DIAGNOSTIC STABILITY OF ACUTE AND TRANSIENT PSYCHOTIC DISORDERS IN PATIENTS ATTENDING TERTIARY CARE HOSPITAL

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ABSTRACT

INTRODUCTION: Acute and Transient Psychotic Disorders (ATPDs) have been the subject of nosological debate. Some authors argue that these conditions should be considered as an independent group of disorders. Others view these psychoses as variants of schizophrenia or mood disorders, pointing to their diagnostic instability. There have been few studies of the diagnostic stability based on the International Classification of Diseases-tenth edition (ICD-10) category of ATPDs, and these studies have mixed results. This study was done to examine the diagnostic stability of ATPDs according to ICD-10.

MATERIAL AND METHODS: Thirty patients diagnosed as ATPDs at psychiatry department of B.P. Koirala Institute of Health Science (BPKIHS) were followed up at one month and after three months of their onset of illness. Their diagnosis was reassessed at every follow-up using standard instrument.

RESULTS: The diagnosis of ATPDs was unchanged in twenty four (80%) out of thirty patients. Diagnostic change was to schizophrenia in three cases and to mood disorders in three other cases.

CONCLUSION: Overall, ATPDs is a diagnostically stable entity.

KEY WORDS: Acute and Transient Psychotic Disorders, Diagnostic stability, Nepal

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INTRODUCTION

Acute insanity has frequently been mentioned in western literature. It was thought to be the result of emotional shock or God's curse. During the eighteenth and nineteenth century such acute insanities were given different names , like 'Cycloid psychosis', 'Bouffee delirante', 'Psychogenic psychosis' or 'Good prognosis schizophrenia'.[1] This condition was not well defined and recognized in previous editions of ICDs. The tenth revision of the international classification of diseases and related health problems (ICD 10) has included these psychoses under a group called "Acute and Transient Psychotic Disorders (ATPDs)".[2]

ATPDs have been the subject of a long nosological debate. Some authors argue that these conditions should be considered as an independent group of disorders a "third psychosis" along with the two classic syndromes of schizophrenia and mood disorder. Others view these psychoses as variants of schizophrenia or mood disorders, pointing to their diagnostic instability as evidence. A consensus seems to be emerging that ATPDs should be categorized separately. There have been few studies of the diagnostic stability based on the ICD-10 category of ATPDs, and these studies yielded mixed results.[3]

Diagnostic stability has been defined as the degree to which the original diagnosis is confirmed at follow-ups. It is based on the longitudinal diagnosis over time and is irrespective of cross-section diagnosis at the point of follow up. The more stable the diagnosis, the more likely it is to reflect basic and consistent psychopathological or pathophysiological processes. Stability of psychiatric diagnoses is subject to various influences, including changes of symptoms, effects of treatments on clinical status, reinterpretation of previously gathered information and the uncertain reliability of diagnostic measures.[4]

Some studies have shown acute and transient psychotic disorder to be diagnostically stable entity[1, 4-8] but other studies have found ATPDs to be a diagnostically unstable entity.[9-11] As these different studies show conflicting findings we studied the diagnostic stability of patients with ATPDs in Nepal.

MATERIAL AND METHODS

This was hospital-based, prospective, follow-up study carried out in the tertiary care hospital of eastern Nepal on thirty patients with diagnosis of ATPD. The diagnosis was made by consultant psychiatrists of psychiatry department at BPKIHS. Brief Psychiatric Rating Scale (BPRS) was used to study the progress of the patient. Brief Psychiatric Rating Scale (BPRS) is principally used as an outcome measure in treatment studies of schizophrenia and other psychotic illness. Reliability of the BPRS is good to excellent when raters are experienced [12]. Validity is also good.[12] This scale has frequently being used by the rater. Its English version was first translated into Nepali by English to Nepali translator and the translated Nepali version was again translated into English by independent translator. This scale was first applied in other patients and was found to be effective. Verbal and written consent of the patients or his attendants were taken before enrolling them in the study. The study was carried out from January 2005 to June 2006 in the tertiary care hospital of eastern Nepal.

Inclusion Criteria:

Patients aged between 15 to 60 years who fulfilled the diagnostic criteria of ATPDs according to ICD-10 were included in this study. Only the patients whose relatives or caretaker had given written consent to participate in this study were included.

Exclusion Criteria:

Patients having gross organic brain disorders, obvious drugs or alcohol intoxication, mental retardation, history of previous episode of psychotic illness and the patients who have been on continuous antipsychotic treatment for more than one week immediately prior to our contact were excluded from the study. Uncooperative patients were also excluded from the study.

The subjects presenting to emergency, psychiatry OPD and inpatient services with provisional diagnosis of ATPDs were screened to check eligibility criteria to include in the study. The presence of any of the conditions mentioned in the exclusion criteria were also scrutinized with the help of detailed history and physical examination. Patients fulfilling inclusion and exclusion criteria were included in this study. Brief psychiatric rating scale was administered at the time of admission and at the time of discharge.

The patients were followed up at one month and then after three months and at each follow up the diagnosis was systematically reviewed and brief psychiatric rating scale was used at each follow-ups. Follow-ups were done at one month as the maximum duration criteria for 'ATPD with symptoms of schizophrenia and acute schizophrenia like psychotic disorder' is one month. The maximum duration criteria for others subcategories of ATPDs are three months. Diagnostic change can be considered only after these duration criteria

exceeds. So follow-ups were done at one month and after three months. Effort was made to contact through telephone or postal means to the patients who did not report during followed up time-line.

Patients were treated with antipsychotic medication. Electroconvulsive therapy, benzodiazepines were used where appropriate. Patients were put on maintenance antipsychotic medication as per the consensus of the department of Psychiatry, BPKIHS. Chi-square test was applied to analyze the significance of the result of diagnostic change at follow-ups.

RESULTS

At one month follow up, the diagnosis of ATPD remained the same in twenty six out of thirty patients (86.7%). Diagnosis was changed to mood disorder in three patients (10%) and to schizophrenia in one patient (3.3%) as shown in table 1.

Table 1: Diagnosis at one month follow up

Diagnosis	No. of patients (n)	Percent (%)
ATPD	26	86.7
Schizophrenia	1	3.3
Mood disorder	3	10.0
Total no. of patient	30	100.0

After three months, twenty four out of thirty patients (80%) retained the diagnosis of ATPDs. Diagnosis was changed to schizophrenia in three cases (10%), and the same number to mood disorder in another three cases (10%). Details are given in table 2.

Table 2: Diagnosis after three month of follow up

Diagnosis	No. of patients (n)	Percent (%)
ATPD	24	80.0
Schizophrenia	3	10.0
Mood disorder	3	10.0
Total no. of patient	30	100.0

Diagnostic stability outcome after three months: (change of initial diagnosis of ATPDs after three months follow- up) The initial diagnosis of acute and transient psychotic disorders was retained among 80% of cases. The diagnosis was changed to other psychotic disorders in six out of thirty cases (20%) as shown in table 3.

Table 3: Outcome (change of initial diagnosis of ATPDs after 3 months follow- up)

Outcome	No. of patients (n)	Percent (%)
Unchanged	24	80.0
Changed	6	20.0
Total no. of patient	30	100.0

It was found that the change in the diagnosis was not statistically significant at 0.05 level of p value. Chi-square test was computed ($x^2 = 0.274$) as shown in table 4.

Table 4: Result

Results	At Admission	After 3 months
Actual	30	24
Expected	30	30

' P' value =0.273321894

DISCUSSION

With the limitation of shorter duration of follow-up, this relatively high diagnostic stability of ATPDs points towards a distinct diagnostic entity. Most of the studies available are in support of our result which shows ATPDs to be a diagnostically stable entity. In Indian Council of Medical Research (ICMR) report, 75% of all cases with acute psychosis were fully recovered with no relapse of psychotic illness at one year follow-up, 8.7 % of cases had 'full remission' with one psychotic relapse and less than 1% had full remission with more than one relapse during the one year follow-up period.[1]

Mojtabai et al. study showed that at twenty four month follow-up, 75% of the patients with non-affective acute remitting psychosis (NAARP) were in 'full remission' and the patients did not experience further episodes after the index episode thus sharing that NAARP had a distinctively benign course.[6] Alaghband-Rad et al. reported that 'non-affective acute remitting psychosis' patients had a distinctively benign course: 67% were relapse-free in twenty four months follow-up and most others experienced a very short-lived relapse with complete recovery.[7]

Susser et al. compared acute brief psychosis with other remitting psychoses, in North India, over a twelve year course. At twelve year follow-up, the proportion with remaining signs of illness was six percent for acute brief psychosis versus fifty percent for comparison group. Using ICD-10 criteria, the majority in both groups were diagnosed as having

schizophrenia. They reported that acute brief psychosis has a distinctive and benign long-term course compared with other remitting psychoses and that their finding supports the ICD-10 concept of a separable group for ATPDs.[8] Study done at JIPMER hospital, Pondicherry India showed that at the end of three years, 33 (73.3%) patients retained their index diagnoses of Acute Polymorphic Psychotic Disorder (APPD). About 22.2% of the patients were diagnosed as bipolar affective disorder and two cases (4.4%) had a diagnostic revision to unspecified non-organic psychosis.[5]

Amini et al. followed up forty eight patients with first episode psychosis admitted to Roozbeh Hospital Tehran. Patients were assessed at the time of discharge from the hospital and at three, six and twelve months interval following admission. They found that the diagnosis of all patients with ATPDs remained the same at follow-up.[4] On the other hand there are few studies which rejected the concept that ATPD is a stable diagnosis. Jorgensen et al. showed that half of the patients (48%) suffering from acute and transient psychotic disorder had diagnostic change, most often to schizophrenia (15%) and affective disorder (28%) at one year follow up. They, therefore, reported that their findings highlight the need for validation of the concept of ATPD.[10]

Study done by Singh et al. found that after three years, the longitudinal diagnosis of ATPD remained unchanged in eight out of eleven women (73%) and in only three out of twenty one men (14%). They therefore concluded that ATPDs is a diagnostically unstable group of disorders.[9] However, our study confirms and extends findings from most of earlier follow-up studies which have shown ATPD as a stable diagnosis. This study supports the view that ATPDs are diagnostically stable and deserves a separate category.

CONCLUSION

Acute and Transient Psychotic Disorders are diagnostically stable group of disorders.

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