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*Original Research Article.*

# Analysis of Prevalence of Residual Symptoms in Bipolar Disorder Patients: An Institutional Based Study

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## ABSTRACT

**Background:** Bipolar disorder is a chronic illness that is typically experienced first in early adulthood, although onset in childhood or in older age may also occur. The present study was conducted for assessing the prevalence of residual symptoms in subjects with bipolar disorder.

**Materials & Methods:** A total of 100 patients with bipolar disorder were enrolled. Complete demographic and clinical details of all the patients was obtained. Only those patients were enrolled which had remission for a minimum of 3 months before induction. Exclusion criteria for the present study included patients with history of any other systemic illness. The patients were evaluated clinically during assessment, and their treatment records were reviewed for the presence/absence of any comorbid physical illnesses. Residual symptoms, if any were evaluated on follow-up.

**Results:** A total of 100 patients with mean age of 52.3 years were enrolled. Residual symptoms were present in 38 percent of the patients. Among these 38 patients, 25 patients were males while the remaining 13 patients were females. 20 patients were of urban residence while the remaining 18 patients of rural residence. Majority proportion of patients belonged to the age group of more than 50 years.

**Conclusion:** Relatively many BD patients still have residual symptoms.

**Key words:** Residual, Bipolar disorder.

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## INTRODUCTION

Bipolar disorder is a chronic illness that is typically experienced first in early adulthood, although onset in childhood or in older age may also occur. Bipolar disorder can be divided into subtypes, including bipolar I and bipolar II disorder. Bipolar I disorder is distinguished by full-blown manic episodes that are more impairing than the hypomanic episodes that characterize bipolar II disorder. Depression, which is the presenting symptom of bipolar disorder in most patients, may impose a greater disease burden, in terms of both duration and impact, than manic symptoms. Depressive symptoms may be of similar severity in bipolar I and II disorder, and, therefore, bipolar II disorder should not be considered a "milder" illness than bipolar I. The form of the disease that individuals experience tends to be stable over their lifetime. For patients with either condition, the primary care physician can play an important role, often working with psychiatric consultants, in both managing treatment and monitoring the bipolar disorder and ensuring that other health care needs are met, including preventive care and managing chronic comorbid medical conditions.[1-3]

The pioneering trials of lithium and chlorpromazine were done in the 1970s and were followed by a focus on antiepileptics (eg, valproate and carbamazepine) in the 1980s and 1990s. Few trials directly assessing the comparative efficacy of different second-generation antipsychotics exist, but a mixed treatments meta-analysis compared 13 agents studied in 68 randomised controlled trials (16 073 participants). This review found substantial and clinically important differences in terms of both efficacy and tolerability between agents. Antipsychotic drugs seem to be better than anticonvulsants and lithium in the treatment of manic episodes. Olanzapine, risperidone, and haloperidol seem to have the best profile of presently available agents.[4-7] Hence; the present study was conducted for assessing the prevalence of residual symptoms in subjects with bipolar disorder.

## MATERIALS & METHODS

The present study was conducted in the Department of Psychiatry, Narayan Medical College & Hospital, Jamuhar, Sasaram, Bihar (India) for assessing the prevalence of residual

symptoms in subjects with bipolar disorder. A total of 100 patients with bipolar disorder were enrolled. Complete demographic and clinical details of all the patients was obtained. Only those patients were enrolled which had remission for a minimum of 3 months before induction. Exclusion criteria for the present study included patients with history of any other systemic illness. The patients were evaluated clinically during assessment, and their treatment records were reviewed for the presence/absence of any comorbid physical illnesses. Residual symptoms, if any were evaluated on follow-up.

**Table 1: Prevalence of residual symptoms**

| Residual symptoms | Number | Percentage |
|---|---|---|
| **Present** | 38 | 38 |
| **Absent** | 62 | 62 |
| **Total** | 100 | 100 |

**Table 2: Data of patients with residual symptoms**

| Residual symptoms | | Number |
|---|---|---|
| **Gender** | **Males** | 25 |
| | **Females** | 13 |
| **Age group (years)** | **Less than 50** | 12 |
| | **More than 50** | 26 |
| **Residence** | **Rural** | 18 |
| | **Urban** | 20 |

## RESULTS

A total of 100 patients with mean age of 52.3 years were enrolled. Residual symptoms were present in 38 percent of the patients. Among these 38 patients, 25 patients were males while the remaining 13 patients were females. 20 patients were of urban residence while the remaining 18 patients of rural residence. Majority proportion of patients belonged to the age group of more than 50 years.

## DISCUSSION

Bipolar illness, among psychiatric conditions, has served a central role in advancing clinical psychiatry, especially the interaction of biological predisposition with environmental stress. For one thing, there is a clear genetic diathesis for bipolar illness. Also, there are six different clinical state changes that can be studied: two states (depression and mania), and four phase changes (from depression to mania, from mania to depression, from depression to mixed states, and from mixed states to depression). These multiple clinical features of bipolar illness have served as a powerful research tool. And, as noted, there is substantial new bearing on the role of psychosocial factors in the emergence of episodes of affective illness (eg, the kindling paradigm) and in its treatment as well.[7- 9]

Despite methodological difficulties in assessing central nervous system (CNS) noradrenergic (NE) functions in humans, extensive investigation supports the presence of NE systems abnormalities in BD. Postmortem studies have shown an increased NE turnover in the cortical and thalamic areas of BD subjects, whereas in vivo studies have found plasma levels of NE and its major metabolite, 3-methoxy-4-hydroxyphenylglycol (MHPG), to be lower in bipolar than unipolar depressed patients, and higher in bipolar patients when manic than when depressed. The same occurs with urinary MHPG levels, which are lower in bipolar depressed patients, while longitudinal studies show that MHPG excretion is higher in the manic compared to depressed state. Finally, in a consistent mode, cerebrospinal fluid (CSF) NE and MHPG are also reported to be higher in mania than in depression.[10- 12] Hence; the present study was conducted for assessing the prevalence of residual symptoms in subjects with bipolar disorder.

A total of 100 patients with mean age of 52.3 years were enrolled. Residual symptoms were present in 38 percent of the patients. Among these 38 patients, 25 patients were males while the remaining 13 patients were females. 20 patients were of urban residence while the remaining 18 patients of rural residence. Majority proportion of patients belonged to the age group of more than 50 years. Keitner GI et al evaluated the nature of prodromal and residual symptoms of mania and depression, as reported by patients with bipolar I disorder and their family members. Prodromal and residual symptoms of mania and depression were elicited from 74 patients with bipolar I disorder. In 45 cases, an adult family member provided similar information. Three clinicians classified the symptoms into six broad categories: behavioral, cognitive, mood, neurovegetative, social, and other. The clinicians also categorized symptoms as typical or idiosyncratic. Seventy-eight percent of the patients reported prodromal depressive symptoms and 87% reported prodromal manic symptoms; greater than half of the patients disclosed residual symptoms of depression (54%) and mania (68%). Within each of these four illness categories, cognitive symptoms were consistently the most common symptoms reported by patients. A substantial number of symptoms were idiosyncratic, particularly those reported for residual depression. Agreement between patient and family members on reported symptoms was strong for the prodromal phase of both polarities, but less so for the residual phases.[13]

A sample of 64 depressed patients meeting the Research Diagnostic Criteria (RDC) for definite primary unipolar major depression was identified on presentation, and followed to remission, or for 15 months. Only 4 subjects in the sample of 64 failed to remit to the criterion of 2 months below definite major depression by this point. However, on examining the findings in

more detail, although the majority of remitters scored in the lower ranges of the 17-item Hamilton Depression Rating Scale, an important proportion of 32% (19/60) scored 8 or more on the Hamilton scale, the criterion proposed by Frank et al as indicating full remission or recovery. They spanned a range from 8 to 18, although they did not satisfy the criteria for major depression.[14- 17]
Two determinants of psychosocial functioning of euthymic (neither fully depressed nor manic) individuals with bipolar disorder are residual depressive symptoms and cognitive impairment (i.e., difficulties with executive functioning, attention, and memory). The present study explored whether a new cognitive remediation (CR) treatment designed to treat residual depressive symptoms and, for the first time to the best of our knowledge, address cognitive impairment would be associated with improvement in psychosocial functioning in individuals with bipolar disorder. Following a neuropsychological and clinical assessment 18 individuals with DSM-IV bipolar disorder were treated with 14 individual sessions of CR. Results indicated that at the end of treatment, as well as at the 3-months follow-up, patients showed lower residual depressive symptoms, and increased occupational, as well as overall psychosocial functioning. Pretreatment neuropsychological impairment predicted treatment response. Improvements in executive functioning were associated with improvements in occupational functioning. These findings suggest that treating residual depressive symptoms and cognitive impairment may be an avenue to improving occupational and overall functioning in individuals with bipolar disorder.[18- 20]

## CONCLUSION

Relatively many BD patients still have residual symptoms.

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