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Original Research

Assessment of clinical profile of bipoar and unipolar depression patients- A clinical study

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***ABSTRACT*:**
Background: Unipolar (UP) and bipolar (BP) disorders differ in genetics, neurobiology, clinical course, treatment regimens and prognosis. The present study assessed clinical profile of BP and UP depression patients. **Materials & Methods:** This study was conducted on 78 patients of unipolar and bipolar depression of both genders. Clinical profile of patients was also recorded. The Hamilton Rating Scale for Depression-21 item (HAM-D) was used assessment of depression. **Results:** In unipolar depression, males were 25 and females were 20, in bipolar depression, males were 21 and females were 12. Age of onset in unipolar patients was 28.4 years and in bipolar patients was 22.5 years, total duration was 12.6 years in unipolar and 16.3 years in bipolar, number of episode was 3.5 in unipolar patients and 7.2 years in bipolar patients, number of hospitalizations was seen in 42 and 33 patients respectively and catatonic features were seen in 1 and 3 patients respectively. The difference was significant (P< 0.05). Suicidal thoughts were seen in 34 patients in unipolar and27 bipolar patients, anhedonia in 9 and 2 patients respectively, pseudodementia in 3 and 5 patients respectively, panic symptoms in 6 and 14 patients respectively, delusions in 8 and 25 patients respectively, auditory hallucinations in 10 and 16 patients respectively and first rank symptoms in 5 and 7 patients respectively. The difference was significant (P< 0.05). **Conclusion:** Authors found that unipolar and bipolar depression showed almost similar clinical features such anhedonia, pseudodementia, panic symptoms and delusions etc.
Key words: Anhedonia, Bipolar depression, Pseudodementia

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INTRODUCTION

Unipolar (UP) and bipolar (BP) disorders differ in genetics, neurobiology, clinical course, treatment regimens and prognosis. Approximately, 40% of patients with BP affective disorder (BPAD) initially receive an incorrect diagnosis of recurrent depressive disorder (RDD).[1] 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. Bipolar disorder (BD) is one of the top ten most debilitating of all illnesses. Yet, the absence of biologically-relevant diagnostic markers of BD results in misdiagnosis of the illness as major depressive disorder, or recurrent unipolar disorder (UD) depression, in 60% of bipolar individuals seeking treatment for depression.[2]

Only 20% of BD individuals during a depressive episode receive the correct diagnoses of BD within the first year of seeking treatment and latency from onset to diagnosis and appropriate treatment averages 5–10 years. Close to 60% of BD individuals are initially diagnosed as having UD depression.[3] Furthermore, despite notions that BD depression may be associated with more psychosis than UD depression, it remains extremely difficult to distinguish depressed patients with BD from those with UD.[4] Use of antidepressant monotherapy for BP depression increases the risk of

manic switch, mixed state, rapid cycling, poor or partial response and resistance to antidepressant therapy. UP depression is characterized by excessive self-reproach, somatic complaints, more severe appetite and weight loss, loss of energy, and diminished libido.[5] The present study assessed clinical profile of BP and UP depression patients.

MATERIALS & METHODS

This study was conducted in the department of Psychiatry. It consisted of 78 patients of unipolar and bipolar depression of both genders. The institutional ethical committee approval was taken. All patients were informed and their consent was obtained.

Data related to patients such as name, age, gender, total duration, mood chart, hospitalizations, substance abuse/dependence, deliberate self-harm, postpartum/perimenstrual behavioral disturbances and history of electroconvulsive therapy were included. Clinical profile of patients were also recorded.

The Hamilton Rating Scale for Depression-21 item (HAM-D) was used assessment of depression. The strengths include its excellent validation/research base, and ease of administration. Total scores range from 0 to 53. Results were tabulated and subjected to statistical analysis. P value less than 0.05 was considered significant.

RESULTS

Table I Distribution of patients

Gender	Unipolar	Bipolar
Male	25	21
Female	20	12
Total	45	33

Table I shows that in unipolar depression, males were 25 and females were 20, in bipolar depression, males were 21 and females were 12.

Table II Socio- demographic profile

Clinical profile	Unipolar	Bipolar	P value
Age of onset (Years)	28.4	22.5	0.17
Total duration (Years)	12.6	16.3	0.05
No. of episodes	3.5	7.2	0.02
No. of hospitalizations	2.4	5.4	0.05
Depressive cognitions	42	33	0.04
Catatonic features	1	3	0.01

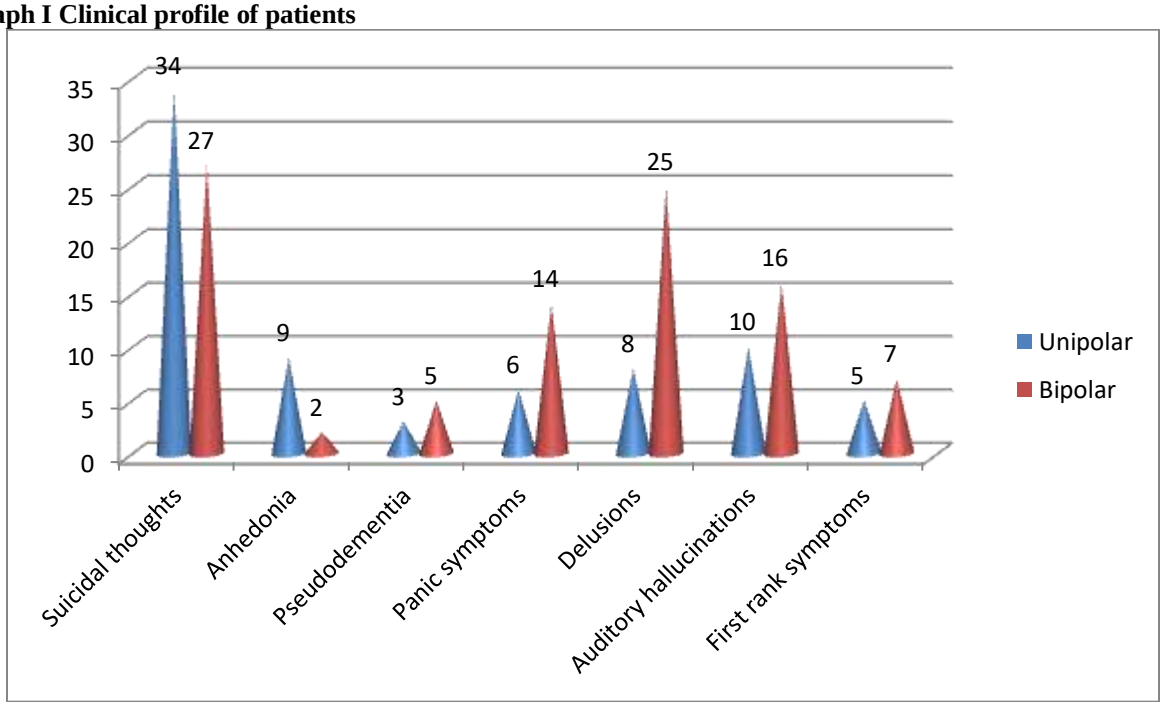
Table II shows that age of onset in unipolar patients was 28.4 years and in bipolar patients was 22.5 years, total duration was 12.6 years in unipolar and 16.3 years in bipolar, number of episode was 3.5 in unipolar patients and 7.2 years in bipolar patients, number of hospitalizations was seen in 42 and 33 patients respectively and catatonic features were seen in 1 and 3 patients respectively. The difference was significant ($P< 0.05$).

Table III Clinical profile of patients

Clinical profile	Unipolar	Bipolar	P value
Suicidal thoughts	34	27	0.12
Anhedonia	9	2	0.02
Pseudodementia	3	5	0.05
Panic symptoms	6	14	0.01
Delusions	8	25	0.01
Auditory hallucinations	10	16	0.15
First rank symptoms	5	7	0.92

Table III, graph I shows that suicidal thoughts were seen in 34 patients in unipolar and27 bipolar patients, anhedonia in 9 and 2 patients respectively, pseudodementia in 3 and 5 patients respectively, panic symptoms in 6 and 14 patients respectively, delusion in 8 and 25 patients respectively, auditory hallucinations in 10 and 16 patients respectively and first rank symptoms in 5 and 7 patients respectively. The difference was significant ($P< 0.05$).

Graph I Clinical profile of patients



DISCUSSION

Patients with UP depression unnecessarily exposed to mood stabilizers would suffer poorer outcomes. Several studies have focused on longitudinal course factors such as age, gender, age at onset, episode duration and frequency.[6] Postpartum episodes, co-morbidities (substance use, suicide, anxiety disorders), family loading of bipolarity, affective temperament, frequent job changes, marital discord, and hospitalization rates - All were found to be significantly higher in the BP group. 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.[7] The present study assessed clinical profile of BP and UP depression patients.

In this study, in unipolar depression, males were 25 and females were 20, in bipolar depression, males were 21 and females were 12. We observed that age of onset in unipolar patients was 28.4 years and in bipolar patients was 22.5 years, total duration was 12.6 years in unipolar and 16.3 years in bipolar, number of episode was 3.5 in unipolar patients and 7.2 years in bipolar patients, number of hospitalizations was seen in 42 and 33 patients respectively and catatonic features were seen in 1 and 3 patients respectively. Singh et al[8] found significantly increased frequency of blood group O and lesser frequency of blood group A in BP group compared to normal controls and UP group. UP depression is characterized by excessive self-reproach, somatic complaints, more severe appetite and weight loss, loss of energy, and diminished libido.

We found that suicidal thoughts were seen in 34 patients in unipolar and 27 bipolar patients, anhedonia in 9 and 2 patients respectively, pseudodementia in 3 and 5 patients respectively, panic symptoms in 6 and 14 patients respectively, delusions in 8 and 25 patients respectively, auditory hallucinations in 10 and 16 patients respectively and first rank symptoms in 5 and 7 patients respectively. Nisha et al[9] compared 30 UP and 30 BP depression patients using a specially designed intake proforma, International Classification of Diseases-10 diagnostic criteria for research. 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 presence of delusions as predictors of bipolarity. Chopra et al[10] have attempted to study the socioeconomic status and manic depressive psychosis 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.

Goldberg et al[11] conducted a study in which patients who were hospitalized for unipolar major depression were assessed prospectively as inpatients and then

followed up five times over 15 years, at approximately 2, 5, 8, 11, and 15 years after discharge. It was found that by the 15-year follow-up, 27% of the study group had developed one or more distinct periods of hypomania, while another 19% had at least one episode of full bipolar I mania. Depressed patients with psychosis at the index depressive episode were significantly more likely than nonpsychotic patients to demonstrate subsequent mania or hypomania at follow-up. Those with family histories of bipolar illness showed a non-significantly higher rate of switching to mania or hypomania. Spontaneous and antidepressant-associated manias did not differ in frequency. Fewer than one-half of the patients who showed an eventual bipolar course had received prescriptions for mood stabilizers in any follow-up year.

The shortcoming of present study is small sample size.

CONCLUSION

Authors found that unipolar and bipolar depression showed almost similar clinical features such anhedonia, pseudodementia, panic symptoms and delusions etc.

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