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Comparison Of Socio-Demographic And Clinical Profile Of Patients Of Unipolar And Bipolar Depression

[1]Dr. Ajay Deshmukh, [2]Dr. Sharad Kshirsagar, [3]Dr. Ajish Mangot

[1]Assistant Professor, [2]Professor, [3]Associate Professor, Department of Psychiatry, Krishna Institute of Medical Sciences, Karad, Maharashtra, India

Corresponding author: Dr Ajish Mangot, Associate Professor, Department of Psychiatry, Krishna Institute of Medical Sciences, Karad, Maharashtra, India Email: dr.ajish@outlook.com

Abstract

Background: Unipolar (UP) and bipolar (BP) disorders differ in genetics, neurobiology, clinical course, treatment regimens and prognosis. The present studycompared socio-demographic and clinical profile of patients of unipolar and bipolar depression.
Materials & Methods: 76 patients of unipolar and bipolar depression of both genderswere kept in group I and bipolar in group II. Socio-demographic and clinical profile of unipolar and bipolar patients was recorded.
Results: Out of 76 patients, males were 46 and females were 30. Total duration (years) was 13.5 and 17.2, age of onset (years) was 29.4 and 20.5, number of hospitalization was 2.3 and 5.4, number of episodes was 3.4 and 7.6, panic symptoms was seen in 11 and 7, delusions in 15 and 1, anhedonia in 21 and 13, pseudodementia in 6 and 2, suicidal thoughts in 2 and 5, catatonic featuresin 10 and 4 and depressive cognitionsin 5 and 3. The difference was significant (P< 0.05).
Conclusion: With the advent of the BP spectrum concept, it becomes all the more important not to miss bipolarity in patients with first episode depression. Adequate measures should be taken to understand the clinical markers of bipolarity.

Keywords: Unipolar, Bipolar, Depression.

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.[2] 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.[3]

Depression is a common mental disorder, with an estimated global burden of 350 million. Lifetime prevalence rates range from approximately 3% to 16.9%, with most countries falling somewhere between 8% and 12%. Depressive disorder is diagnosed when the patient suffers from depressed mood, loss of interest and enjoyment, and reduced energy leading to increased fatigability and diminished activity for at least 2 weeks.[4]

The distinction between unipolar and bipolar depression remains a challenging clinical problem, particularly when bipolar individuals present in the depressive phase and they may

easily be mistaken for unipolar depression. There are differences in the optimal management of these conditions.[5] Patients with bipolar depression who are assumed to have unipolar depression will receive inappropriate therapy that can increase the risk of manic switch or cycle acceleration. Measures to clinically recognize or at least to suspect the kind of disorder in the early stage can greatly improve diagnosis and management of such disorders, with more appropriate treatment selection which will help in long-term care of these groups of people.[6]The present studycompared socio-demographic and clinical profile of patients of unipolar and bipolar depression.

Materials & Methods

The present study comprised of 76 patients of unipolar and bipolar depressionof both genders. All gave their written consent for the participation in the study.

Data such as name, age, gender etc. was recorded. Unipolar patients were kept in group I and bipolar in group II. Socio-demographic and clinical profile of unipolar and bipolar patients was recorded. Data thus obtained were subjected to statistical analysis. P value < 0.05 was considered significant.

Results

Table I Distribution of patients

Total- 76		
Gender	**Males**	**Females**
Number	46	30

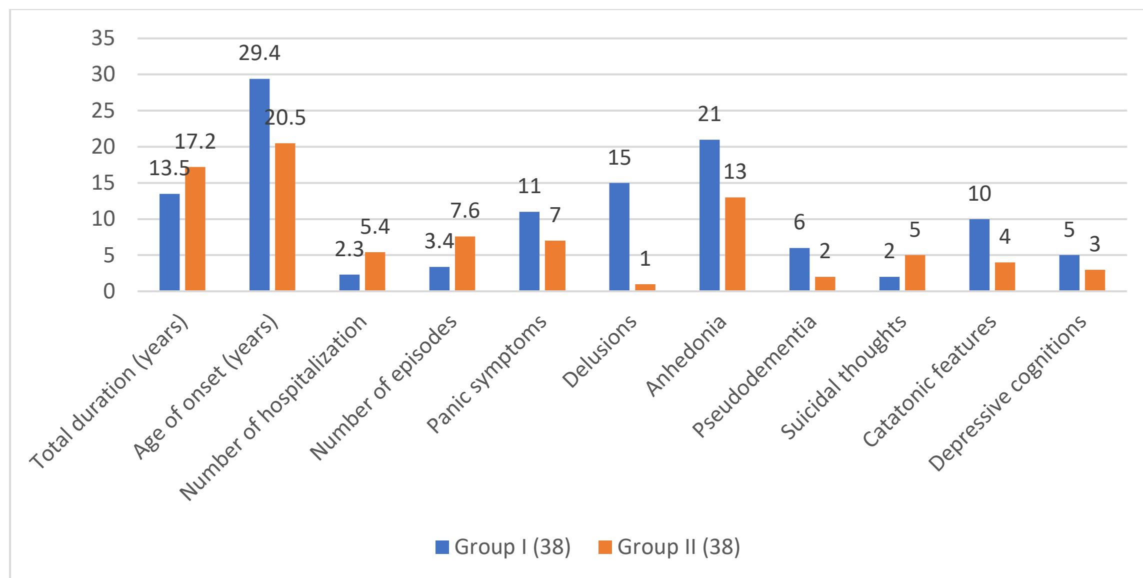
Table I shows that out of 76 patients, males were 46 and females were 30.

Table II Comparison of parameters

Parameters	Group I (38)	Group II(38)	P value
Total duration (years)	13.5	17.2	0.02
Age of onset (years)	29.4	20.5	0.05
Number of hospitalization	2.3	5.4	0.01
Number of episodes	3.4	7.6	0.04
Panic symptoms	11	7	0.05
Delusions	15	1	
Anhedonia	21	13	
Pseudodementia	6	2	
Suicidal thoughts	2	5	
Catatonic features	10	4	
Depressive cognitions	5	3	

Table II, graph I shows that total duration (years) was 13.5 and 17.2, age of onset (years) was 29.4 and 20.5, number of hospitalization was 2.3 and 5.4, number of episodes was 3.4 and 7.6, panic symptoms was seen in 11 and 7, delusions in 15 and 1, anhedonia in 21 and 13, pseudodementia in 6 and 2, suicidal thoughts in 2 and 5, catatonic features in 10 and 4 and depressive cognitions in 5 and 3. The difference was significant (P< 0.05).

Graph I Comparison of parameters



Discussion

Unipolar depressive disorders were ranked fourth in 2004 and will rise to the first place by 2030 in terms of the global burden of all diseases.[7] Bipolar disorder affected an estimated 29.5 million individuals worldwide in 2004, according to the World Health Organization.[8] If the current trends for demographic and epidemiologic transition continue, it is estimated that by the year 2020, the burden of depression will increase to 5.7% of the total burden of disease and it would be the second leading cause of disability-adjusted life years.[9]The present studycompared socio-demographic and clinical profile of patients of unipolar and bipolar depression.

We found that out of 76 patients, males were 46 and females were 30. Kalita et al[10]included total of 330 subjects selected through purposive sampling technique. Mini-International Neuropsychiatric Interview (M.I.N.I.) version 6.0 and Beck Depression Inventory (BDI) were applied. Bipolar group had onset of illness at significantly younger age with more chronicity (32.85 ± 11.084). Mean BDI score was significantly higher in the unipolar depressive group. Conclusion: Careful approach in eliciting symptom severity and associated socio demographic profiles in depressed patients may be helpful in early diagnosis of bipolar depression

We found that total duration (years) was 13.5 and 17.2, age of onset (years) was 29.4 and 20.5, number of hospitalization was 2.3 and 5.4, number of episodes was 3.4 and 7.6, panic symptoms was seen in 11 and 7, delusions in 15 and 1, anhedonia in 21 and 13, pseudodementia in 6 and 2, suicidal thoughts in 2 and 5, catatonic features in 10 and 4 and depressive cognitions in 5 and 3.Chopra et al[11] 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.

Berlim et al[12]compared the impact of illness on quality of life (QOL) in adult outpatients with unipolar (N = 89) and bipolar (N = 25) depression. While attending a university hospital in southern Brazil, patients completed the WHO's QOL Instrument-Short Version and the Beck Depression Inventory. After analyses, patients with bipolar depression reported significantly lower scores on the psychological QOL domain (p = .013) than patients with unipolar depression. There were no significant differences between the study groups in terms of social and demographic variables, in the other QOL domains assessed (i.e., physical health, social relationships, and

environmental), and in the severity of depressive symptoms.

The limitation the study is small sample size.

Conclusion

Authors found that patients with bipolar and unipolar depressions have different QOL profiles. With the advent of the BP spectrum concept, it becomes all the more important not to miss bipolarity in patients with first episode depression. Adequate measures should be taken to understand the clinical markers of bipolarity.

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