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ORIGINAL ARTICLE

Comparison of clinical profile of patients with unipolar and bipolar depression

[1]Tushar Goyal, [2]Deepak Bansal

[1]Assistant Professor, Department of Psychiatry, Major S D Singh Medical College & Hospital, Farukkhabad, Uttar Pradesh, India;
[2]Assistant Professor, Department of General Medicine, Major S D Singh Medical College & Hospital, Farukkhabad, Uttar Pradesh, India

ABSTRACT:
Background: Genetics, neurobiology, clinical course, treatment plans, and prognosis distinguish bipolar (BP) from unipolar (UP) disorders. The present study compared the clinical profile of patients with unipolar and bipolar depression. **Materials & Methods:**80 patients of unipolar and bipolar depression of both genders were classified in groups I and II, respectively. Bipolar and unipolar patients' clinical profiles and sociodemographic information were documented. **Results:** Out of 80 patients, males were 48 and females were 32. The total duration was 12.5years and 16.4 years, the age of onset was 30.4years and 20.5, number of episodes was 3.1 and 7.2, panic symptomswere seen in 12 and 8, delusions in 14 and 2, anhedonia in 18 and 14, pseudodementia in 6 and 2, suicidal thoughts in 3 and 6, catatonic features in 9 and 5 and depressive cognitions in 4 and 5. The difference was significant (P< 0.05). **Conclusion:** The authors found that the QOL profiles of patients with bipolar and unipolar depression differ. It is now even more crucial to rule out bipolarity in patients with first-episode depression in light of the BP spectrum idea. Sufficient steps have to be takento comprehend the clinical indicators of bipolar disorder.
Keywords: Unipolar, Bipolar, Depression

Corresponding author: Deepak Bansal, Assistant Professor, Department of General Medicine, Major S D Singh Medical College & Hospital, Farukkhabad, Uttar Pradesh, India

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INTRODUCTION

Genetics, neurobiology, clinical course, treatment plans, and prognosis distinguish bipolar (BP) from unipolar (UP) disorders. About 40% of patients with BP affective disorder (BPAD) are initially misdiagnosed as having recurrent depressive disorder (RDD).[1] Three factors make it difficult to accurately diagnose BP depression: therapists' failure to recognize patients' history of hypomanic symptoms, patients' failure to report them, and the assumption that BP and UP depression share similar phenomenology.[2] Antidepressant monotherapy for BP depression increases the risk of manic switch, mixed state, rapid cycling, poor or partial response, and resistance to antidepressant therapy.[3]

Differentiating between bipolar and unipolar depression is still a difficult clinical issue, especially in cases where bipolar people appear during the depressive phase and are readily confused for unipolar depression. Different approaches work best for managing these issues.[4] Patients with bipolar depression who are treated inappropriately, increasing the chance of manic switch or cycle acceleration, on the mistaken assumption that they have unipolar depression.[5] The diagnosis and treatment of such diseases can be much improved by taking steps to clinically diagnose or at least suspect the type of disorder in its early stages. This will help with the long-term care of these populations by selecting more appropriate treatments.[6]The present studycomparedthe clinical profile of patients with unipolar and bipolar depression.

MATERIALS & METHODS

The present study comprised 80 patients of unipolar and bipolar depression of both genders.

All gave their written consent for the participation in the study.

Data such as name, age, gender, etc. was recorded. Bipolar and unipolar patients were classified in groups I and II, respectively. Bipolar and unipolar patients' clinical profiles and sociodemographic information were documented. Data thus obtained were subjected to statistical analysis. P value < 0.05 was considered significant.

RESULTS

Table I Distribution of patients

Total- 80		
Gender	**Males**	**Females**
Number	48	32

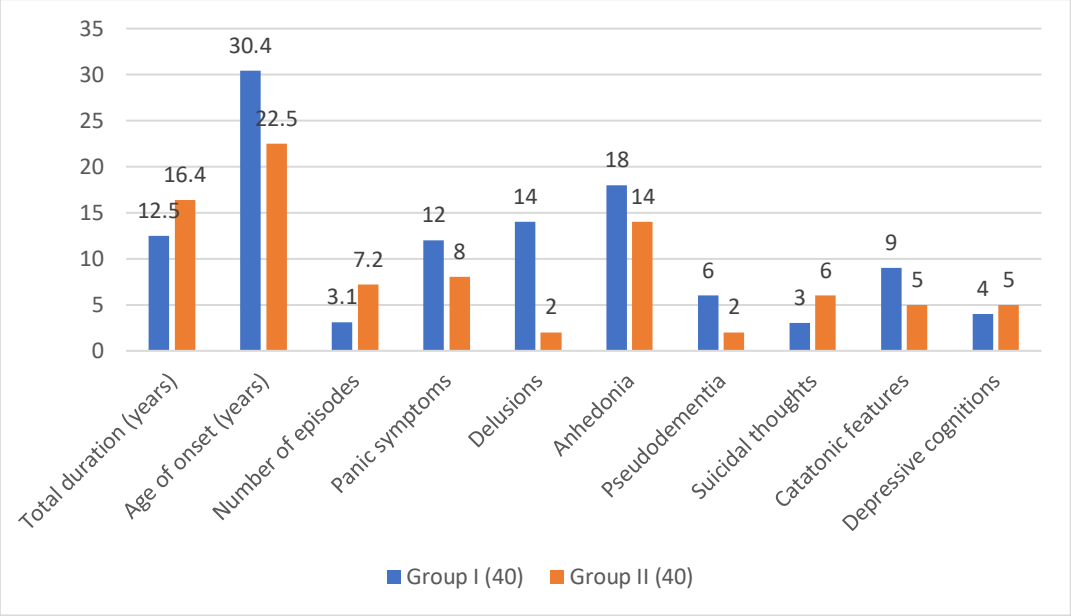
Table I shows that out of 80 patients, males were 48 and females were 32.

Table II Comparison of parameters

Parameters	Group I (40)	Group II (40)	P value
Total duration (years)	12.5	16.4	0.04
Age of onset (years)	30.4	22.5	0.05
Number of episodes	3.1	7.2	0.01
Panic symptoms	12	8	0.05
Delusions	14	2	
Anhedonia	18	14	
Pseudodementia	6	2	
Suicidal thoughts	3	6	
Catatonic features	9	5	
Depressive cognitions	4	5	

Table II, graph I shows that total duration was 12.5yearsand 16.4 years, age of onset was 30.4yearsand 20.5, number of episodes was 3.1 and 7.2, panic symptoms was seen in 12 and 8, delusions in 14 and 2, anhedonia in 18 and 14, pseudodementia in 6 and 2, suicidal thoughts in 3 and 6, catatonic featuresin 9 and 5 and depressive cognitionsin 4 and 5. The difference was significant (P< 0.05).

Graph I Comparison of parameters



DISCUSSION

By 2030, unipolar depressive disorders will be the most common condition worldwide, having been ranked fourth in 2004.[7] The World Health Organization estimates that 29.5 million people worldwide suffered from bipolar illness in 2004.[8] According to estimates, depression will account for 5.7% of all illness burden by 2020 and rank second in terms of disability-adjusted life years if present demographic and epidemiologic trends continue.[9]The present studycomparedthe clinical profile of patients with unipolar and bipolar depression.

We found that out of out of 80 patients, males were 48 and females were 32. In this study, Berlim et al[10] examined the effects of disease on adult outpatients with unipolar (N = 89) and bipolar (N = 25) depression in terms of their quality of life (QOL). Patients filled out the Beck Depression Inventory and the WHO QOL Instrument-Short Version while undergoing treatment at a university hospital in southern Brazil. Following analysis, bipolar depression patients reported considerably poorer psychological QOL domain scores than unipolar depression patients (p =.013). Regarding social and demographic factors, the other QOL dimensions evaluated (i.e., physical health, social interactions, and environmental), and the intensity of depression symptoms, there were no statistically significant differences seen between the study groups.

We found that total duration was 12.5years and 16.4 years, age of onset was 30.4years and 20.5, the number of episodes was 3.1 and 7.2, panic symptoms were seen in 12 and 8, delusions in 14 and 2, anhedonia in 18 and 14, pseudodementia in 6 and 2, suicidal thoughts in 3 and 6, catatonic features in 9 and 5 and depressive cognitions in 4 and 5. To examine the relationship between manic depressive psychosis and socioeconomic position in a private psychiatric hospital at Ranchi, Chopra et al[11] found that the middle class is more prevalent in this population. A greater proportion of patients in both

groups indicated that they lived in nuclear households, which would increase the strain on caregivers.

Forty et al[12]compared clinical course variables and depressive symptom profiles in a large sample of individuals with major depressive disorder (n=593) and bipolar disorder (n=443). Clinical characteristics associated with a bipolar course included the presence of psychosis, diurnal mood variation and hypersomnia during depressive episodes, and a greater number of shorter depressive episodes. Such features should alert a clinician to a possible bipolar course. This is important because optimal management is not the same for bipolar and unipolar depression.

The limitation of the study is the small sample size.

CONCLUSION

The authors found that the QOL profiles of patients with bipolar and unipolar depression differ. It is now even more crucial to rule out bipolarity in patients with first-episode depression in light of the BP spectrum idea. Sufficient steps have to be takento comprehend the clinical indicators of bipolar disorder.

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