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Research report

Late-life bipolar depression due to the soft form of bipolar disorder compared to unipolar depression: An inpatient chart review study

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ABSTRACT

Background: Several studies have been conducted regarding the clinical features of the manic state in elderly patients with bipolar disorder; however, little information is available about bipolar depression in these patients, especially depression related to bipolar II disorder (BP-II) and bipolar disorder not otherwise specified (BP-NOS).
Methods: A chart review study of 87 patients (age ≥ 60 years) hospitalized due to a major depressive episode (MDE) was conducted.
Results: Thirty-two (36.8%) and 55 (63.2%) patients were diagnosed with bipolar disorder and major depressive disorder (MDD), respectively. BP-II/BP-NOS accounted for 81.3% of bipolar disorder and 29.9% of MDE. Of the 26 BP-II/BP-NOS patients, 73% had been initially diagnosed with MDD (61.0%) or others (12.0%). Compared to MDD patients, BP-II/BP-NOS patients showed a significantly younger age-at-onset of the first MDE (median, 52 vs. 66 years, $p = 0.000$) and significantly more frequent MDEs (median, 3 vs. 1, $p = 0.000$). The depressed mixed state (DMX) was observed in 61.5% of BP-II/BP-NOS patients in contrast to only 16.4% of MDD patients ($p = 0.000$). The multiple logistic regression analysis revealed that younger age at onset of first MDE and DMX were independent markers of bipolarity.
Limitations: Certain features were retrospectively specified by a single reviewer.
Conclusion: Late-life depression due to BP-II/BP-NOS is generally misdiagnosed, but should never be neglected in elderly inpatients. Some features of the depression suggest bipolarity. In particular, DMX was found to be an independent marker of bipolarity, which supports the mixed nature of this disorder across generations.

1. Introduction

With the aging population, the number of older patients with mental disorders will increase dramatically over the next several decades. Although dementia is a concern, unipolar depression has been the focus of attention in geriatric psychiatry. Many studies have been conducted to further understand unipolar depression in elderly patients (Andreescu et al., 2008; Sewitch et al., 2008; Weyerer et al., 2008).

Recent advances in the field of psychiatry for relatively younger population have refined the existing knowledge about bipolar depression, especially depression related to the soft form of the bipolar disorder, bipolar II disorder (BP-II). The prevalence of BP-II and related disorders (the bipolar spectrum) in the community is about 5%, which is much higher than that estimated previously (Angst et al., 2003; Judd and Akiskal 2003; Merikangas et al., 2007). Furthermore, the prevalence of BP-II associated with a major depressive episode (MDE) in outpatients of mixed age cohorts (mean age, about 40 years) is about 50% (Benazzi, 1997; Hantouche et al., 1998). In patients with BP-II, hypomanic episodes are often experienced as pleasant periods of improved function and absence of marked impairment, and individuals tend to seek help when in a depressed phase rather than in a hypomanic phase (Akiskal et al., 2000; Ghaemi et al., 2001). Therefore, the prevalence of BP-II had been underestimated (Hantouche et al., 1998; Hirschfeld et al., 2003). Furthermore, a recent study revealed that patients with BP-II spend more

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time in a depressive phase than in a hypomanic or euthymic phase (Judd et al., 2003), which leads to considerable psychosocial disability (Judd et al., 2005). Vigorous efforts have been made to increase the knowledge about depression due to BP-II and improve its diagnosis and treatment (Akiskal and Benazzi, 2005; Fountoulakis et al., 2008). For example, the depressive mixed state (DMX) in which several manic/hypomanic symptoms are exhibited during an MDE has been reported to be one of the most useful clinical markers of BP-II in depressed patients, and to be one of risk factors of suicidality of mood disorders (Benazzi, 2002, 2003a,b, 2005; Akiskal and Benazzi, 2005; Dilsaver et al., 2005a; Balázs et al., 2006; Takeshima et al., 2008).

These views may also apply to elderly patients. However, a number of reviews have indicated the relative lack of knowledge about bipolar disorder in later life and much of the existing knowledge about bipolar disorder in this cohort relates to the manic phase rather than the depressive phase of the illness (Depp and Jeste, 2004). At present, only a few studies have investigated the prevalence and clinical features of bipolar depression in the elderly (Meeks, 1999; Benazzi, 2001). Using multiple logistic regression analysis, Benazzi (2003c) reported that clinical differences between BP-II and unipolar depression are not related to age; however, the patients included in their study were considerably young (median age of 40 years).

In the present study, we aim to enhance the knowledge about the prevalence and the clinical features of bipolar depression, especially BP-II and related disorders, in elderly patients by reviewing medical records of MDE patients aged 60 years or older. The diagnoses of the patients were reexamined based on a chart review and the data was used to classify patients as those with major depressive disorder (MDD) or those with BP-II and its related disorders. We also compared the prevalence and clinical features of the two disorders.

2. Methods

2.1. Patients

Subjects comprised consecutive patients aged 60 years or older who were hospitalized in the psychiatric emergency ward of Ishikawa Prefectural Takamatsu Hospital due to MDE from January 2000 to December 2007. According to the Japanese medical system, a psychiatric emergency ward is defined as one that accepts emergency hospitalization of patients with severe psychiatric symptoms, such as suicidal attempts, at night or during holidays and ordinary hospitalization during the day. The ward serves about 1.2 million people in Ishikawa Prefecture, Japan. About 50% of patients who are hospitalized in this ward are referred from other institutions or police, and emergency hospitalization accounts for about 60% of all episodes of hospitalization.

2.2. Procedure

All data were obtained from medical records prepared by psychiatrists and nurses containing information about everything from the first to the last observation of individual patients during routine psychiatric examinations and treatment. The first author (having 19 years of clinical experience in studying and treating mood disorders) reviewed the medical records of all objective patients. The following data was collected: initial and final diagnoses, age at index hospitalization, gender, age-at-onset of first MDE, number of prior MDEs, psychiatric co-morbidities, features of the MDE index (i.e., psychotic features, melancholic features, atypical features, and DMX), family history of mood disorders in first-degree relatives, physical co-morbidities, vascular risk factors, brain atrophy, and medications being taken at last observation.

As a characteristic of Japanese clinical practice, initial diagnosis was made at the time of hospitalization by experienced psychiatrists (median, 19 years of experience; range, 7–35 years) according to the Diagnostic and Statistical Manual of Mental Disorders 4th Edition (DSM-IV; American Psychiatric Association, 1994) based on past records and unstructured clinical interviews with the patient and significant others. A change in the diagnosis could be made with further interviews regarding past history, information from other institutions, or observation of symptoms and signs during the follow-up period. The diagnosis at the time of discharge or the last observation of the patient was considered the final diagnosis. Any disagreements about the final diagnosis between the reviewer and psychiatrists in charge were resolved by consensus. According to DSM-IV, patients exhibiting hypomania only during periods of treatment with causative agents such as antidepressants, and patients whose hypomania disappeared after withdrawal from the causative agents were regarded as MDD patients, and not bipolar disorder patients. A patient was diagnosed with bipolar disorder not otherwise specified (BP-NOS) if he had experienced at least one MDE in addition to hypomanic symptoms that had lasted less than the DSM-IV-specified 4 days.

Psychotic features, melancholic features, atypical features, and DMX were retrospectively evaluated and specified by the reviewer. If a patient had to be hospitalized more than once because of MDE during the study period, those in the first episode were evaluated. The psychotic, melancholic, and atypical features were defined based on the descriptions from DSM-IV. DMX was defined based on descriptions from previous studies (Benazzi, 2002, 2003a,b, 2005; Akiskal and Benazzi, 2005). Briefly, the patient was diagnosed with DMX if three or more manic/hyopmanic symptoms were exhibited during an MDE, continued for at least 1 week, and were present during hospitalization. If the index hospitalization was related to an overdose of alcohol or medicines such as benzodiazepines, the patient was evaluated only when not under the influence of the causative agent. Patients were regarded to have vascular risk factors if they had at least one of the following conditions: hypertension, hypercholesterolemia, diabetes mellitus, ischemic heart disease, or a past history of cerebrovascular diseases. Brain atrophy was determined by X-ray computed tomography. Treatment was determined by the psychiatrist in charge and performed naturalistically. Patients whose medical records contained insufficient details of their history were excluded. Patients with severe mental retardation, pervasive developmental disorders, schizophrenia and related psychotic disorders, a clinically significant general medical illness, or borderline