ORIGINAL RESEARCH PAPER

Psychiatry

PREVALENCE OF RESIDUAL SYMPTOMS AND RELATIONSHIP WITH QUALITY OF LIFE IN REMITTED PATIENTS WITH MAJOR DEPRESSIVE DISORDER.

KEY WORDS: residual symptoms, quality of life, Major Depressive Disorder, remission.

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ABSTRACT

Background: Remission in major depressive disorder usually indicates that patient is free from disorder while as same at time it has been seen that definition for remission require patient to have HAM D less than 7. So those patients who score between 1-7 still have few symptoms even if they have been labeled as remitters. These symptoms are called residual symptoms and these can have direct consequences on quality of life. **Material & Method:** Remitted patients of Major Depressive Disorder as per ICD-10 Criteria attending outpatient department of psychiatry were enrolled for study, socio demographic data was collected and patients were administered HAM-D scale to find out residual symptoms, also WHOQOL-BREF was administered for assessment of Quality of life in these patients. **Results:** 80 patients were enrolled. Mean age was {43 ±1.32} with majority of female gender and higher education and marital status. (90.2%) were found to have between 2 to 7 symptoms on HAM-D. The most common symptom domains was insomnia symptom (74.1%; 95% confidence interval 0.68–0.80). On assessment of quality of life it was seen that 46% patients reported impairment in quality of life and predominant impairment was seen in physical component (28.95 ± 10.04). On comparison of Quality of life with predominant residual symptoms significant relationship was seen with insomnia and anxiety symptoms (B = -1.125, p= 0.004 & B =-2.629, P =0.008). **Conclusion:** There is presence of residual symptoms even in patients who have remitted from major depressive disorder and these residual symptoms have significant impact on quality of life of these patients. Identification and attending these residual symptoms should be part of treatment program in order to achieve a better quality of life.

INTRODUCTION

MDD is diagnosed when a person who meets criteria for major depressive disorder without manic or hypomanic features or a psychotic disorder. According to WHO by 2030. Major depressive disorder (MDD) will be second leading cause of burden of disease worldwide.[1] Course of depressive disorder has been described in various terms. The term remission has usually been applied to achievement, of low or absent symptom levels, representing an end to the immediate episode. The term recovery has been used to reflect remission beyond this state, persistent for a longer time period and more complete. A further term Response is defined as a 50% or more reduction in level of presenting symptomatology, as typically measured using a standardized rating scale, such as the Hamilton Depression Rating Scale (HAM-D) or the Montgomery Asberg Depression Rating Scale (MADRS). Relapse may occur even before full recovery is achieved.[2,3]

With invent of newer pharmacological agents and various psychotherapies it has become easy to manage depressive episodes and prevent relapses and maintain remission. It has been seen that even after adequate antidepressant and psychotherapy varying amount of residual symptoms are present in the patients on long term course.[4]

Remission has been operationalized in clinical trials as a threshold, or cut-off score, using standardized scales. A HAM-D17 score of seven or less, a MADRS score of ten or less, or a Clinical Global Impression (CGI) score of one, all typically designate a state of remission.[5] Importantly these criteria do not require that patients be completely asymptomatic to be considered in remission.

Residual symptoms include both symptoms that persist at baseline and new-onset symptoms that are seen during remission. Greater numbers of residual symptom are associated with a higher probability of relapse in patients with complete remission. In achieving and maintaining remission various factors have been identified among which Residual symptoms have been seen as an important factor in maintaining remission and predisposing an individual for relapse.[6] Taking the STAR*D Phase 1 study as an example, of the 2876 patients included, only 92 (9.8%) had no residual symptoms, while N 90% of completely remitted patients had at least one residual symptom.[7] The common residual Symptoms of depression include sleep disorders, fatigue, physical symptoms, and cognitive dysfunction.[8]

It has been reported that patients having residual symptoms who got treated for their depressive episode had more impairment in social functioning and disability. It has been found that patients who are in remission have at least one residual symptom and it is associated with significant functional impairment and impaired quality of life. Nevertheless, there are few clinical studies related to the residual symptoms of depression and most studies performed post-hoc analysis.[9] These studies also differ in defining residual symptoms the study aimed to determine residual symptoms and to assess the correlation between residual symptoms and QoL subdomains in depressive disorder.

Our study aims at finding residual symptoms in remitted cases of depressive disorder among Kashmiri population and also to see the effect of these residual symptoms on their quality of life.

METHODS:

Participants and procedure

This was a cross-sectional study conducted in psychiatry department of tertiary hospital of Kashmir. The patients were enrolled from March 2019 to December 2019. This study was approved by the Ethics Committee of Skims MCH. All patients enrolled in the current study provided signed informed consent.

Inclusion criteria's were:

1. Outpatient depressive patients with single episode or recurrent depressive disorder according to The International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10);
2. Treatment with antidepressants for 8 –12 weeks (inclusively), with total treatment interruption not exceeding 14 days; and
3. Consideration by the patient to have recovered by HAM D scale.

Exclusion criteria's were:

1. A history of manic or hypomanic episodes; or
2. Diagnosis of bipolar disorder, schizophrenia, schizoaffective disorder, or other disease associated with mental disorders.
3. Age more than 60years

Measures:

HAM-D: instrument is used widely to measure the severity of depression among patients and the residual symptoms experienced during treatment. Remission was defined as a HAMD-17 score of ≤7 and a response as an improvement of 50% or more from the baseline score. We used the definition of residual symptoms described by Dombrovski et al, with the presence of residual core mood symptoms indicated by a score of 1 or more on the HAMD-17 core symptom subscale World health organization quality of life

WHO QOL-BREF: scale is a highly validated instrument, purports to measure the individuals perception of their life in terms of their goals, achievements and satisfaction in their social cultural and economic background. WHO QOL BREF is an abbreviated version with about 26 items measuring the quality of life across four domains vis physical, psychological, social relationship and environmental domains. The responses range from 1 (very dissatisfied) to 5 (very satisfied). High internal consistency with cronbach's alpha values were ranging from, .71 to .86 were established in many studies.[10]

Statistical Analysis:

Results obtained were analyzed using descriptive and interferential methods. Chi square test was used for categorical data and students t test for continuous data & Pearson's correlation for assessing the correlation between variables.

RESULTS

A total of 80 patients were enrolled with mean age of {43 ±1.32} more of female participates and higher education and married status. Mean duration of illness was (4.1±1.32) with mean number of episodes (3.1±2.15) and mean duration of remission was calculated in months (8.9±2.10). HAMD score was reported between 0 and 17 items. Few patients reported 7 symptoms (9.8%), but most (90.2%) were found to have between 2 and 7 (median =6). On assessment of quality of life it was seen that 46% patients reported impairment on WHOQOL BREF. And predominant impairment was seen in physical component (28.95 ± 10.04) ***(Table 1).***

Table 1: Sociodemographic profile and clinical data of participants.

Participants (N)	80
Age, mean (SD)	43 ±1.32
Gender, n (%)	
Male	30 (37.5)
Female	50 (62.5)
Education, n (%)	
Illiterate	5 (6.2)
Middle school	18 (22.5)
High school	22 (27.5)
Bachelor's or Higher	35 (43.7)
Marital status, n (%)	
Single	12 (15.0)
Married	61 (76.2)
Living.alone (widow/divorced/separated)	07 (8.7)
Employment, n (%)	
Yes	59 (73.7)
No	21 (26.2)
Duration of illness, mean (SD)	4.1±1.32
No. of depressive episodes, mean (SD)	3.1±2.15
Duration of remission, mean (SD)	8.9±2.10
HAM D, mean (SD)	3.5±2.6
WHOQOL BREF	
Physical	28.95 ± 10.04
Social	20.04 ± 9.23
Environmental	22.18 ± 12.58
Psychological	19.60 ± 10.46

Among all the patients, 93.3% of them were experiencing at least one residual symptom, and when assembling the residual symptoms into groups, the most common symptoms domains were core mood symptoms (56%; 95% CI, 0.47–0.60), insomnia symptoms (74.1%; 95% confidence interval 0.68–0.80), anxiety symptoms (68.3%; 95% CI, 0.71–0.82), and somatic symptoms (52%; 95% CI, 0.63–0.74). Insomnia and anxiety symptom were the most common residual symptom domains found as shown in ***Figure 1***.

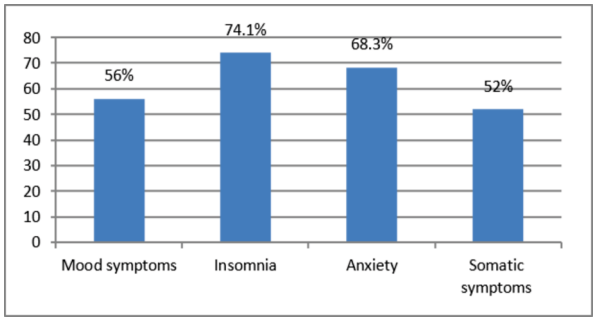

Figure 1: Prevalence of Residual symptoms

On comparison of Quality of life with predominant residual symptoms there was significant relation with insomnia and anxiety symptoms, results of a linear regression analysis show that Qol scores at the (B =0.477, p <0.005), and particularly those for residual insomnia and anxiety symptoms (B = -1.125, p= 0.004 & B =-2.629, P =0.008) ***(Table 3)***

Table 3: Summary of linear regression results for residual symptoms

Clinical variable	Unstandardized coefficient		t	P value
	B	Std error		
Qol score	0.477	0.058	6.329	0.005
Mood symptoms	-0.101	0.036	-3.570	0.325
Insomnia	-0.105	0.041	-1.125	0.004*
Anxiety	-0.035	0.033	-2.629	0.006
Somatic symptoms	0.011	0.039	0.416	0.231

DISCUSSION:

The purpose of this study was to find out the prevalence of residual symptoms among remitted depressive patients. Also to access the quality of life and its association with residual symptoms. When assessing residual depressive symptoms it was found out that four groups similar to previous studies (such as core mood symptoms, anxiety symptoms, insomnia, and somatic symptoms) were predominant residual symptoms in this study as well.

In this study, we found that predominant residual symptoms were Insomnia and anxiety a followed by core mod and somatic symptoms which is similar result similar to various studies.[2,11,12] However residual anxiety and core mood

symptoms, were predominant symptoms in study done by Romera et al.[13] Gasto et al found that depressed mood reported by 38.4% of their sample was the most frequent symptom in remitters which is in contrast to our study.[14] While as insomnia was referred to as most common residual symptom that could predict relapse of depressive episode. Our results also emphasize the importance of residual insomnia; that it not only plays a vital role with regard to relapse but also in terms of quality of life as a whole.

Residual symptoms are also associated with poor quality of life. In this study, the quality of life scores found that there was varied response in different domains of WHOQOL BREF and even if the patients qualified to be called as remitters on HAM D they still have impairment in one or more domain of their quality of life. This study used WHOQOL-BREF as tool for assessments of quality of life in while as other studies have used EQ5D.[15]

In the current study, even in remitters, residual symptoms were present and remission status is statistically associated with impairment in physical domain of QoL. This can confirm that even if the patient is in remission as per the criteria still he can have Impairment in his quality of life.

The results of this study highlight very important area for clinicians and advocates to be careful regarding residual symptoms when treating depressive disorder, especially insomnia , anxiety and core mood symptoms, in order to prevent relapse and help patient to attain a sense of complete wellbeing. Further long term study with large sample size are required.

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