Eur. J. Psychiat. 2018;xxx(xx):xxx—xxx

THE EUROPEAN JOURNAL OF PSYCHIATRY
www.elsevier.es/ejpsy

ORIGINAL ARTICLE

Early-onset psychosis: What is the diagnostic outcome?

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Received 4 October 2017; accepted 12 February 2018

KEYWORDS
Early-onset psychosis;
Diagnosis;
Phenomenology

Abstract
Background and objectives: Schizophrenia and bipolar disorder may show overlapping symptom profiles especially in early-onset cases. The aim of this study was to establish a final diagnosis, examine possible similarities and differences in symptom presentations, and overall functioning of patients with early-onset psychotic episode.
Methods: Adolescents, presenting with at least one psychotic symptom, who were clinically followed up for at least 6 months, constituted our sample. Psychiatric diagnoses were established by using Schedule for Affective Disorders and Schizophrenia for School Aged Children Present-Lifetime Version (K-SADS-PL), psychotic symptoms were assessed by Positive and Negative Syndrome Scale (PANSS), and level of functioning was determined by Children's Global Assessment Scale (CGAS).
Results: Of 51 patients, 55% received a diagnosis of Psychotic Disorder (PD) and 45% a Mood Disorder (MD). Besides a major overlap in symptom presentation, there were significant differences in distribution. Hallucinations, disorganized speech, and withdrawal/isolation were encountered significantly more in the PD group, whereas hyperactivity, increased speech, and aggression were significantly more frequent in the MD group. PANSS positive, negative, and general psychopathology scores were significantly higher in the PD group. The difference was more pronounced in terms of PANSS negative scores. Overall functioning was similar in two groups.
Conclusions: Adolescents with early-onset psychotic episodes present with a combination of psychotic and mood related symptoms. Initial assessments may have the risk of misdiagnosis. During follow-up, clinicians should not underestimate the possibility of a mood disorder with psychotic features, whereas negative psychotic symptoms may have a discriminative value in favor of psychotic disorders.
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https://doi.org/10.1016/j.ejpsy.2018.02.002
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Introduction

In current operational classification systems, DSM-V (Diagnostic and Statistical Manual of Mental Disorders-V) and ICD-10 (International Classification of Diseases-10), psychotic illnesses are described as distinct categorical conditions.[1,2] Rooting from ''Kraepelinian dichotomy'', this categorical approach assumes that schizophrenia and affective disorders can be clearly distinguished. On the other hand, in the last two decades the family, twin, and whole-genome linkage studies increasingly have shown that there has been an overlapping genetic background for schizophrenia (SCZ) and bipolar disorder (BD).[3] Due to the underlying polygenic etiology and similar genetic insults, the two disorders are considered to share a common neurodevelopmental etiological model with a typical onset in late adolescence or early adulthood. In addition, studies revealed that many patients with first-episode psychosis, especially the early onset adolescent cases had common clinical features of schizophrenia and bipolar disorder.[4,5] These findings led many clinicians to argue for a dimensional approach for psychotic illnesses where schizophrenia and bipolar disorder are standing at the two ends of the continuum.[6,7] Among these, Bipolar and Schizophrenia Network for Intermediate Phenotypes (BSNIP) consortium refers to the concept of psychosis as a broad clinical phenotype.[8] Also, several symptom dimensions have been proposed to better formulate clinical psychosis phenotype.[9,10] Nevertheless, many other researchers argue in favor of the ''Kraepelian dichotomy'' and find categorical approach more useful.[11]

Around 11–18% of patients with psychosis experience their first-episode of before age 18.[12] These so called ''early-onset psychosis'' cases represent the most heterogeneous group with overlapping symptoms and clinical characteristics.[5,13,14] Psychotic symptoms per se are not pathognomonic of a specific disorder. They may be encountered in other psychiatric disorders, more frequently in affective and anxiety disorders.[15] Thus, many of the adolescents presenting with psychotic symptoms fail to fit into a specific diagnosis at the time of the initial presentation. Uncertainty of the diagnosis during acute episodes necessitates clinical follow-up to ascertain the diagnosis.[16] This variance in clinical presentation and the symptomatic overlap may lead to a low diagnostic stability during the follow-up[17,18] and there is a risk of misclassification at early stages of psychotic disorders.[16] Although there is a growing effort and accumulating knowledge to define the features of psychosis as a broad clinical phenotype, we still need diagnostic categorical criteria for clinical practice. Guidelines underscore importance of adherence to diagnostic criteria and periodic re-evaluations to enhance diagnostic accuracy.[19,20]

The aim of this study was to follow-up a heterogeneous group of patients whose initial presentation was a psychotic episode, and after establishing psychiatric diagnoses, to examine possible similarities and differences in symptom presentations, overall functioning, and other clinical characteristics.

Material and methods

Participants

In this observational study, patients were recruited from Marmara University Child and Adolescent Psychiatry Clinic within a three-year period (2014–2017). All patients, presenting with a psychotic episode (presence of at least one psychotic symptom; hallucinations, delusions, disorganized behavior, disorganized speech or withdrawal/isolation) who were clinically followed up for at least 6 months (up to 72 months) constituted our sample. The age range of the sample was 14–17 years. The exclusion criteria were: presence of mental retardation, pervasive developmental disorders, and significant neurological illness, including history of head injury leading to loss of consciousness.

The study was approved by Marmara University Ethical Committee (09.2017.268). Patients and parents gave written informed consent for the participation in the study.

Measures

Schedule for Affective Disorders and Schizophrenia for School Aged Children Present-Lifetime Version (K-SADS-PL)

The psychiatric diagnoses were established by using Turkish version of K-SADS-PL.[21,22] It is a semi-structured diagnostic interview designed to assess current and past episodes of psychopathology in children and adolescents, according to DSM-IV criteria.

Positive and Negative Syndrome Scale (PANSS)

The psychotic symptoms were assessed by using Turkish version of PANSS.[23,24] This semi-structured interview scale evaluates positive and negative symptoms and general psychopathology. Higher ratings reflect greater severity of symptoms.

The Children's Global Assessment Scale (CGAS)

CGAS is a clinician-rated scale evaluating overall well-being and functioning, where higher scores indicate higher levels of functioning.[25] It has been regarded as a useful measure of overall severity of disturbance in children.

Procedure: The adolescents, presenting with a psychotic episode assessed by clinical psychiatric interview in the first admission. Additional clinical information and history of the symptoms were gathered from the parents. According to the needs of the patients, medical treatment and supportive therapy were initiated. During the follow-up, consensus diagnoses were determined by using K-SADS-PL, which is a semi-structured clinical interview conducted with the adolescents and the parents. The other semi-structured interview scale, PANSS, was used to evaluate the severity and the distribution of psychotic symptoms. PANSS items are scored along a continuum of severity between

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