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Outcome of acute and transient psychotic disorder in an index episode: A study from a tertiary care centre in North India

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ABSTRACT

Background: Acute and Transient Psychotic Disorder (ATPD) is a psychotic disorder of brief duration with acute onset and uncertain diagnostic stability.
Aim: To study the diagnostic stability of ATPD during the index episode.
Method: 140 patients diagnosed with ATPD as per ICD-10, attending a tertiary care hospital in North India were evaluated at follow ups.
Results: Other acute and transient psychotic disorder (ICD10: F23.8) was the most common (69.3%) subtype of ATPD. In 14.28% patients, there was a past episode of ATPD. In our study, 66.3% patient's episodes resolved as ATPD, 32.7% patients converted into either a mood disorder or schizophrenia spectrum disorders.
Conclusion: The diagnostic stability of ATPD during the index episode was 66.3% during three months follow up period. Nearly two third of patients with ATPD evolve to either, schizophrenia or mood disorders during the index episode.

1. Introduction

Acute transient psychotic disorder (as per International Classification of Diseases, 10th edition) and Brief psychotic disorder (as per Diagnostic and Statistical Manual – 5th edition) represent a spectrum of psychotic disorders having a sudden to acute onset and lasting for a brief period (Kar et al., 2014). The recovery in this group of disorders is prognosticated to be usually quick with complete resolution of symptoms (Kar et al., 2014; Vignat, 2014). The time duration of the illness should not exceed one month as per Diagnostic and Statistical Manual – 5th edition (DSM-5), whereas it can last as long as three months as per International Classification of Diseases, 10th edition (ICD-10) (Jager et al., 2007). As per the ICD, the duration of ATPD with schizophrenic symptoms is limited to 1 month beyond which the disorder would be diagnosed as schizophrenia, in ATPD with polymorphic features or non-bizarre delusions, the diagnosis should be changed to other non-organic psychotic disorders or persistent delusional disorder after 3 months. The diagnosis of ATPD carries a high risk of relapse and has a poor diagnostic stability (Farooq, 2012; Jager et al., 2007; Singh et al., 2004). Most patients with a diagnosis of ATPD frequently convert into schizophrenia or mood disorder during follow up (Jager et al., 2007). In some recent studies, the incidence of ATPD was found to be ranging from 3.9 to 9.6 per 100,000 population and diagnostic stability ranged from 39% to approximately 54% (Castagnini et al., 2008, 2013; Farooq, 2012; Queirazza et al., 2014). However, Asian studies report better diagnostic stability ranging from 35.5% to 73.3% over a 3 to 12 year follow up period (Udomratn et al., 2012). Shorter duration of illness (<1 month) and abrupt onset (<48 h) has been reported to predict a stable diagnosis of ATPD (Mehta, 2015) whereas early onset and long hospitalizations in first episode of ATPD also increases the risk of development of schizophrenia (Queirazza et al., 2014).

ATPD is a common diagnosis in our clinical setting. The clinical symptoms evolve during the index episode and may receive an alternative diagnosis in the follow up. We planned this study to see the evolution of ATPD during the index episode and associate ATPD with various socio-demographic as well as clinical variables for a meaningful conclusion.

2. Method

The aim of the study was to evaluate the outcome of patients with a diagnosis of Acute and Transient Psychotic Disorder (ICD 10: F23) seeking treatment from a tertiary care centre in Northern

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India and to examine the relation of socio-demographic and clinical variables with the outcomes.

Patients suffering from Acute and Transient Psychotic Disorder (ATPD), attending the adult psychiatry outpatient clinic of King George's Medical University, Lucknow were included in the study after written consent from the caregivers on a specified day (Wednesday) of every week. The study was approved by the institutional ethical committee. The study was conducted during September, 2011–February, 2012. Sample size was not decided a priory. All adult patients (age more than 16 years) were evaluated clinically as per the 10th revision of International Classification of Diseases (ICD-10- DCR) on the specified day of every week. The patients were initially evaluated by post graduate trainees in psychiatry and the diagnoses were confirmed by the consultant psychiatrist. Other psychiatric disorders were ruled out on Mini International Neuropsychiatric Inventory 5.0 version (M.I.N.I, 5.0 version). Detailed physical examination of the patients was done. Patients were investigated with routine hematological investigations. Those who were suspected to have underlying medical disorder (on clinical assessment and blood investigation) were referred to appropriate medical facilities for management. Patients with post-partum onset of symptoms (post-partum psychosis), temporal correlation of symptoms with increased substance use (substance induced psychosis) or seizure (post-ictal psychosis) were not included in the study. Their socio-demographic variables and clinical variables were obtained in a semi-structured proforma. The assessment had also included the history of presence and absence of stressor (psychological trauma, abuse or violence). Patients were prescribed appropriate antipsychotic medication (mostly olanzapine or risperidone) and were followed up at regular intervals (two weekly) for a period of three months. Benzodiazepines (lorazepam or nitrazepam) were given for sedation. None of the patients were prescribed mood stabilizer or antidepressants at the first visit. In the follow up visits, mood stabilizers and antidepressants were prescribed to those patients whose diagnosis had been changed to mania or depression. Benzodiazepines were tapered off in the follow up. Monitoring of side effects was also done during the follow up. Titration of the dose of medications had been done keeping the side effects and therapeutic response in consideration. Anticholinergic agents (Trihexyphenidyl) and propranolol had been added in patients who had Parkinsonian expyramidal side effects or akathesia respectively. In the follow up visit, patients were assessed by a postgraduate resident and discussed with the consultant psychiatrist. All patients were seen by the same persons. Patient's caregivers were contacted telephonically for follow up visits.

3. Results

3.1. Demographic profile of patients with baseline diagnosis of ATPD

In our study, a total of 140 patients with ATPD were included. Most patients (86.43%) were between 16 and 35 years of age with mean age of 26.34 years (SD = 3.54). In the study sample, majority (57.86%) were female. Of the total patients, 22.86% were illiterate and 58.61% were educated up to high school (10th standard). Most of the study sample were Hindu (91.43%) and were of rural background (50.71%). Among the 140 patients included in the study, 120 patients had no past episode of psychiatric illness (the index episode being the first episode of psychiatric illness) and their average age was 25.76 years (SD = 9.89). Most of the patients in our study were housewives (36.43%), followed by unskilled occupational (22.15%). Most patients were married (53.57%) in our study. Most patients (57.86%) in our study belonged to lower socio-economic status with family income less than 10,000 INR per month.

3.2. Clinical profile of patients with baseline diagnosis of ATPD

In the study sample of 140 patients, most patients (69.3%) were diagnosed with other acute and transient psychotic disorders (F23.8). Acute polymorphic psychotic disorder without symptoms

Table 1
The illness variables of patients with baseline diagnosis of ATPD.

Illness variables	N = 140
1. Sub type of ATPD	
a. F23.0 (Acute polymorphic psychotic disorder without symptoms of schizophrenia)	22 (15.7%)
b. F23.1 (Acute polymorphic psychotic disorder with symptoms of schizophrenia)	3
c. F23.2 (Acute schizophrenia-like psychotic disorder)	18 (12.85%)
d. F23.3 (Other acute predominantly delusional psychotic disorder)	0
e. F23.8 (Other acute and transient psychotic disorders)	97 (69.3%)
g. F23.9 (Acute and transient psychotic disorder, unspecified)	0
2. Past history of psychiatric illness	
a. Present	
i. ATPD	20 (14.28%)
ii. Schizophrenia spectrum disorders	0
iii. Mood disorder	0
iv. Anxiety Disorder	0
v. Substance use disorder	
a. Alcohol	4
b. Cannabis	4
vi. Other psychiatric disorders	0
b. Absent	112 (80%)
3. Family history of psychiatric illness	
a. Present	21 (15%)
b. Absent	119 (85%)
4. Episode of ATPD	
a. First	120 (85.7%)
b. 2nd	17 (12.14%)
c. 3rd	3
d. More than three episodes in past	0