipolar disorder endorsing pain symptoms or impairment related to pain.

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