LETTER TO THE EDITOR
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Comorbid Bipolar Disorder and Obsessive-Compulsive Disorder: An Old Debate Renewed

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To the Editor,

Apparent comorbidity between bipolar disorder (BD) and anxiety disorders is a common condition in psychiatry with higher prevalence rates for generalised anxiety disorder, social phobia, panic disorder.[1]

Overlapping clinical criteria for many diagnoses, especially mood and anxiety disorders, produced by the Diagnostic and Statistical Manual of Mental Disorders (DSM) might lay behind these high prevalence rates.[2] Using DSM, it is unclear whether concomitant diagnoses actually reflect the presence of distinct clinical entities or refer to multiple manifestations of a single clinical entity.

With regard to anxiety disorders, one of the most difficult additional psychiatric diagnosis to manage in BD patients is obsessive-compulsive disorder (OCD).[3,4] In our recent meta-analysis, the pooled prevalence of OCD in BD was 17.0%, which was comparable to the results reported by the pooled prevalence of BD in OCD (18.35%).[5] In line with previous studies,[6] OCD prevalence rate was higher among BD children and adolescents (24.2%, compared to 13.5% in adults).

The co-occurrence of symptoms of BD and OCD was noted 150 years ago by Morel,[7] but the topic is insufficiently studied and the relationship between BD and OCD remains unclear.

In agreement with Kraepelin's thought a psychiatric diagnosis is best established by its longitudinal course of illness, the evidence so far supports the view that, especially among patients with a primary diagnosis of BD, the majority of comorbid OCD cases appeared to be related to mood episodes.[8] OC symptoms in comorbid patients appeared more often-and sometimes exclusively-during depressive episodes, and comorbid BD and OCD cycled together, with OC symptoms often remitting during manic/hypomanic episodes.

Therefore, only a substantial minority of comorbid BD-OCD may represent "true" OCD independent of BD with OC symptoms that improve or worsen during mood episodes without being related to these.

These findings are in line with Feinstein's definition of *comorbidity*, as "any distinct additional entity that has existed or may occur during the clinical course of a patient who has the index disease under study".[2] "True" OCD comorbid with BD would represent the random co-occurrence of two independent diseases, estimated by multiplication of prevalence rates, which are about 1% for each condition, and producing a very low expected true comorbidity of 0.1% in the general population.

The treatment of BD-OCD patients remains a great challenge, since the gold standard for one disease (serotonin reuptake inhibitors for OCD) can worsen the other (antidepressants can cause mania and/or more mood episodes in BD).

The clinical features of comorbid BD-OCD patients would explain why OCD and BD symptoms respond to adequate mood stabilizer treatment.[3] Only in a minority of comorbid patients with persistent OCD, despite improvement in mood episodes, addition of low doses of antidepressants could be considered while strictly monitoring emerging symptoms of mania or mixed states. Benefit with antipsychotics was also seen, although a few reports also exist of exacerbation of OC symptoms with neuroleptic agents.

Considering the growing interest over the last decades into shared pathophysiologies across psychiatric disorders, stud-

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ies addressing neurobiological substrates are essential to illuminate pathogenetic mechanisms that underlie comorbid BD-OCD.

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Conflicts of Interest

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