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N. O. Maruta, G. M. Verbenko

FEATURES OF CLINICAL SYMPTOMS AT DIFFERENT STAGES OF THE FLOW OF BIPOLAR AFFECTIVE DISORDER

Н. О. Марута, Г. М. Вербенко

ОСОБЛИВОСТІ КЛІНІЧНОЇ СИМПТОМАТИКИ НА РІЗНИХ СТАДІЯХ ПЕРЕБІГУ БІПОЛЯРНОГО АФЕКТИВНОГО РОЗЛАДУ

Н. А. Марута, Г. М. Вербенко

ОСОБЕННОСТИ КЛИНИЧЕСКОЙ СИМПТОМАТИКИ НА РАЗНЫХ СТАДИЯХ ТЕЧЕНИЯ БИПОЛЯРНОГО АФФЕКТИВНОГО РАССТРОЙСТВА

Keywords: bipolar affective disorder, bipolar index episode, manifestation, course, therapeutic response, heredity.

In the diagnosis of an affective episode modern operational criteria do not take into account the peculiarities of clinical symptoms, and the criteria for bipolar affective disorders (BAD) do not take into account important factors such as age of onset, family history and course of the disease. More reliable diagnosis can be achieved by the introduction of the information collected in different categories typically used to refine psychiatric diagnosis.

Peculiarities of clinical symptoms were conducted at different stages of the flow of bipolar disorder in 120 patients with bipolar disorder (40 patients with a predominance of depressive symptoms (F31.3—5, F31.6), 30 patients with a predominance of manic symptoms (F31.0—2, F31.6) 50 patients euthymic period (F31.7). psychometric study using a questionnaire "bipolarity index" (G. Sachs, 2004), which allows to estimate in points (from 0 to 20) if the patient has the five most characteristic signs of BAD: 1) description of the episode; 2) age of onset; 3) the course of the disease; 4) the effect of therapy; 5) heredity. It has been revealed that the clinical heterogeneity indicators index bipolarity in the first and fourth categories due to the phase of the disease (reflected in the outcome of the integral index of bipolarity on separate groups). Clinical examples of the evaluation of patients at index bipolarity in separate groups show that the individual index bipolarity of the individual patient may be too high and ultralow regardless of the group bar. This scoring system takes the concept of bipolarity with categorical plane in a continuous, largely meets the needs of clinical practice and allows you to improve the quality of diagnosis and treatment of BAD.

Ключові слова: біполярний афективний розлад, індекс біполярності, епізод, маніфестація, перебіг, терапевтична відповідь, спадковість.

Під час діагностики афективного епізоду сучасні операціональні критерії не враховують особливостей клінічної симптоматики, а критерії афективних розладів не приймають до уваги такі важливі чинники, як вік маніфестації, спадковість і перебіг захворювання. Більша достовірність діагностики може бути досягнута введенням інформації, зібраної за різними категоріями, які зазвичай використовують для уточнення психіатричного діагнозу.

Вивчено особливості клінічної симптоматики на різних стадіях перебігу біполярного афективного розладу (БАР) у 120 пацієнтів з біполярним афективним розладом (40 пацієнтів з переважанням депресивних симптомів (F31.3—5, F31.6), 30 пацієнтів з переважанням маніакальних симптомів (F31.0—2, F31.6), 50 пацієнтів в еутимному періоді (F31.7). Психометричне дослідження проводили з використанням: опитувальника «Індекс біполярності» (G. Sachs, 2004), який дозволяє оцінити в балах (від 0 до 20) наявність у пацієнта п'яти найбільш характерних для БАР ознак: 1) характеристика епізоду; 2) вік маніфестації; 3) перебіг хвороби; 4) ефект терапії; 5) спадковість. За даними дослідження, клінічна неоднорідність показників індексу біполярності в першій та четвертій категоріях обумовлена фазою перебігу захворювання, що певним чином впливає і на підсумковий інтегральний індекс біполярності у окремих групах. Клінічні приклади оцінки пацієнтів за індексом біполярності в окремих групах доводять, що індивідуальний індекс біполярності кожного окремого пацієнта може бути зависоким і наднизьким незалежно від групи БАР. Така оціночна система дозволяє переводити поняття біполярності з категоріальної площини в континуальну, що більшою мірою задовольняє потребам клінічної практики і дозволяє поліпшити якість діагностики і терапії БАР.

Ключевые слова: биполярное аффективное расстройство, индекс биполярности, эпизод, манифестация, течение, терапевтический ответ, наследственность.

При диагностике аффективного эпизода современные операциональные критерии не учитывают особенностей клинической симптоматики, а критерии аффективных расстройств не принимают во внимание такие важные факторы как возраст манифестации, наследственность и течение заболевания. Большая достоверность диагностики может быть достигнута введением информации, собранной по категориям, обычно используемым для уточнения психиатрического диагноза.

Изучены особенности клинической симптоматики на разных стадиях течения биполярного аффективного расстройства у 120 пациентов с биполярным аффективным расстройством (40 пациентов с преобладанием депрессивных симптомов (F31.3—5, F31.6), 30 пациентов с преобладанием маниакальных симптомов (F31.0—2, F31.6), 50 пациентов в эутимном периоде (F31.7). Психометрическое исследование проводили с использованием опросника «Индекс биполярности» (G. Sachs, 2004), который позволяет оценить в баллах (от 0 до 20) наличие у пациента пяти наиболее характерных для БАР признаков: 1) характеристику эпизода; 2) возраст манифестации; 3) течение болезни; 4) эффект терапии; 5) наследственность. Выявлено, что клиническая неоднородность показателей индекса биполярности в первой и четвертой категориях обусловлена фазой течения заболевания (отражено в итоговом интегральном индексе биполярности по отдельным группам). Клинические примеры оценки пациентов по индексу биполярности в отдельных группах показывают, что индивидуальный индекс биполярности каждого отдельного пациента может быть слишком высоким и сверхнизким независимо от группы БАР. Такая оценочная система переводит понятие биполярности из категориальной плоскости в континуальную, в большей степени удовлетворяет потребностям клинической практики и позволяет улучшить качество диагностики и терапии БАР.

The fact that around 16 million of persons per year at the age of 60 are incapacitated due to unipolar and bipolar depression provides the timeliness for the problem of early diagnosis and the choice of effective therapy for affective disorders treatment. Affective disorders are one of the leading causes of morbidity and disability among working-age population [1, 3].

According to statistics, the incidence of BAD in Ukraine is at the same level as in the other developed countries. And in the period from 2000 to 2009 it ranged from 10.1 to 10.3 cases per 100 thousand of population [2].

At the moment there are two classification models for mental disorders — DSM-5 (Diagnostic and Statistical Manual of mental disorders 5) and the 5th section of the ICD-10 (International classification of diseases, 10th revision). DSM-5 describes affective disorders (or mood disorders) taking into account three components — affective episode (manic, hypomanic, depressive, or mixed), the affective disorder and its description, i.e. the characteristics of the last episode, or the long-term course of the disease. Affective disorders are divided into depressive, bipolar and mood disorders due to physical illness and substance abuse. The description of the last episode in the DSM-5 includes the severity, the presence of remission of psychotic symptoms or other clinical characteristics. It also indicates the course of the disease, the quality of intermission, seasonal pattern and the presence of fast phase transitions. It should be noted that in the DSM-5 (in comparison with the previous version of the DSM-IV) it has been a reduction of the threshold for the diagnosis of a mixed episode from having all the criteria for depression and mania to having only three criteria. On the one hand this change largely reflects the real manifestations of mixed states, because all the symptoms of mania and depression are rarely found in the real life in their pure form. On the other hand, the formulation of such kind of diagnosis may not have any clinical loading, the prognostic value or may not require changes in the treatment regimen [4, 5, 7].

While making the clinical assessment of BAD, in accordance with the guidelines, the special attention should be paid to comorbidity with other disorders of 1 and 2 axis (according to the DSM-5), family history of mental disorders, the course of the disease, the patient's age at the time of onset, frequency of phase transitions, the presence of mixed episodes and seasonality [5, 7, 8].

For example, the early age of onset correlates with a more severe course of BAD and also with the poorer prognosis. Searching the correlates in relation to this indicator, *Lin P.-I. et al.* (2006) concluded that the earlier onset of the disorder (< 21 years) is characterized by more frequent occurrence of comorbid alcohol and drug addiction, obsessive-compulsive disorder, eating disorders, rapid phase transitions, more episodes, suicide attempts, etc. [9]. Earlier similar conclusions were obtained by *Carter T.D.C. et al.* (2003): in their work the beginning of the disease in individuals of ≤ 18 years correlated with the presence of comorbid anxiety disorders, alcohol and drug addiction, rapid phase changing, more frequent suicidal thoughts and suicide attempts [10]. The presence of comorbid psychiatric disorders is diagnosed at approximately 30 % of patients with BAD. Their presence, as demonstrated by the results of the studies, is associated with plenty of mixed and depressive episodes, suicide attempts. In addition, comorbid psychiatric disorders are more common in individuals with depressive manifestation of BAD [11]. The presence of family history of BAD and major depressive disorder also has a great prognostic value. So, the response to treatment with lithium inversely correlated with the presence of major depressive disorder [12] and any affective disorder [13] in close relatives.

At the present time views on BAD extend from a pathology, which is characterized by change of depressive and manic phases, reaching more comprehensive understanding. Way back in the second half of the last century, *Bertelsen A. et al.* (1977) have identified possible candidates for inclusion in the bipolar spectrum on the basis of research involving monozygotic twins: mania, depression with hypomania (without considering the duration of hypomania), depression, associated with cyclothymic and hyperthymic temperament, recurrent (pseudounipolar) depression with a family history of BAD, cyclic depressions that respond to treatment with lithium and other mood stabilizers [14]. Furthermore, *Akiskal H.S. and O. Pinto* (1999) emphasized that mood changes within the "soft" BADs which arise separately from periods of alcohol and psychoactive substances abuse should be considered as a part of the bipolar spectrum with the development of clear criteria for their statement [15].

The system of diagnosis of bipolar disorder by measuring "the index of bipolarity" was proposed at first by the director of Harvard University G. Sachs for an extended treatment program for bipolar disorder (Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD). It is the epitome of a clinical diagnostic approach when a doctor does not receive an overall score on a particular scale as an appropriate statistical reflection of patient's disease state, but an individualized assessment of problems and mood of a particular patient. At the same time, in the contrast to standardized diagnostic systems ICD-10 or DSM-5, which emit certain diagnostic categories, the bipolarity index identifies a range of diagnostic signs of possible bipolar disorder, and not only the state of hypomania [16].

The system combines 5 "dimensions" of bipolarity. Moreover, the presence of hypomania or mania is evaluated only in one of them. However, all other categories have the same diagnostic value. Separate dimensions are dedicated to: hypomania or mania (actual also in personal history); the age of onset of the first symptoms of mood swings, clinical features and course of the disease, therapeutic responses to drugs (antidepressants and mood stabilizers); family history of affective disorders and substance use. Each dimension is assigned from 0 to 20 points (maximum possible total of 100 points). G. Sachs's researches have showed that the index of bipolarity in patients with BAD reaches more than 60 points. Instead, the patients with BAD II or other variants of this disorder (according to H.S. Akiskal, 2005) can get a lower rate. Moreover, it can be determined by other indicators than hypomania or mania.

The aim of the research was to study the peculiarities of clinical symptoms at different stages of bipolar disorder course to improve the further diagnosis, therapy and prevention.

After obtaining the patient's informed consent we have examined 120 patients with bipolar affective disorder (40 patients with predominance of depressive symptoms (F31.3—5, F31.6), 30 patients with predominantly manic symptoms (F31.0—2, F31.6), and 50 patients in euthyme period (F31.7)).

Psychometric investigation was conducted using the questionnaire "Index of bipolarity" (G. Sachs, 2004) in adaptation of Mosolov S. N. (Mosolov S. N., Kostyukova Ye. G., Ushkalov A. V., 2009) for scoring typical BAD signs: description of the episode; age of manifestation; course of the

disease; effect of therapy; heredity. Patients were verified once for each indicator (Tables 1—5) for the highest score. Mathematical processing of the results was performed using the statistical program SPSS 16.0 for Windows.

The average age of the surveyed sample was 41.3 ± 6.2 years. The patients' educational level (total number of years spent on education in schools, colleges and universities) was 13.2 ± 2.8 years. The duration of the current depressive/manic episode before the start of this study was 2.6 ± 1.6 weeks. The duration of euthyme period was 25.8 ± 9.6 weeks.

In order to determine the significance of individual clinical characteristics of bipolar disorder there was conducted categorical and average evaluation of patients' bipolar index in three groups (BAD-D, BAD-M and BAD-E) with the help of psychometric research.

By definition of the current episode symptoms the group with BAD-M, of course, has received the highest scores (table 1). 100 % of patients of this group were distributed according to certain signs of mania/hypomania, namely: 14 (46,7 %) patients of BAD-M group had symptoms of mania in combination with increased dysphoria and irritability; 11 individuals (36.6 %) demonstrated pronounced euphoria, grandiosity or expansiveness against the background of mania; 3 individuals (10 %) had symptoms of mania as a result of taking antidepressants which were prescribed for treatment of depression; 2 persons (6.7 %) with a history of BAD had psychotic hallucinatory-paranoid episodes without affective component.

In the BAD-D group 38 patients (95.0 %) had signs of an episode which were appropriate for BAD: 13 persons (32.5 %) had a typical depressive episode, 11 persons (27.5 %) had symptoms of atypical depression (presence of at least two symptoms of excessive sleepiness, bulimia, dysmotility or depression after separation), 9 persons (22.5 %) had flickering symptoms of subthreshold hypomania, 3 persons (7,5 %) with hypomania symptoms due to antidepressants use, 2 persons (5.0 %) with psychotic symptoms.In 9 persons in the group of BAD-E according to the characteristics of the current episode (euthyme state) (18.0 %) there were noted: subthreshold hypomania symptoms (7 persons, 14.0 %) and hypomanic symptoms as a result of antidepressants use (2 persons, 4, 0 %).

Thus, the average value of bipolarity index according to the signs of an episode for the studied groups respectively was equal to: BAD-M — 15.47 points, BAD-D — 3.9 points, BAD-E — 1.1 points.

Table 1

Distribution of patients according to the episode

Signs of the episode	Points	Study groups					
		BAD-D *n* = 40		BAD-M *n* = 30		BAD-E *n* = 50	
		Abs.	%	Abs.	%	Abs.	%
Manic or mixed episode with a bright euphoria, grandiosity/effusiveness	20	—	—	11	36.6	—	—
Acute episode of mixed, irascible nature (symptoms of mania with dysphoria, irritability)	15	—	—	14	46.7	—	—
Symptoms of hypomania; mania as a result of antidepressants taking	10	3	7.5	3	10.0	2	4.0
Symptoms of subthreshold hypomania (below threshold of DSM)	5	9	22.5	—	—	7	14.0
Signs of atypical or postpartum depression		11	27.5	—	—	—	—
Psychotic symptoms of any genesis	2	2	5.0	2	6.7	—	—
Typical MDD		13	32.5	—	—	—	—
Total		38	95.0	30	100	9	18.0
The average score according the index of bipolarity		3.90		15.47		1.1	

In turn, while distributing the patients according to the age of disease onset, we did not reveal significant difference in the average score of bipolarity index: in accordance BAD-M — 15.00 points, BAD-D — 14.25 points, BAD-E — 14.20 points (Table 2). In all three groups the onset of the disease mainly occurred at the age of 20—30 years.

Table 2

Distribution of patients according the age of symptoms onset

Age of symptoms onset	Points	Study groups					
		BAD-D *n* = 40		BAD-M *n* = 30		BAD-E *n* = 50	
		Abs.	%	Abs.	%	Abs.	%
15—19	20	5	12.5	4	13.3	6	12.0
< 15 or 20—30	15	26	65.0	23	76.7	34	68.0
30—45	10	7	17.5	2	6.7	6	12.0
> 45	5	2	5.0	1	3.3	4	8.0
The average score according the index of bipolarity		14.25		15.00		14.20	

Somewhat mixed picture has appeared in the analysis of patients distribution by disease course and other characteristics (Table 3). The course of the disease in the form of current episode of mania, regardless of the recovery degree, greatly increases the value of the index for BAD-M and keeps the group on the front page. But inclusion of the evaluation of other characteristics for patients with BAD indicates a significant involvement of patients in euthyme period, even in comparison with a group of BAD-D (index of bipolarity, respectively 6.74 vs. 5.60). Thus, the most important other factors for BAD-D group were: recurrent (3 or more) episodes of depression without hypomania (12 individuals, 30 %), substance use (9 individuals, 22.5 %), as well as the presence of comorbid anxiety disorder (7 individuals, 17.5 %). The group BAD-E, in turn, was characterized by the large number of people who use psychoactive substances (PAS) (18 individuals, 36.0 %) or people prone to gambling and other risk behaviors (7 people, 14.0 percent).

Table 3

Distribution of patients according to the course of disease and other signs

Disease course and other signs	Points	Study groups					
		BAD-D *n* = 40		BAD-M *n* = 30		BAD-E *n* = 50	
		Abs.	%	Abs.	%	Abs.	%
Manic episodes separated by periods of complete recovery	20	—	—	4	13.3	—	—
Incomplete recovery between episodes of mania	15	—	—	3	10.0	—	—
Hypomania with full recovery between episodes		—	—	—	—	3	6.0
Substance use	10	9	22.5	5	16.7	18	36.0
Psychosis only during affective episodes		—	—	2	6.7	—	—
Financial and legal challenges against the background of mania		—	—	5	16.7	—	—
Repeated episodes of MDD without hypomania (3 or more)	5	12	30.0	—	—	—	—
Hypomania with incomplete recovery between episodes		—	—	—	—	—	—
Borderline personality disorder		—	—	—	—	2	4.0
Anxiety disorder		7	17.5	—	—	5	10.0
Eating disorder		—	—	—	—	2	4.0
Syndrome of hyperactivity in childhood		3	7.5	2	6.7	2	4.0
Gambling or other risky behavior with no signs of mania		2	5.0	—	—	7	14.0
Premenstrual syndrome (PMS)		—	—	3	10.0	—	—
Hyperthymic temperament	2	1	2.5	2	6.7	3	6.0
> 3 marriages		2	5.0	2	6.7	2	4.0
Change of two jobs for 2 years		2	5.0	1	3.3	3	6.0
2 higher educations (or other major educational projects)		2	5.0	1	3.3	3	6.0
The average score according the index of bipolarity		5.60		9.4		6.74	

The analysis of patient groups for therapeutic response showed that mood stabilizers found the most efficiency in BAD-M group after 4 weeks of therapy, and BAD-D group showed the lowest sensitivity for such kind of therapy Table 4). And after 12 weeks of treatment with mood stabilizers the BAD-E group took first place, with no significant difference between BAD-M and BAD-D groups. Additionally, all three groups showed the same risk of relapse within 12 weeks after discontinuation of mood stabilizers (accordingly BAD-D — 5 persons, 12.5 %; BAD-M — 4 persons, 13.3 %; BAD-E — 6 persons, 12.0 %), and almost the same partial response to mood stabilizers (12 weeks, 2 drugs) — accordingly BAD-D — 3 persons, 7.5 %; BAD-M — 3 persons, 10.0 %; BAD-E — 4 persons, 8.0 %. It is worth to note that transition to the mixed state/mania was observed totally in 9 persons within 12 weeks after initiation of therapy with antidepressants (among them in 5 patients (12.5 %) the change of state occurred during the follow-up period in the BAD-D group, and in 4 patients (13.3 %) in the BAD-M group — before the beginning of the study prior to admission). Instead, the increase of dysphoria or other symptoms under treatment with antidepressants (4 persons, 10.0 %), resistance to such therapy (3 persons, 7.5 %) and ultrafast response (≤ 1 week) on treatment with antidepressants (2 persons, 5.0 %) was observed only in the BAD-D group. In general, the average score on bipolarity index according to therapeutic response was, in descending order, BAD-E — 16.10; BAD-M — 15.67; BAD-D — 12.98.

Table 4

Distribution of patients according to the respond on treatment

Therapeutic response	Points	Study groups					
		BAD-D *n* = 40		BAD-M *n* = 30		BAD-E *n* = 50	
		Abs.	%	Abs.	%	Abs.	%
Full recovery in 4 weeks of treatment by mood stabilizers	20	3	7.5	7	23.3	16	12.0
Full recovery in 12 weeks of treatment by mood stabilizers	15	14	35.0	12	40.0	23	46.0
Relapse within 12 weeks after discontinuation of mood stabilizers		5	12.5	4	13.3	6	12.0
Transition to the mixed state/mania within 12 weeks after initiation of therapy with antidepressants		5	12.5	4	13.3	—	—
The increase of dysphoria or other symptoms under treatment with antidepressants	10	4	10.0	—	—	—	—
Or partial response to mood stabilizers (12 weeks, 2 medications)		3	7.5	3	10.0	4	8.0
Or appearance/worsening of rapid change cycles induced by antidepressant therapy		1	2.5	—	—	1	2.0
Resistance to therapy: no response for 3 or more antidepressants	5	3	7.5	—	—	—	—
Mania/hypomania when stopping antidepressants		—	—	—	—	—	—
Ultrafast response (≤ 1week) to therapy with antidepressant	2	2	5.0	—	—	—	—
The average score according the index of bipolarity		12.98		15.67		16.10	

The component of bipolarity index in terms of family history was the biggest in BAD-E group (5.06), mainly due to the presence of 1st degree relatives (brother/sister, parent, child) with a clear BAD in this group of patients, relatives with clear problems with PAS/alcohol or relatives with mental disorders primarily in the form of anxiety disorders and recurrent episodes of depression, eating disorders and hyperactivity syndrome (Table 5). The category "relatives of 1st degree with clear problems with PAS/alcohol" was significant for groups BAD-D (8 persons, 20.0 %) and BAD-M (9 persons 30.0 %), "relatives of 1st degree with anxiety disorder" — BAD-D — 5 persons (12.5 %), and "relatives of 1st degree with eating disorder" — BAD-M (3 persons, 10.0 %).

Table 5

Distribution of patients by family history

Family history	Points	Study groups					
		BAD-D *n* = 40		BAD-M *n* = 30		BAD-E *n* = 50	
		Abs.	%	Abs.	%	Abs.	%
1st degree relatives (brother/sister, parent, child) with a clear BAD	20	—	—	—	—	2	4.0
2nd degree relatives with a clear BAD	15	1	2.5	—	—	—	—
1st degree relatives with recurrent MDD and individual symptoms of BAD		2	5.0	1	3.3	4	8.0
1st degree relatives with recurrent MDD or schizoaffective disorder	10	—	—	1	3.3	1	2.0
Any other relative with MDD and individual symptoms of BAD		4	10.0	3	10.0	6	12.0
1st degree relatives with clear problems with PAS/alcohol	5	8	20.0	9	30.0	11	22.0
1st degree relatives with recurrent episodes of depression	2	2	5.0	2	6.7	2	4.0
with anxiety disorder		5	12.5	2	6.7	7	17.0
with eating disorder		1	2.5	3	10.0	2	4.0
with hyperactivity syndrome		—	—	—	—	3	6.0
Total		23	57.5	21	70.0	38	76.0
The average score according the index of bipolarity		3.53		3.8		5.06	

The clinical heterogeneity of bipolarity index indicators in the first and fourth categories is associated with the disease phase that in some way affects the final integral bipolarity index in separate groups (BAD-M group — 59.34; BAD -E group — 43.2; BAD-D group — 40. 26). Moreover, in the BAD-M group there are more patients with bipolar disorder of first rather than of second type. However, the clinical examples of patients' assessment by bipolarity index in some groups prove that the individual index of bipolarity for each individual patient may be too high and ultra-low regardless of group. For each indicator (Table 1—5) patients were verified one time for the biggest score, even in the presence of several factors. For example, in the BAD-D group — the patient M. with the first postpartum depression (5 points) in 18 (20 points); depression; with episodes of alcohol abuse against the background of depression (10 points); agitation while taking antidepressants (10 points); and a sister, who suffers BAD (20 points) with no signs of mania/hypomania gets 65 points. In the BAD-M group **—** patient K. in the manic state with dysphoria (15 points), onset at 32 years (10 points), prone to risky behavior (5 points), relapse within 12 weeks after discontinuation of mood stabilizers (15 points), patient's mother was treated about the anxiety disorder (2 points) — total score 47 points.

While diagnosing affective episode, the modern operational criteria do not take into account the nature of the clinical symptoms, and criteria for affective disorders do not take into account important factors, such as age of onset, family history and disease course. The greater accuracy of diagnosis can be achieved by the introduction of information collected in different categories that are typically used for more accurate psychiatric diagnosis. This can be achieved by using the bipolarity index (G. Sachs, 2004), which allows us to estimate, by the points (from 0 to 20), the presence of five most typical signs of BAD in patient: 1) description of the episode; 2) age of manifestation; 3) disease course; 4) the effect of therapy; 5) heredity. According to our data, the clinical heterogeneity of bipolarity index indicators in the first and fourth categories is associated with the disease phase that in some way affects the final integral bipolarity index in separate groups (BAD-M group — 59.34; BAD-E group — 43.2; BAD-D group — 40.26). Moreover, in the BAD-M group there are more patients with bipolar disorder of first rather than of second type. However, the clinical examples of patients' assessment by bipolarity index in some groups prove that the individual index of bipolarity for each individual patient may be too high and ultra-low regardless of group. This evaluation system transfers the concept of bipolarity from categorical to continual plane that largely meets the needs of clinical practice and can improve the quality of diagnosis and treatment of BAD.

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МАРУТА Наталья Александровна, доктор медицинских наук, профессор, руководитель отдела неврозов и пограничных состояний Государственного учреждения «Институт неврологии, психиатрии и наркологии Национальной академии медицинских наук Украины» (ГУ «ИНПН НАМН Украины»), г. Харьков; e-mail: mscience@ukr.net

ВЕРБЕНКО Георгий Николаевич, внештатный научный сотрудник отдела неврозов и пограничных состояний ГУ ИНПН НАМН Украины, г. Харьков; e-mail: verbenko_georg@mail.ru

MARUTA Natalia Oleksandrivna, Doctor of Medical Sciences, Professor, Head of the Department of Neuroses and Borderline Conditions of State Institution "Institute of Neurology, Psychiatry and Narcology of the National Academy of Medical Sciences of Ukraine" (SI "INPN of NAMS of Ukraine"), Kharkiv; e-mail: mscience@ukr.net

VERBENKO Georgiy Mykolaiovych, Out-Staff Researcher of SI "INPN of NAMS of Ukraine", Kharkiv; e-mail: verbenko_georg@mail.ru

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Б. В. Михайлов, Є. В. Лісова

ОСОБЛИВОСТІ КЛІНІЧНОГО ПЕРЕБІГУ НЕВРАСТЕНІЇ У ХВОРИХ З РІЗНИМИ КОНСТИТУЦІОНАЛЬНИМИ СОМАТОТИПАМИ

Б. В. Михайлов, Е. В. Лесная

ОСОБЕННОСТИ КЛИНИЧЕСКОГО ТЕЧЕНИЯ НЕВРАСТЕНИИ У БОЛЬНЫХ С РАЗЛИЧНЫМИ КОНСТИТУЦИОНАЛЬНЫМИ СОМАТОТИПАМИ

B. V. Mykhaylov, E. V. Lisova

FEATURES OF CLINICAL COURSE IN PATIENTS WITH NEURASTHENIA DIFFERENT CONSTITUTIONAL SOMATOTYPE

Досліджено особливості клінічного перебігу неврастенії у хворих з різними конституціональними соматотипами. Очевидною є схильність до фіксації хворого у певній фазі неврастенії в залежності від його конституціонального соматотипу. Наявність у деяких обстежених представників певних соматотипів різних фаз неврастенії, без характерної для цього соматотипу фіксації на певній фазі захворювання, пояснюється ступенем виснаження його компенсаторного ресурсу з плином часу. Виявлено взаємозв'язок конституціонального соматотипу та особливостей клінічного перебігу та формування неврастенії, що можливо завдяки адаптаційно-компенсаторним можливостям та специфіці конкретного конституціонального типу.

Ключові слова: непсихотичні розлади, неврастенія, конституціональні соматотипи

Исследованы особенности клинического течения неврастении у больных с различными конституциональными соматотипами. Очевидна склонность к фиксации больного в определенной фазе неврастении в зависимости от его конституционального соматотипа. Наличие у некоторых обследованных представителей определенных соматотипов различных фаз неврастении, без характерной для этого соматотипа фиксации на определенной фазе заболевания, объясняется степенью истощения его компенсаторного ресурса с течением времени. Выявлена взаимосвязь конституционального соматотипа и особенностей клинического течения и формирования неврастении, возможно благодаря адаптационно-компенсаторным возможностям и специфике конкретного конституционального типа.

Ключевые слова: непсихотические расстройства, неврастения, конституциональные соматотипы

Studies of clinical course in patients with neurasthenia different constitutional somatotype. Evidently, there is a tendency to commit the patient to a particular phase of neurasthenia according to its constitutional somatotype. Having surveyed some members of certain somatotype different phases of neurasthenia, no representative of the somatotype fixation on a particular phase of the disease, due to the degree of depletion of compensatory resource over time. The interrelation somatotype and constitutional peculiarities of clinical course and form of neurasthenia, which is possible thanks to adaptive-compensatory features and specifics of a particular constitutional type.

Keywords: nonpsychotic disorders, neurasthenia, constitutional somatotype

В останні десятиліття в усьому світі велика увага приділяється проблемам психічного здоров'я, що в першу чергу обумовлено їх широкою поширеністю і медико-соціальними наслідками. За даними Всесвітньої психіатричної асоціації, одна чверть населення всіх країн світу в певний момент життя переносить ті чи інші розлади психіки. Поширеність психічних розладів в Україні становить 2,6 % населення. Такий високий рівень пацієнтів,