



Asian pearls

Clinical characteristics of patients with non-affective, non-organic, late onset psychosis

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ARTICLE INFO

Article history:

Received 30 July 2016

Received in revised form 17 October 2016

Accepted 23 October 2016

Keywords:

Psychosis

Schizophrenia

Late onset

Elderly psychosis

Geriatric psychosis

ABSTRACT

Objective: Schizophrenia and related psychotic disorders are predominantly studied in young population. However some individuals do develop psychotic disorder for the first time during their old age. The aim of this study is to look at the clinical characteristics of non-affective, non-organic, late onset psychosis.

Participants and methods: Retrospective chart review study, medical records of all patients registered between 1st of January 2006 and 31st May 2011 at geriatric clinic in NIMHANS, Bangalore was screened, 83 files with a diagnosis of late onset psychosis and meeting the study criteria were systematically analyzed.

Results: The mean age at onset of illness was 67 ± 10 years; 98.8% were married, females formed 67.5% of the sample, commonest phenomenon was delusions followed by hallucinations, 80.5% of the subjects had delusion of persecution, 38.5% had referential delusion, 51.8% had accusative and derogatory auditory hallucinations, negative symptoms was seen only in 2.4% of subjects, none had formal thought disorder. 3.6% had co-morbid Axis II diagnosis.

Conclusion: Despite its rarity non affective, non organic, late onset psychosis forms a distinct group with unique manifestation. Further systematic research is needed for better understanding of this condition.

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1. Introduction

Schizophrenia and related Non-Affective psychotic disorders are predominantly studied in adolescence and young adults. However some individuals do develop psychotic disorder for the first time during their old age. Community prevalence estimates for schizophrenia range from 0.1% to 0.5% (Castle and Murray, 1993; Copeland et al., 1992, 1998; Kua, 1992). 1-year prevalence rate of schizophrenia in individuals between ages 45 and 64 is 0.6% (Keith et al., 1991). For individuals over 65 years of age, incidence rate of schizophrenia with first onset after 44 years is 12.6 per 100,000 population per year (Copeland et al., 1998). The Studies on late-onset schizophrenia began with Manfred Bleuler, Late onset schizophrenia constituted 15% of patient whom he examined; 4% of the patients had an onset after 60 (Bleuler, 1943). About 50% of the patients with late-onset schizophrenia had symptoms that were similar to those seen in early onset schizophrenic patients. However he did report certain striking differences; more than 50% of patients had Paraphrenia like symptoms, depressive, anxious,

catatonic or confused agitated symptoms, but with less affective flattening (Harris and Jeste, 1988; Jeste et al., 1988, 1995; Mayer et al., 1993; Pearlson et al., 1989; Rabins et al., 1984). Subsequently there are lot of studies on late onset psychosis (LOP), mostly from developed countries of Europe and America, but the research findings in this area is struck with difficulties because neither ICD 10 nor DSM V contain separate codes of diagnosis for 'late onset schizophrenia'; different terms being used to describe a similar illness occurring in old age and using different age cut-off to be called late onset psychosis (LOP) (Howard et al., 2000). But other limitations of existing literature in this field are some studies include patients who had early onset psychosis but grown old, including patients with affective disorder and organic psychosis. Some of these confusions were cleared after The International Late Onset Schizophrenia group came up in the year 2000 with consensus on nomenclature defining Late Onset Schizophrenia and Very Late Onset Schizophrenia like Psychosis. For developing countries like India and China with their large population and increasing geriatric population, late onset psychosis is a major concern. Socio cultural factors like globalization, migration, breaking up of joint families, poorer healthcare facilities etc in developing countries in Asia are certainly different to that of developed countries in Europe and America. There are many

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factors that increase the risk of developing psychiatric disorder in elderly like loss of close relatives, social network, previous status in society, sensory functions, functional ability, and health (Skoog, 2008). These psycho socio cultural factors can influence the presentation of individuals with late onset psychosis. Currently there is a paucity of literature on the clinical manifestation of late onset psychosis in Asia especially from India. So the aim of this study is to study the clinical characteristics of non-affective, non-organic, late onset psychosis in an Indian set-up.

2. Methods

2.1. Study design & setting

This is a retrospective chart review study conducted at the Geriatric clinic & Services in National institute of mental health and neuro sciences (NIMHANS) Bangalore, a tertiary care hospital in India, which caters to individuals with psychiatric, neurology and neurosurgery problems. Geriatric clinic is run by a multi disciplinary team which includes psychiatrists, neurologists, neuro psychologists and social workers. All the patients attending geriatric clinic are assessed using a semi structured workup proforma, thorough physical examination, Hindi Mental State Examination scale (HMSE) which is an Indian adaptation of Mini Mental State Examination, Geriatric Depression Scale (GDS), Clinical Dementia Rating Scale (CDR), Neuro Psychiatric Inventory (NPI) and Everyday Abilities Scale for India (EASI). They also undergo basic investigations like complete haemogram with peripheral smear, random blood sugar test, liver function test, renal function test, serum electrolytes and Computerized tomography of brain. Other investigations are done if necessary.

2.2. Study participants

We retrieved and screened medical records of all patients who got registered in the geriatric clinic between 1st of January 2006 and 31st of May 2011. In this study we included medical records of patients diagnosed to have psychosis (Schizophrenia, delusional disorder, acute psychosis, nonspecific psychotic disorder, other psychotic disorder) as per International classification of disease 10th version (ICD-10), who were above 50 years of age at the time of onset of psychosis and those who followed up in geriatric clinic atleast for 3 months. We excluded files of patients whose diagnosis was other than psychosis, who developed psychotic symptoms secondary to affective disorder or substance use or organicity (epilepsy, cerebral tumors etc), dementia, whose age at onset of psychosis was below 50 years, those who had major mental illness in the past and medical records that lacked sufficient data. Finally we selected 83 medical records which satisfied our inclusion and exclusion criteria, these records were analyzed.

This study was approved by NIMHANS Institute ethics committee, written informed consent was not taken as it is a retrospective chart review, and anonymity of all patients was maintained.

2.3. Materials

1. Hindi Mental Status Examination (HMSE) – Is an Indian adaptation of *Mini Mental Status Examination* (MMSE) that is being used in epidemiological studies of dementia in India. It contains 23 items which test different components of intellectual capability. The scale has a total score of 31, a score less than 19 is indicative of dementia and warrants a detailed cognitive assessment (Ganguli et al., 1995).

2. Everyday Abilities Scale for India (EASI) – This is brief, reliable and valid scale to assess activities of daily living, with norms, which

is appropriate for use in assessing dementia in elderly people in India. This is a 12-item uni-dimensional scale which measures mobility, instrumental and personal care activities, the scale has good internal consistency (Pandav et al., 2002). Each item is scored either 0 or 1, less number of 1 score, in other words lower total scores indicates better functioning.

3. Neuropsychiatric Inventory (NPI) – The purpose of NPI is to obtain information on the presence of psychopathology. The NPI was developed for application to patients with Alzheimer's disease and other dementias, but it may be useful in the assessment of behavioral changes in other conditions as well. It assesses ten behavioral symptoms including psychotic and affective symptoms and two neurovegetative symptoms. The NPI has been proven to be sensitive to change with treatment, it is available in many languages, has been shown to be valid and reliable in cross-cultural studies (Wood et al., 2000).

4. Geriatric Depression Scale (GDS) – Short version – GDS short version is a 15 item scale. The GDS was found to have a high sensitivity and specificity. The validity and reliability of the tool have been supported through both clinical practice and research. In a validation study comparing the Long and Short Forms of the GDS for self-rating of symptoms of depression, both were successful in differentiating depressed from non-depressed adults with a high correlation (Sheikh and Yesavage, 1986). Scores of 0–4 are considered normal; 5–8 indicate mild depression; 9–11 indicate moderate depression; and 12–15 indicate severe depression.

2.4. Statistical analysis

Descriptive statistics (frequency, ratio, mean, standard deviation) was used to define the socio demographics and clinical characteristics of the patients. Chi square test and Fisher's exact tests were conducted for to compare the symptomatology between different age groups. Person's correlation test was used to analyze the association between cognitive functions and different variables, with p value of <0.05 considered as significant. The data was analyzed using SPSS version 19.

3. Results

Among the 83 medical records that were reviewed, the mean age of the patient was 69 ± 9 years at the time of initial consultation, and age ranging between 51 and 91 years. The average age at the time of onset of illness was 67 ± 10 years. The mean duration of illness was 2.5 years ($SD \pm 2.2$ years); 55.4% of the patients were uneducated and 54.2% belonged to low socio economic class.

3.1. Socio demographics and clinical characteristics

The socio demographics and clinical characteristics of the patients are depicted in (Table 1). The sample had female preponderance; with number of females being almost double that of males. Except one person all others were married, most of them followed Hindu religion. Psychosis not otherwise specified (psychosis NOS) was the most common diagnosis in these patients, followed by schizophrenia, delusional disorder and acute and transient psychosis. Interestingly all patients diagnosed with acute and transient psychosis developed illness only at ≥ 60 years. Only 3/83 (3.6%) patients had Axis II disorder (Anankastic personality disorder – 1; Anxious avoidant personality disorder – 1; and Paranoid personality disorder – 1) Precipitating factor was noticed in 12% of these patients, with some developing psychosis following a loss of family member, some following hearing or visual impairment etc. Positive family history was found in more than 20% of patients, with nearly 11% of them had either a first or second

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