Does Follow-up in a Specialized Center Influence Symptom Profile and Severity of Bipolar Depression?

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ÖZET

Uzmanlaşmış bir merkezde izlem iki uçlu depresyon belirti sayısını ve şiddetini etkiler mi?

Amaç: İki uçlu bozukluk hastaları, hayatlarının önemli bir bölümünde depresif belirtiler yaşamaktadırlar. Buna karşın, iki uçlu depresyon belirti örüntüsü oldukça az çalışılmıştır. İki uçlu depresif dönemde, hastaların daha çok atipik depresyon belirtileri yaşaması beklenirken, etnokültürel farklılıklar ve düzenli izlem, klinik belirtilerin ortaya çıkış şeklini ve dışavurumunu etkileyebilmektedir. Buradan hareketle, bu çalışmada özelleşmiş bir duygudurum merkezinde takip edilen iki uçlu hastaların depresif dönemde yaşadıkları belirtilerin gözden geçirilmesi amaçlanmıştır.

Yöntem: Bakırköy Ruh Sağlığı ve Sinir Hastalıkları Hastanesi Raşit Tahsin Duygudurum Merkezi'nde iki uçlu bozukluk tanısıyla takip edilmekte olan 144 hastanın en şiddetli depresif dönemine ilişkin belirtileri kaydedilmiştir. Klinik belirtiler yapılandırılmış bir veri formundan ve hastane kayıtlarından elde edilmiştir. Depresif belirtiler, tanımlayıcı istatistikle değerlendirilmiştir.

Bulgular: Hastaların %10'undan daha azında depresif belirtilerin şiddetli olduğu saptandı. Suçluluk duygusu ve benlik saygısında azalma hastaların yaklaşık yarısında görülmezken (%45,8), aktif (%3,5) ya da pasif (%15,3) intihar fikri yaklaşık beşte bir oranında görülmekteydi. Psikotik belirtilerin görülme oranı ise oldukça düşüktü (%4,2). Ayrıca enerji kaybı ve dikkat-konsantrasyon güçlüğü dışındaki vejetatif bulgular hastaların yarısından daha çoğunda görülmemekteydi. Tedavide ise, duygudurum dengeleyici ekleme ya da doz titrasyonu ve terapötik görüşmenin hastaların yaklaşık üçte birinde remisyon için yeterli olduğu saptandı.

Tartışma ve Sonuç: İki uçlu depresyonun, daha şiddetli seyrettiği ve daha sık özkıyım girişimiyle ilişkili olduğu bildirilmesine karşın, tüm belirtiler için, şiddetli olan vakaların oranının %10'un altında ve aktif özkıyım fikrine sahip vakaların oranının %3,5 olduğu tesbit edilmiştir. Ayrıca, psikotik bulguların sıklığı %4,2 olarak bulunmuştur. Daha hafif şiddette belirtilerin görülmesi literatürle çelişse de, bu durum hastaların uzmanlaşmış bir birimde takip edilmesi ve belirtilerin şiddetlenmeden müdahale edilmesi ile açıklanabilmektedir. Hastalara daha az farmakolojik tedavi müdahalesinde bulunma ihtiyacı da, aynı nedenden kaynaklanabilmektedir.

Anahtar kelimeler: İki uçlu depresyon, belirti örüntüsü, özelleşmiş merkez

ABSTRACT

Does follow-up in a specialized center influence symptom profile and severity of bipolar depression?

Introduction: Despite bipolar patients spend up to one third of their lives in depression, the treatment of bipolar depression remains as an understudied area. Although more atypical depressive symptoms are expected to be seen in bipolar depression, ethnocultural differences and regular follow-ups can change the onset and expression of clinical symptoms. Thus, in the present study, we aimed to evaluate the symptoms of depressive bipolar patients who are followed up in a specialized mood disorder unit.

Methods: The most severe depressive symptoms of 144 bipolar patients were followed up using standardized forms in a specialized mood disorder outpatient unit. Obtained data analyzed by descriptive statistics.

Results: It was determined that less than 10% of depressive symptoms were severe. Feelings of guilt and low self-esteem were not detected in nearly half of the patients (45,8%); active (3,5%) or passive (15,3%) suicidal ideation was seen approximately in one-fifth of the patients. The rate of psychotic symptoms was considerably low (4,2%). Beside this, vegetative symptoms other than loss of energy and lack of concentration were not seen in more than half of the patients. Adding a mood stabilizer or titrating the levels and psychotherapeutic interventions were adequate for remission in one-third of the patients.

Discussion: Although previously it was reported bipolar depressive symptoms were severe with higher suicide rates, in less than 10% of patients, depressive symptoms were severe and the rate of active suicidal ideation was 3,5% in our study. Moreover, the rate of psychotic symptoms was found 4,2%. Although occurrence of milder symptoms contradicts with the literature, this can be explained by the follow-up of the patients in a specialized unit and early intervention before symptoms get more severe. Decreased need for pharmacological intervention can also be explained by the same reason.

Key words: Bipolar depression, symptom profile, specialized unit

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INTRODUCTION

Bipolar depression is a severe psychiatric disease with a chronic course of recurrent manic, depressive and mixed periods. Its lifelong prevalence is approximately 1-3.5% (1,2). Reports have shown that most depressive bipolar patients were misdiagnosed due to the difficulty of detecting previoud history of manic-hypomanic periods (3,4).

For the majority of patients, the initial disease period is depression (5) and the length of a depressive period is 3 times longer than the length of manic periods (6). In a 13 years follow-up study, Judd et al. (7) determined that weeks without symptoms were observed at a rate of 53%; 90% of the patients experienced depressive symptoms for at least one week.

It is reported that depressive bipolar patients have more uncompleted suicide attempts than unipolar depressive patients (8). Depressive episodes are the strongest determinant of the functioning and well-being in bipolar patients (9) and chronic subthreshold depressive symptoms are the strongest predictor of deterioration in functioning (10), consequently, treatment of the depressive period of the disease becomes more important.

Although bipolar depression is different from unipolar depression, treatment options are still borrowed from major depression treatment. The limited number of treatment options available, compared to treating mania, makes the treatment of depressive periods difficult (11). Despite the economic and social burdens caused by bipolar depression (12), the symptom pattern of this disease has not been studied as much. Atypical depressive symptoms are seen more frequently in bipolar depression and it can be differentiated from unipolar depression by an early age of onset, shorter and more severe episodes, acute commencement and conclusion, more frequent seasonal features, psychomotor retardations, anergy and more marked and severe vegetative symptoms (13-15). From this perspective, our aim was to review the symptoms experienced by the patients with bipolar depression. These patients were followed-up and treated regularly in a specialized mood disorders unit during depressive periods.

MATERIALS AND METHODS

The clinical records of 784 patients, who were being followed-up in the Raşit Tahsin Mood Center of Bakırköy Research and Training Hospital for Psychiatry, Neurology & Neurosurgery, with the diagnosis of bipolar depression were investigated retrospectively between March-June 2007. The most severe 144 depressive periods of 144 patients experiencing depressive periods in the mood disorder center during their follow-up were included into statistical evaluation. Clinical symptoms were obtained from a structured data form (16) and hospital records. Depressive symptoms were noted as "absent", "mild", "intermediate" and "severe" on the structured data form and suicidal ideation was distinguished by active-passive discrimination. All depressive symptoms and treatments were analyzed by descriptive statistics using the SPSS 16 statistical program.

RESULTS

The majority of the patients (92.3%) in the Bipolar Disorder Type I diagnosis group were female (70.1%). The mean age of disease onset was 24.7 years and the mean disease duration was 15.3 years (Table 1).

The two most frequently seen depressive symptoms were depressive mood (98.6%) and loss of interest (93.8%).

Table 1: The demographic characteristics of the patients

	Min.	Max.	Mean	SD
Age (year)	18	73	39,64	10,99
Onset of illness (year)	10	58	24,74	9,38
Duration of the illness (year)	2	48	15,27	9,32

Min. Minimum, Max: Maximum, SD: Standard Deviation

Table 2: Distribution of depressive symptoms

Symptom	Absent (%)	Mild (%)	Intermediate (%)	Severe (%)	Total (%)
Depressive mood	1.4	34.7	55.6	8.3	98.6
Interest-wish loss	6.2	36.1	47.9	9.7	93.8
Guilt feelings	45.1	24.3	25.0	5.6	54.9
Anergy	9.0	37.5	45.8	7.6	91.0
Attention / concentration disorder	37.5	25.0	29.9	7.6	62.5
Sleep disorder	68.1	17.4	9.7	4.9	31.9
Psychomotor slowness	76.4	13.9	7.6	2.1	23.6
Anxiety	97.9	1.4		0.7	2.1
Appetite disorder	57.6	24.3	12.5	5.6	42.4
Obsession	97.9	1.4	0.7		2.1
Delirium	95.8	2.8	0.7	0.7	4.2
Delusion	95.8	1.4	2.1	0.7	4.2

Table 3: Distribution of suicidal ideation or attempts

Suicidal Ideation	n	%
Absent	94	65.3
Life is not worth living	23	16.0
Passive suicidal ideation	22	15.3
Active suicidal ideation or attempts	5	3.5
Total	144	100

Table 4: Intervention performed during the most severe depressive period

	n	%
No pharmacological intervention	18	12,5
Mood stabilizing titration (1)	27	18,8
Addition of antipsychotic agent/increasing the dose (2)	13	9,0
Addition of antidepressant agent/increasing the dose (3)	29	20,1
1+2	21	14,6
1+3	16	11,1
2+3	15	10,4
1+2+3	3	2,1
Hospitalization	2	1,4
Total	144	100

Anergy was observed in 91% of depressive episodes. Mild-intermediate depressive symptoms occurred more often in evaluations of depressive symptom severity. More than half of the patients did not have sleep-appetite disturbance (68.1%-57.6%), anxiety signs (97.9%) and psychomotor retardation (76,4%). Obsession (2.1%), delusion or hallucination (4.2%) were seen very infrequently during depressive periods (Table 2).

In addition, a minority of the patients had suicidal ideation and only 3,5% of them had actively attempted suicide or had suicidal ideation (Table 3).

Observations revealed that there were improvements in one-third of the patients without any pharmacological intervention, or with only titration of mood stabilizers during the treatment of the most severe depressive periods. Only two patients (1.4%) were hospitalized (Table 4).

DISCUSSION

Many studies have reported that symptoms like hypersomnia or hyperphagia belong to atypical depression, and that vegetative symptoms were seen more frequently in bipolar depression compared to unipolar depression (17-19). Studies have also shown that irritability (20,21), anger (22,23), subthreshold mixed signs (24) and psychotic symptoms (19) were associated with bipolar depression. In a long-term follow-up study, it was determined that early onset of symptoms, a history of bipolar disorder in the family and hypersomnia/ psychomotor retardation symptoms were clinical predictors for bipolar depression at a rate of 98% (25). In our study, although the most severe depressive periods of the patients were evaluated beginning from the follow-up in a specialized center, sleep disorder (68.1%), psychomotor retardation (76.4%) and appetite disturbanca (57.6%), expected to be observed frequently in bipolar depression, were seen in only a minority of the patients, discrepant with the literature. While psychotic symptoms were also reported frequently in bipolar depression (13), the frequency of psychotic symptoms in our study was determined to be quite low (4.2%). The reason for the inconsistency in the frequency of bipolar depressive symptoms determined in our study, compared with

the results in the general literature, can be explained by early treatment intervention as a consequence of regular follow-up of the patients in a specialized center.

Conversely, there have been discussions that various ethnic and cultural features could be a factor in how depressive symptoms manifest. In their study, Patel et al. (26) could not demonstrate a similar difference for depressive symptoms despite stating that manic and psychotic symptoms showed ethnic differences; but they emphasized that cultural beliefs and ethnic variations should not be ruled out (26). As a consequence of research into the difference in depressive symptoms between the sampling groups from Turkey and United Kingdom, Uluşahin et al. (27) stated that their findings indicated that patients in a United Kingdom sample mainly experienced mood symptoms which were the core symptoms, but the patients in the Turkish sample mainly experienced somatic symptoms. They emphasized that this condition might have resulted from the difference in the manifestation of depressive symptoms due to cultural variations (27). While these data are consistent with relatively lower rates of guilt feelings and lack of self-esteem (45.8%), it seems to be inconsistent with the rates of vegetative and somatic symptoms observed in less than half of the patients. This condition may be associated with either the evaluation of the most severe depressive periods of patients beginning treatment in a specialized center or of patients learning how to express their feelings in the psychotherapy groups in which they participate during their follow-ups in our specialized center. However, standard evaluation forms were not used to record depressive periods before patients entered the mood center and this made it impossible for us to evaluate the patients' past depressive periods.

Another finding that is inconsistent with the literature in terms of cultural variations pertains to suicide attempts and ideation. Suicide attempts and suicidal ideation can be influenced by social, cultural, and religious factors (28,29). In our study, active (3.5%) or passive (15.3%) suicidal ideations were observed in approximately one-fifth of the patients. In the literature, lifelong risk of potential suicide for depressive bipolar patients was reported to vary between 25% and 56% (30-32). These relatively low percentages with regard to suicidal ideation or suicide attempts can be explained to a certain extent, by the placement of patients in a specialized center. Another probable factor is that the number of attempted suicides is considerably lower in Islamic countries, according to the literature. (33).

In our study, we also observed that adding mood stabilizer or titration and pychotherapeutic interventions resulted in improvement for approximately one-third of the depressive periods of the patients. An investigation of the literature indicates that the treatment of bipolar depression is not studied as often (34) and that multiple drug use is more widespread today (35,36). The relatively low rate of multiple drug use found in our study could have been due to the follow-up that patients receive in a specialized center and early intervention of the symptoms without exacerbation and, thus, administration of fewer pharmacological treatment interventions to the patients.

Although the retrospective design of our study has limitations, the evaluation of data from the patients who are being followed-up regularly through structured data forms partially balance this limitation. While the exclusion of depressive symptoms exhibited by patients before they entered the mood center is probably the major drawback of our study, their diminished need for multiple drug administration and lessened symptom severity, compared to the current literature, is very illustrative in showing the importance of follow-up for the patient in a specialized center.

CONCLUSION

The patients with bipolar disorder experience depressive symptoms during a great deal of their lives and subthreshold depressive symptoms are frequently missed. In treating bipolar depression, the knowledge and treatment options gained from the study of unipolar depression have yet to be used. Establishing specialized centers enables us to observe patients on a regular basis and implement therapeutic interventions in a controlled environment, without symptom exacerbation. These circumstances also lessen the need for multiple drug use and facilitate the reduction of patients' disease symptoms.

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