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Original Research Paper

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"CLINICAL PROFILE OF UNIPOLAR AND BIPOLAR DEPRESSION PATIENTS IN A TERTIARY CARE HOSPITAL: A CROSS- SECTIONAL STUDY"

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ABSTRACT

Background: Unipolar and bipolar disorders differ in genetics, neurobiology, clinical course, treatment regimens and prognosis. Approximately, 40% of patients with BP affective disorder initially receive an incorrect diagnosis of recurrent depressive disorder. **Materials and Methods:** Sixty eight consecutive subjects (38 in UP and 30 BP depression group) of both genders. All were informed regarding the study and their consent was obtained. **Results:** Age of onset was 31.1 years in unipolar and 20.2 years in bipolar, total duration was 12.2 years in unipolar and 16.4 years in bipolar, the number of episodes was 3.5 unipolar and 6.2 in bipolar, the number of hospitalizations was 2.7 in unipolar and 5.4 in bipolar, suicidal thoughts were seen in 22 in unipolar and 23 in bipolar, anhedonia 9 in unipolar and 22 in bipolar, psuedodementia 6 in unipolar and 12 in bipolar, dissociative features were seen in 10 in unipolar and 26 in bipolar, delusions 3 in unipolar and 7 in bipolar, panic symptoms 9 in unipolar and 16 in bipolar and auditory hallucination 6 in unipolar and 17 in bipolar. **Conclusion:** The results of our study suggest that common clinical features were suicidal thoughts, dissociative features and anhedonia.

KEYWORDS : Clinical Profile,Unipolar and bipolar depression.

INTRODUCTION

Depressive disorders are considered as one of the major worldwide public health burdens.[1] Unipolar and bipolar disorders differ in genetics, neurobiology, clinical course, treatment regimens and prognosis.[2] Approximately, 40% of patients with BP affective disorder (BPAD) initially receive an incorrect diagnosis of recurrent depressive disorder (RDD). Accurate diagnosis of BP depression is complicated by three factors-Assumption of similar phenomenology for BP and UP depression, failure of therapists to recognize previous hypomanic symptoms, and failure of patients to report them.[3] The use of antidepressant monotherapy for BP depression increases the risk of a manic switch, mixed state, rapid cycling, poor or partial response, and resistance to antidepressant therapy.[4] It is now known that the use of antidepressants in bipolar depression can lead to manic switches, mixed state induction and cycle acceleration. Studies have also shown that ECT has equal efficacy and leads to similar symptomatic and functional recovery in unipolar and bipolar depression and probable patients with bipolar depression respond faster than those with unipolar depression.[5] Depressive episodes with sudden onset, psychomotor retardation, diurnal mood variation, worthlessness, anhedonia, pathological guilt, suicidal thoughts, psychotic symptoms, atypical features, and labile mood are important markers for bipolarity. Efficacy of ECT in the manic phase in terms of remission or marked clinical improvement has been reported to be about 80%. It is also reported to be equally or more efficacious than psychotropic medications like lithium, chlorpromazine, and haloperidol.[6] Our aim was to evaluate the clinical profile of unipolar and bipolar depressive patients in a tertiary care hospital.

MATERIALS AND METHODS:

This cross sectional study was conducted in the Department of Psychiatry, World College of Medical Sciences Research and Hospital, Jhajjar during the period from May, 2017 to April, 2018. After obtaining the Institutional Review Board approval, 68 consecutive subjects (38 in UP and 30 BP depression group) of both genders. All were informed regarding the study and their consent was obtained.

Psycho-socio-demographic profile:

To record age, gender, education, occupation, marital status, religion, socioeconomic status, family type, place, and informant details. Age of onset, total duration, mood chart, hospitalizations, substance abuse/dependence, deliberate self-harm, postpartum/perimenstrual behavioral disturbances, history of electroconvulsive therapy and family history of psychiatric illness in first and second degree relatives were included.

Clinical profile:

Details regarding psychomotor activity, depressive cognitions, catatonic features, suicidal thoughts, anhedonia, pseudodementia, dissociative features, panic attacks, delusions, first rank symptoms, auditory hallucinations, and affective reactivity were recorded. Results were tabulated and subjected to statistical analysis. A p-value of less than 0.05 was considered significant.

RESULTS AND DISCUSSION:

This current study was conducted in the Department of Psychiatry, world College of Medical Sciences and Hospital, Jhajjar. Total of 68 patients out of which thirty were males and 38 were females. Fig.1 Shows the age of onset was 31.1 years in unipolar and 20.2 years in bipolar, total duration was 12.2 years in unipolar and 16.4 years in bipolar, the number of episodes was 3.5 unipolar and 6.2 in bipolar, the number of hospitalizations was 2.7 in unipolar and 5.4 in bipolar, suicidal thoughts were seen in 22 in unipolar and 23 in bipolar, anhedonia 9 in unipolar and 22 in bipolar, psuedodementia 6 in unipolar and 12 in bipolar, dissociative features were seen in 10 in unipolar and 26 in bipolar, delusions 3 in unipolar and 7 in bipolar, panic symptoms 9 in unipolar and 16 in bipolar and auditory hallucination 6 in unipolar and 17 in bipolar. The difference was statistically significant at $P < 0.05$.

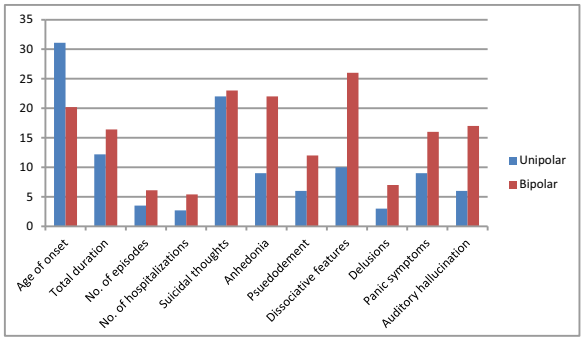

Fig.1: Shows the Clinical profile of unipolar and bipolar patients.

These results indicate that patients with TRD-UP exhibit different psychopathological features compared to depressive episodes in patients with BP, suggesting that TRD-UP is a distinct psychopathological condition and not a prodromal state of BP depression. TRD-UP patients show higher depression severity, higher prevalence of anxiety and panic disorders and of Cluster C personality disorders, a later onset of depression and fewer hospitalizations than BP patients. Distinguishing between bipolar disorder and major depressive disorder is of great clinical importance because optimal management of the two conditions is very different.[7] For example, antidepressants should be used with caution in bipolar depression because of the risk of precipitating mood switches, cycling, or mixed or agitated states.[8] Clinicians should use all available information to guide management (including choice of treatment, advice to patient and intensity of monitoring). The clinical features of depression are not a definitive guide to diagnosis but can help to alert the clinician to a possible bipolar course.[9] These findings also have important implications for future research on type II bipolar disorder and sub-threshold bipolar disorders. Evidence suggests that 25–50% of individuals with recurrent major depression (particularly those within atypical, early-onset or treatment-refractory subgroups) may in fact have a broadly defined bipolar disorder.[10] The present study was conducted to assess the clinical profile of unipolar and bipolar depressive patients. In the present study out of 68 patients, males were 30 and females were 38. Forty et al,[11] found that the proportions of women in the major depression group and the bipolar group were 70.2% and 71.3% respectively. We found that We found that age of onset was 31.1 years in unipolar and 20.2 years in bipolar, total duration was 12.2 years in unipolar and 16.4 years in bipolar, the number of episodes was 3.5 unipolar and 6.2 in bipolar, the number of hospitalizations was 2.7 in unipolar and 5.4 in bipolar, suicidal thoughts were seen in 22 in unipolar and 23 in bipolar, anhedonia 9 in unipolar and 22 in bipolar, psuedodementia 6 in unipolar and 12 in bipolar, dissociative features were seen in 10 in unipolar and 26 in bipolar, delusions 3 in unipolar and 7 in bipolar, panic symptoms 9 in unipolar and 16 in bipolar and auditory hallucination 6 in unipolar and 17 in bipolar. Bhardwaj et al,[12] found that among all the patients who received ECT, 18% were diagnosed to have bipolar disorder. ECT was administered most commonly for mania with psychotic symptoms, followed by severe depression with psychotic symptoms. Comorbid physical problems were seen in many patients. Nearly 90% of patients in both the subgroups showed more than 50% response (based on reduction in the standardized rating scales) with ECT. Few patients reported some kind of side effects. ECT is useful in the management of the acute phase of mania and depression. Nisha et al,[13] compared 30 UP and 30 BP depression patients using a specially designed intake proforma, International Classification of Diseases-10 diagnostic criteria for research, Hamilton Rating Scale for Depression-21 (HAMD- 21), Hypomania Checklist-32 Questionnaire (HCL-32), Brief psychiatric rating scale (BPRS), and Kuppuswami's socioeconomic status scale. BP depression group consisted of mostly males, with earlier age of onset of illness, longer illness duration, frequent episodes, hospitalizations and psychotic symptoms. The total HAM-D score and 4 HAM-D item scores– psychomotor retardation, insight, diurnal variation of symptoms and its severity, and paranoid symptoms were significantly higher in this group. Binary logistic regression identified the age of onset, the total duration of illness, frequency of affective episodes, and the presence of delusions as predictors of bipolarity. This integrated approach will aid clinicians and researchers to disentangle initial diagnostic controversies between unipolar and bipolar spectrum improving the differential management and therapeutics of patients suffering from depression.

CONCLUSION:

In conclusion, the results of our study suggest that common clinical features were suicidal thoughts, dissociative features and anhedonia.

REFERENCES:

1. Ferrari AJ, Charlson FJ, Norman RE, Patten SB, Freedman G, Murray CJ, Vos T, Whiteford HA. Burden of depressive disorders by country, sex, age, and year: findings from the global burden of disease study 2010. PLoS Med. 2013; 10(11):e1001547.
2. Sharma V, Khan M, Smith A. A closer look at treatment resistant depression: is it due to a bipolar diathesis? J Affect Disord. 2005;84(2-3):251–257.
3. Beck A, Steer R. and others, editor; 1987.
4. Wing J, Babor M, Brugha T, Burke J, Cooper J, Giel R, et al. SCAN: Schedules for Clinical Assessment in Neuropsychiatry. Arch Gen Psychiatry. 1990;47:589–93.
5. Cuellar AK, Johnson SL, Winters R. Distinctions between bipolar and unipolar depression. Clin Psychol Rev. 2005;25(3):307–339.
6. Mcguffin P, Farmer A, Harvey I. A polydiagnostic application of operational criteria in studies of psychotic illness. Development and reliability of the OPCRIT system. Arch Gen Psychiatry. 1991;48:764–70.
7. Craddock M, Asherson P, Owen MJ, Williams J, Mcguffin P, Farmer AE. Concurrent validity of the OPCRIT diagnostic system. Comparison of OPCRIT diagnoses with consensus best-estimate lifetime diagnoses. Br J Psychiatry. 1996;169:58– 63.
8. Bowden CL. A different depression: clinical distinctions between bipolar and unipolar depression. J Affect Disord. 2005;84(2-3):117–125.
9. Swann AC, Geller B, Post RM, Altshuler L, Chang KD, DelBello MP, et al. Practical Clues to Early Recognition of Bipolar Disorder. J Clin Psychiatry. 2005;07(01):15–21.
10. Mitchell PB, Wilhelm K, Parker G, Austin MP, Rutgers P, Malhi GS. The clinical features of bipolar depression: a comparison with matched major depressive disorder patients. J Clin Psychiatry. 2001;62:212–228.
11. Forty L, Smith D, Jones L, Jones I, Caesar S, Cooper C, et al. Clinical differences between bipolar and unipolar depression. Br J Psychiatry. 2008;192(5):388–389.
12. Grover S, Chakrabarti S, Avasthi A, Kate N, Bharadwaj V. Clinical profile and outcome of bipolar disorder patients receiving electroconvulsive therapy: A study from north India. Indian J Psychiatry. 2012;54:41–41.
13. Nisha A, Sathesh V, Punnoose V, Varghese P. A comparative study on psycho-socio-demographic and clinical profile of patients with bipolar versus unipolar depression. Indian J Psychiatry. 2015;57:392.