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ORIGINAL ARTICLE

Assessment of unipolar and bipolar depressive patients

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ABSTRACT:

Background: Depressive disorders are considered as one of the major worldwide public health burdens. The present study was conducted to assess the cases of unipolar and bipolar depressive patients. **Materials & Methods:** 90 patients of unipolar and bipolar depressive disorders of both genders. A thorough clinical profile along with parameters such as number of episodes, hospitalizations and suicidal thoughts etc. was recorded. **Results:** Age of onset was 34.2 years, total duration of disease was 11.2 years, number of episodes was 4.6 and number of hospitalizations was 2.7. Suicidal thoughts were seen in 56, anhedonia in 22, psuedodementia in 15 and dissociative features in 37 patients. The difference was significant (P< 0.05). **Conclusion:** Authors found that among unipolar and bipolar patients common features were suicidal thoughts, anhedonia, psuedodementia and dissociative features.

Key words: Anhedonia, Bipolar depressive disorders, Depression.

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INTRODUCTION

Depressive disorders are considered as one of the major worldwide public health burdens. Treatment resistant unipolar depression (TRD-UP) continues to be a clinical challenge due to its heterogeneous presentation with an impact on functional impairment, declined autonomy, and poor cognitive functioning.[1] Although advances have been made to improve our psychiatric diagnostic classification systems, many intermediate phenotypes have not been accurately diagnosed and proposed predictors of treatment outcomes in depression seem controversial with remission rates remaining unchanged.[2] Unipolar (UP) and bipolar (BP) disorders differ in genetics, neurobiology, clinical course, treatment regimens and prognosis.[1] Approximately, 40% of patients with BP affective disorder (BPAD) initially receive an incorrect diagnosis of recurrent depressive disorder (RDD).[3]

It is now known that 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 probably patients with bipolar depression respond faster than those with unipolar depression.[4] A number of clinical and demographic characteristics have been found to be associated with TRD-UP. These include comorbidity with anxiety panic disorder, social phobia, personality disorder, suicidal risk, melancholia, number of hospitalizations, recurrent episodes, early age of onset, total number of unresponsive treatments to antidepressants received during a lifetime as well as severity of depression and having a first degree relative with an affective disorder.[5] The present study was conducted to assess the cases of unipolar and bipolar depressive patients.

MATERIALS & METHODS

The present study was conducted among 90 patients of unipolar and bipolar depressive disorders of both genders. All were informed regarding the study and their consent was obtained.

Data such as name, age, gender etc. was recorded. A thorough clinical profile along with parameters such as number of episodes, hospitalizations and suicidal thoughts etc. was recorded. Results were tabulated and subjected to statistical analysis. P value less than 0.05 was considered significant.

RESULTS

Table I Distribution of patients

Total- 90		
Gender	**Males**	**Females**
Number	60 (66.6%)	40 (34.4%)

Table I shows that out of 90 patients, males were 60 (66.6%) and females were 40 (34.4%).

Table II Clinical assessment of patients

Clinical profile	Mean
Age of onset (Years)	34.2
Total duration (Years)	11.2
Number of episodes	4.6
Number of hospitalizations	2.7

Table II, graph I shows that age of onset was 34.2 years, total duration of disease was 11.2 years, number of episodes was 4.6 and number of hospitalizations was 2.7.

Graph I Clinical assessment of patients

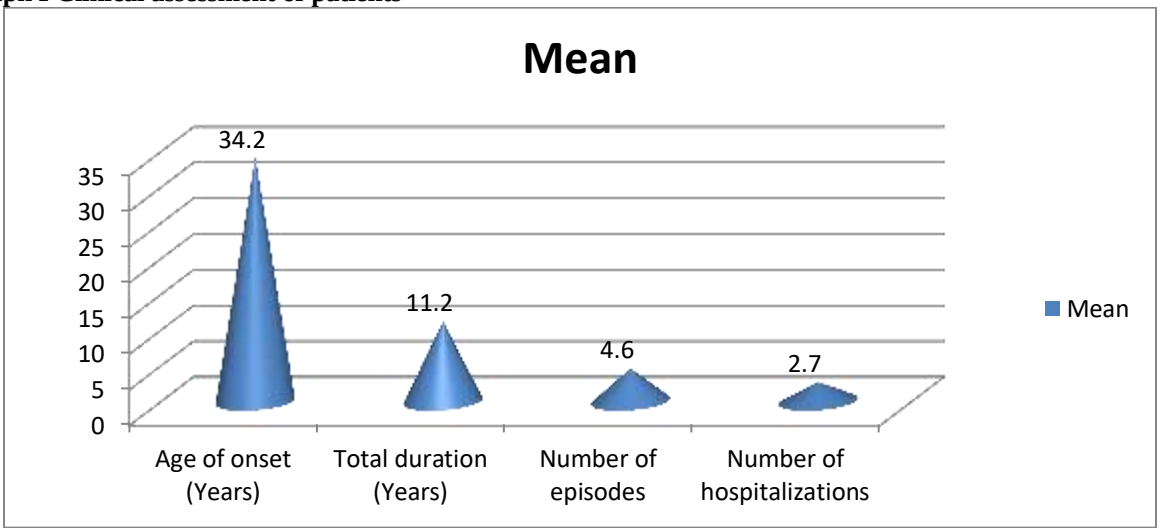

Table III Determination of other parameters

Parameters	Number	P value
Suicidal thoughts	56	0.04
Anhedonia	22	
Psuedodementia	15	
Dissociative features	37	

Table III shows that suicidal thoughts were seen in 56, anhedonia in 22, psuedodementia in 15 and dissociative features in 37 patients. The difference was significant (P< 0.05).

DISCUSSION

It has been described that up to 15% of patients treated for depression will fall into this category and according to the sequenced treatment alternatives to relieve depression study more than 50% of depressed patients do not respond to their first AD trial. However, there is currently no universal definition of TRD-UP and controversies surrounding its prevalence rates, definitions and treatment outcomes remain ambiguous.[6] 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.[7] It is desirable that clinicians use all available information to guide management (including choice of treatment, advice to patient and intensity of monitoring).[8] The present study was conducted to assess the cases of unipolar and bipolar depressive patients.

In present study out of 90 patients, males were 60 (66.6%) and females were 40 (34.4%). Weissman et al[9] compared BP, TRD-UP patients exhibited greater severity of depression, prevalence of anxiety and panic disorders, melancholic features, Cluster-C personality disorders, later onset of depression and fewer hospitalizations. Binary logistic regression indicated that higher comorbidity with anxiety disorders, higher depression scale scores and lower global assessment of functioning (GAF) scores, and lower number of hospitalizations and psychotherapies differentiated TRD-UP from BP patients. Authors found that the rate of unemployment and the number of hospitalizations for depression was higher in BP-I than in BP-II, while the rate of suicide attempts was lower in BP-I than in BP-II depressed patients.

We found that age of onset was 34.2 years, total duration of disease was 11.2 years, number of episodes was 4.6 and number of hospitalizations was 2.7. Chopra et al[10] have attempted to study the socioeconomic status and manic depressive psychosis in a private psychiatric hospital setting at Ranchi and concluded that there is a higher representation of middle class in this group. In both groups, higher number of patients reported residing in nuclear families, which would result in higher care-giver burden.

Bhardwaj et al[11] 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 (22%) reported some kind of side effects. ECT is useful in the management of acute phase of mania and depression. Kessler et al[12] found that the mean age of UP group was 43.1±5.3 years while that of BP group was 39.1±8.8 years. With regard to the current episode, 80% of the BP group consisted of severe depression with psychotic symptoms, whereas in the UP group, 60% had severe depression without psychotic symptoms. This may be accounted for by the fact that both the samples were recruited from inpatients. 56.7% of the total sample consisted of females –73.3% of UP group versus 40% of the BP group (P = 0.009). No significant differences could be obtained between the educational status of the two groups. 80% of the UP group and 63.3% of the BP group were married. BP group consisted of manual labourers and other skilled workers, while housewives and skilled workers predominated the UP group. More than half of both the groups hailed from lower middle class families. 60% of UP group and 53.3% of BP group resided in nuclear families.

The shortcoming of the study was small sample size.

CONCLUSION

Author found that among unipolar and bipolar patients common features were suicidal thoughts, anhedonia, psuedodementia and dissociative features.

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