Diagnosi differenziale del primo episodio psicotico

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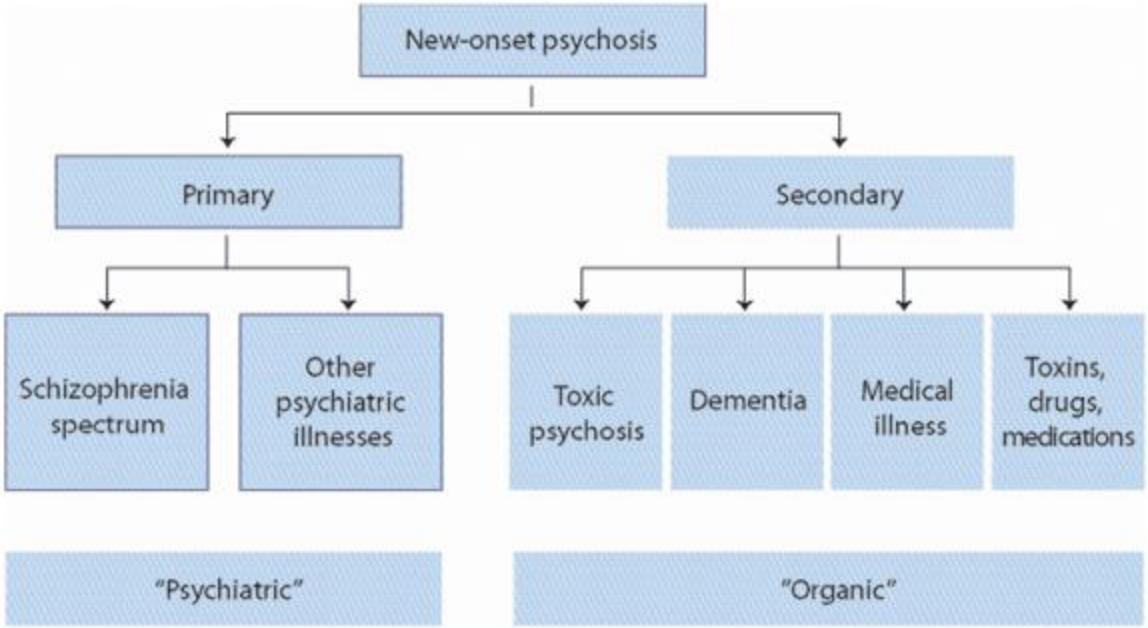
Clinical characteristics of first-episode psychosis

- Typically adolescent or young adult
- Have lived with severe untreated psychotic symptoms
  - On average, for at least a year
- Compared to peers
  - Cognitively impaired
  - Poorer psychosocial functioning
  - More likely to smoke
  - More likely to abuse substances
- Goal is to return to mainstream functioning

Figure

Differential diagnosis of new-onset psychosis



"Schizophrenia Spectrum and Other Psychotic Disorders"

- Schizotypal (Personality) Disorder
- Delusional Disorder
- Brief Psychotic Disorder
- Schizophreniform Disorder
- Schizophrenia
- Schizoaffective Disorder
- Substance/Medication-Induced Psychotic Disorder
- Psychotic Disorder Due to Another Medical Condition
- Catatonia
- Other/Unspecified

DSM-V

- Schizophrenia *Spectrum* and Other Psychotic Disorders
- *Criteria A*: Characteristic Symptoms
  - Two (or more) of the following, each present for a significant portion of time during a one-month period (or less if successfully treated). At least one of these should include 1-3
    1. Delusions
    2. Hallucinations
    3. Disorganized Speech

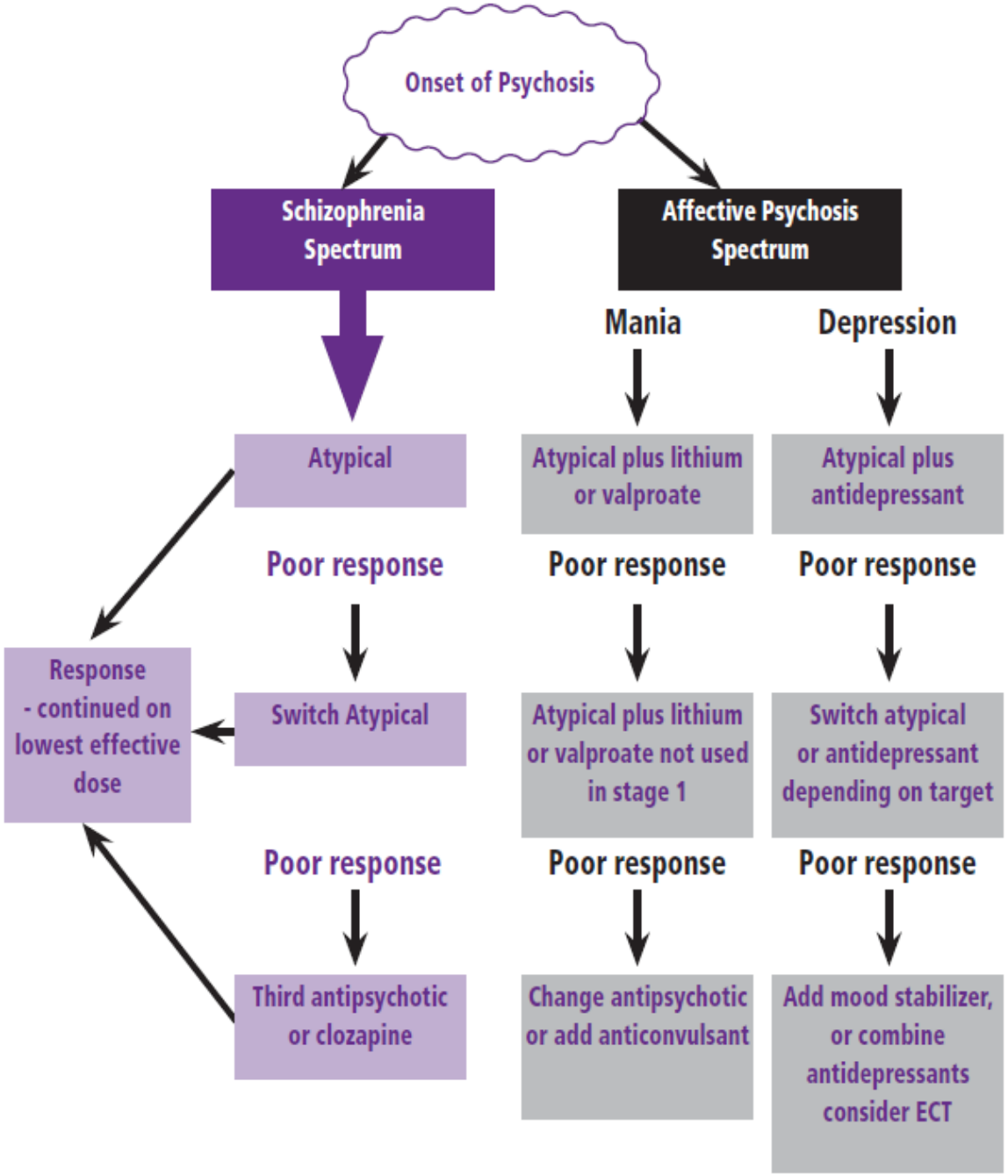
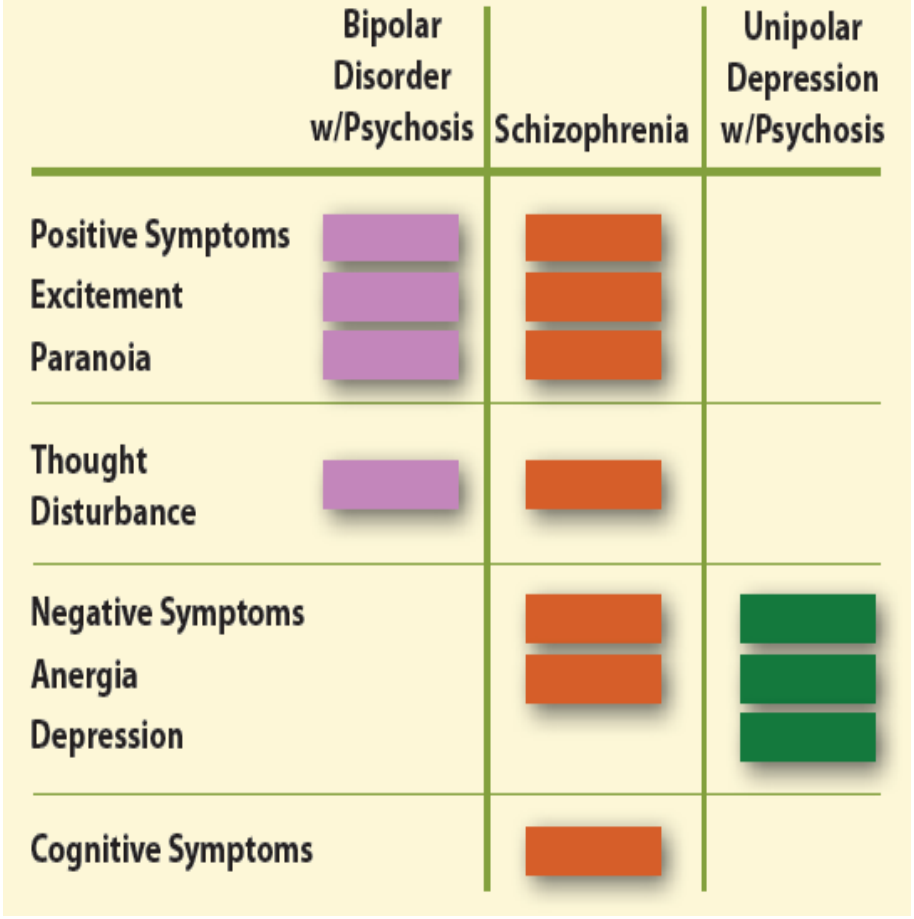

Onset of Psychosis
Schizophrenia Spectrum
Affective Psychosis Spectrum
Mania
Depression
Atypical
Atypical plus lithium or valproate
Atypical plus antidepressant
Poor response
Poor response
Poor response
Response - continued on lowest effective dose
Switch Atypical
Atypical plus lithium or valproate not used in stage 1
Switch atypical or antidepressant depending on target
Poor response
Poor response
Poor response
Third antipsychotic or clozapine
Change antipsychotic or add anticonvulsant
Add mood stabilizer, or combine antidepressants consider ECT

Table 3 Diagnostic Prediction of Clinical Diagnosis using Five-Factor Scores from the PANSS in a Discriminant Function Analysis

SCID Consensus Diagnosis	Predicted Group Membership		
	Schizophrenia	Bipolar Disorder w/Psychosis	Unipolar Depression w/Psychosis
Schizophrenia n=49	49%	37%	14%
Bipolar w/Psychosis n=29	14%	69%	17%
Unipolar Depressed w/Psychosis n=23	13%	4%	82%

Figure 1 PANSS Domains with Significantly Increased Symptom Severity Relative to Other Psychotic Disorders



Schizophrenia

J. Van Os & S. Kapur. Lancet 2009, 374,635

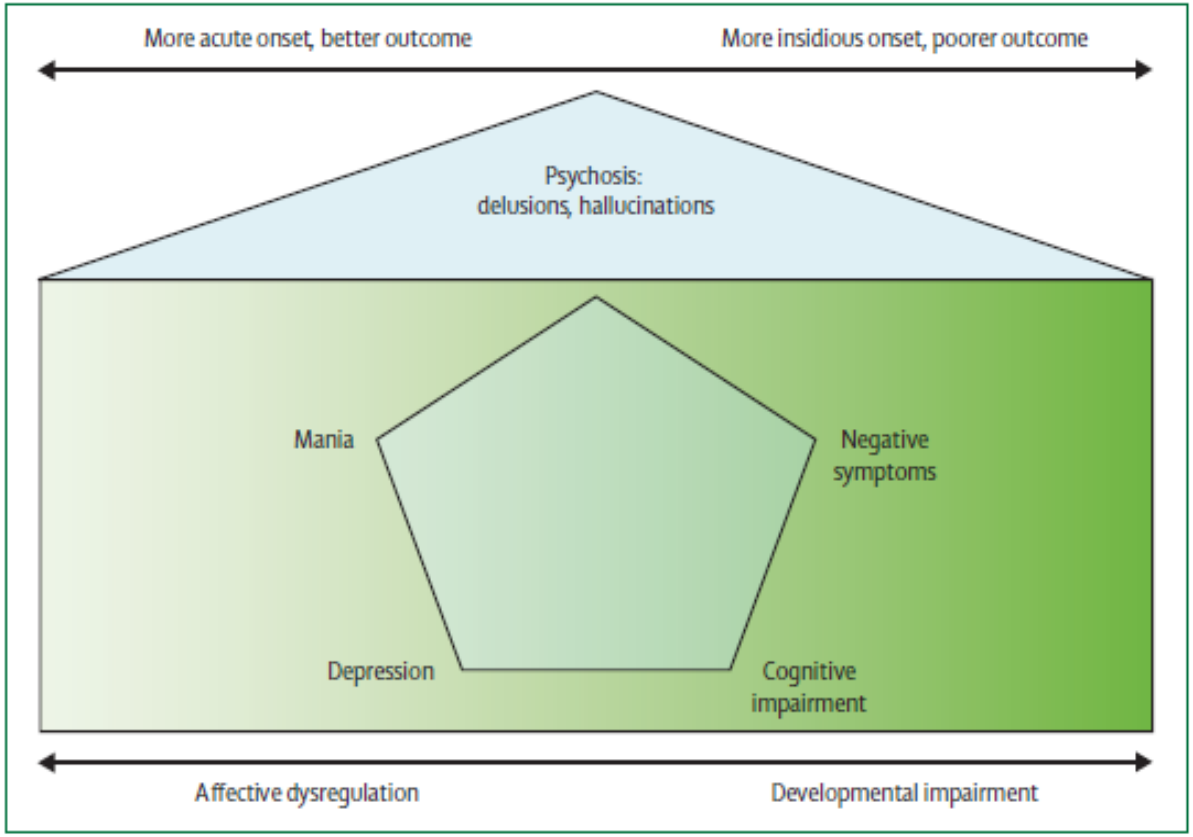


Figure 1: **Principles underlying the main distinction between affective psychosis (eg, bipolar disorder and psychotic depression) and non-affective psychosis (eg, schizophrenia and schizophreniform disorder)**

Schizophrenia

J. Van Os & S. Kapur. Lancet 2009, 374,635

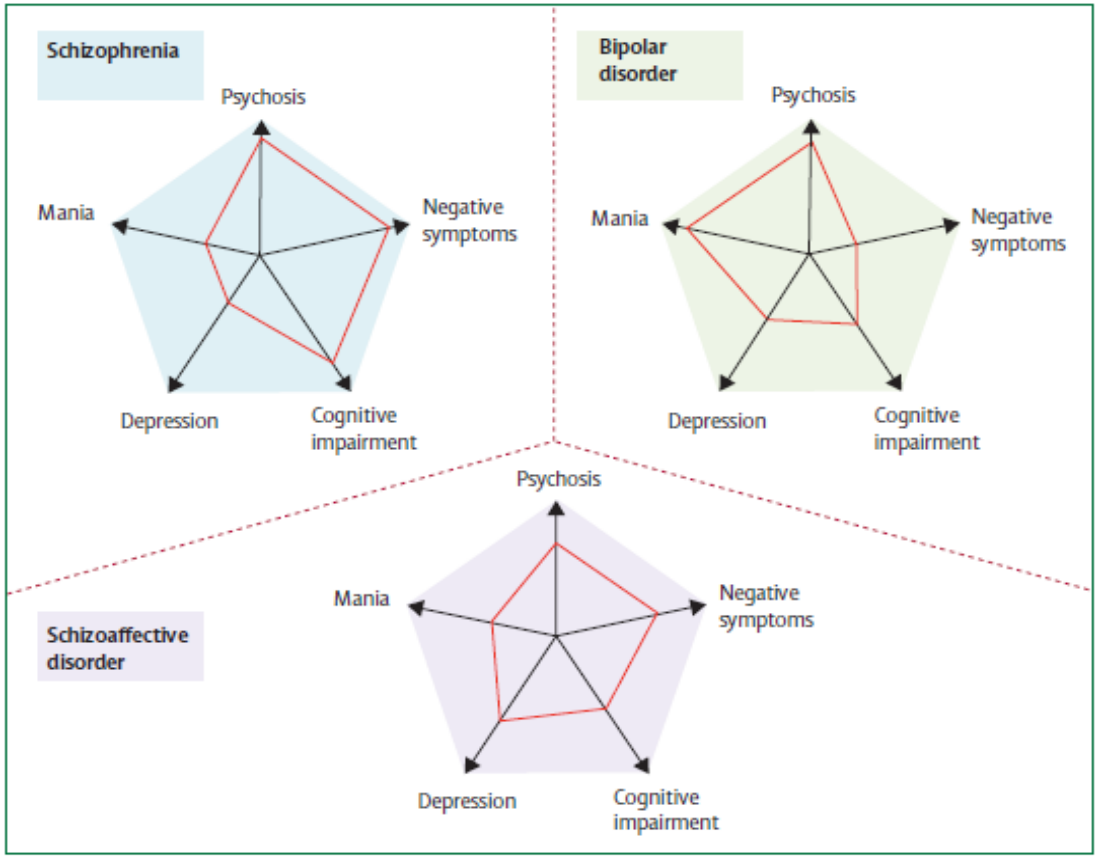
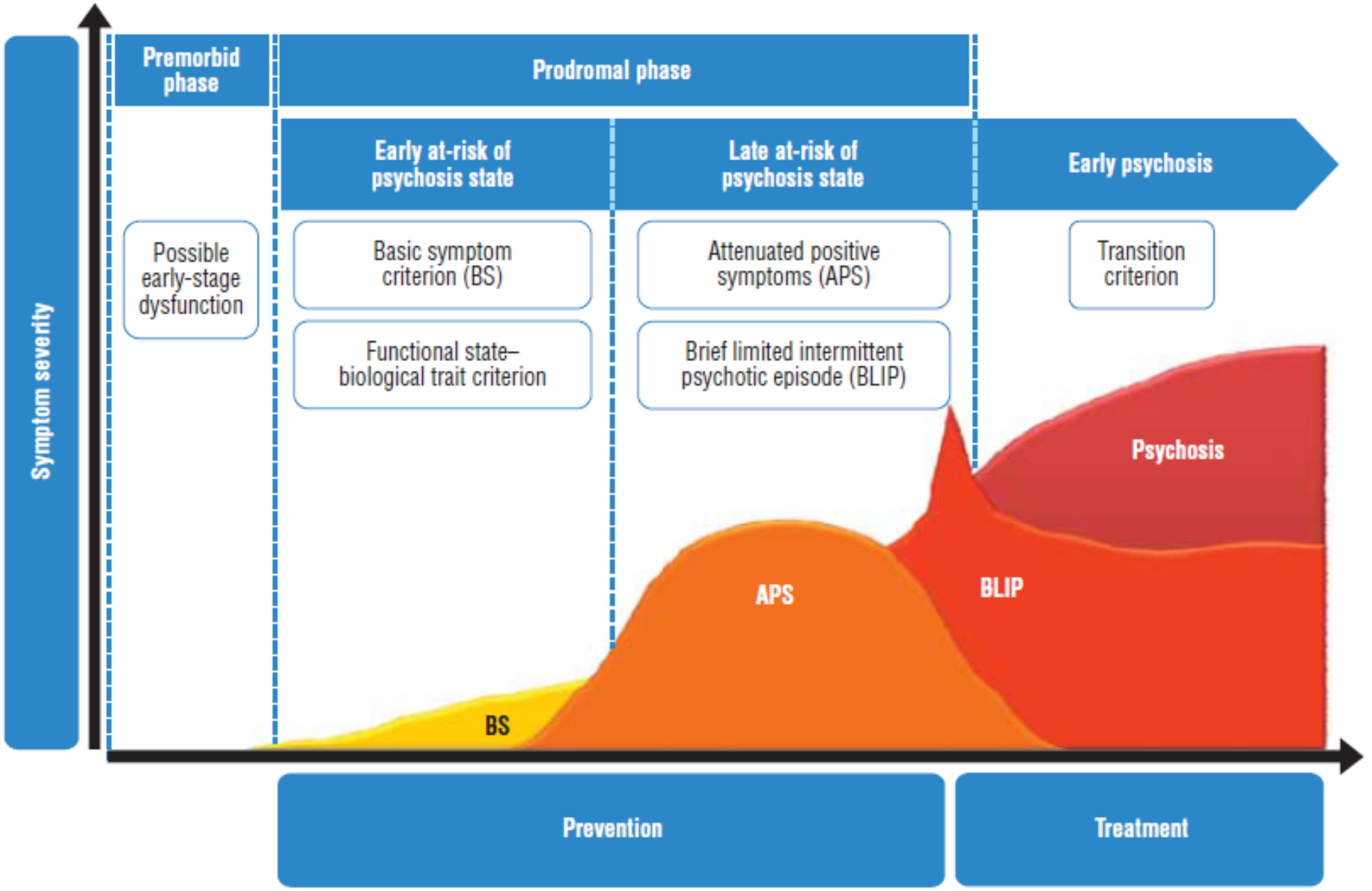


Figure 2: **Three hypothetical typical patients diagnosed with a combination of categorical and dimensional representations of psychopathology**

Categorical diagnoses of schizophrenia (blue), bipolar disorder (green), and schizoaffective disorder (violet) are accompanied by a patient's quantitative scores (connected by red lines) on five main dimensions of psychopathology.


Symptom severity
Premorbid phase
Prodromal phase
Early at-risk of psychosis state
Late at-risk of psychosis state
Early psychosis
Possible early-stage dysfunction
Basic symptom criterion (BS)
Functional state–biological trait criterion
Attenuated positive symptoms (APS)
Brief limited intermittent psychotic episode (BLIP)
Transition criterion
Psychosis
APS
BLIP
BS
Prevention
Treatment

Basic Symptoms

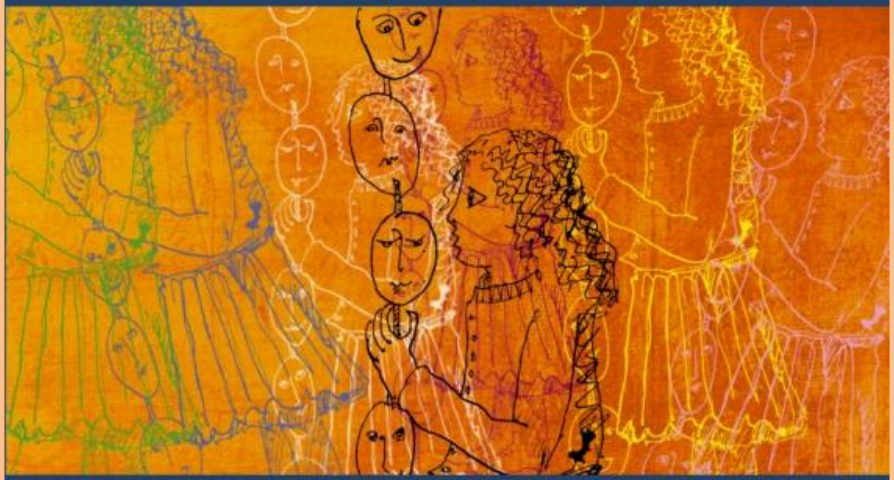
BS are subtle, subjectively experienced subclinical disturbances in drive, affect, thinking, speech, (body) perception, motor action, central vegetative functions, and stress tolerance.[4,5] They can occur and have been reported in every stage of the illness, ie, in the prodrome to the first psychotic episode, in prodromes to relapse, in residual states, and even during psychotic episodes per se.[4–6]

Schizophrenia Bulletin vol. 35 no. 1 pp. 5–8, 2009
doi:10.1093/schbul/sbn139

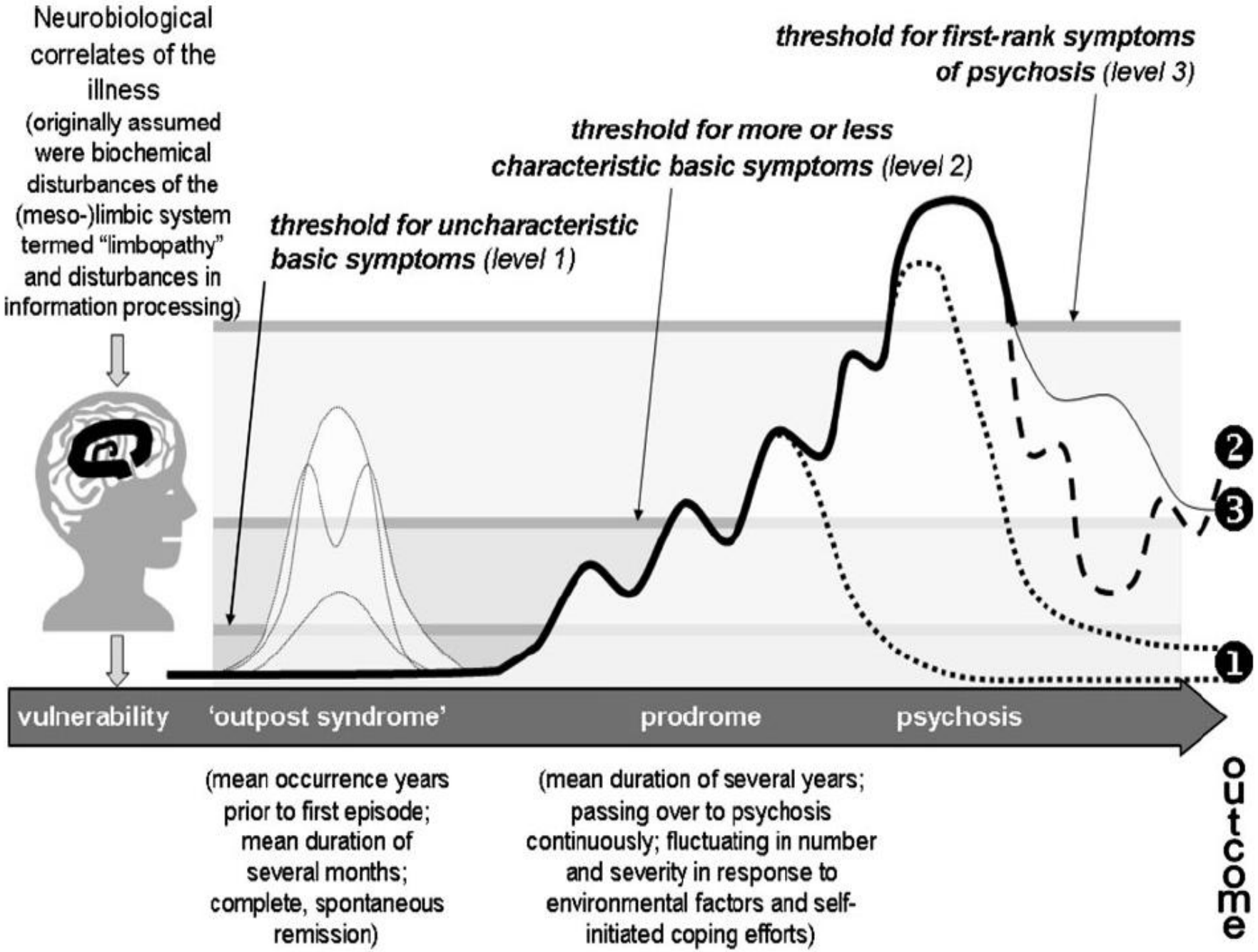
Schizophrenia Proneness Instrument

Adult version (SPI-A)

Frauke Schultze-Lutter • Jean Addington • Stephan Ruhrmann • Joachim Klosterkötter



Giovanni Fioriti Editore


Neurobiological correlates of the illness
(originally assumed were biochemical disturbances of the (meso-)limbic system termed "limbopathy" and disturbances in information processing)
threshold for first-rank symptoms of psychosis (level 3)
threshold for more or less characteristic basic symptoms (level 2)
threshold for uncharacteristic basic symptoms (level 1)
2
3
1
vulnerability
'outpost syndrome'
prodrome
psychosis
outcome
(mean occurrence years prior to first episode; mean duration of several months; complete, spontaneous remission)
(mean duration of several years; passing over to psychosis continuously; fluctuating in number and severity in response to environmental factors and self-initiated coping efforts)

Eur Arch Psychiatr Neurol Sci (1990) 239:293–302

European Archives of Psychiatry and Neurological Sciences

On the Prognostic Relevance of Ego-Psychopathology in Schizophrenia: A 2.5-Year Follow-up*

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Ego-consistency:	I felt an internal split or felt that I was being torn apart.
Ego-demarcation:	I felt I was defenceless, at the mercy of outer influences.
Ego-identity:	I had the feeling that I was someone else than the person I used to be.

International Early Psychosis Association

An international network for the study and treatment of early psychosis

BRITISH JOURNAL OF PSYCHIATRY (2005), 187 (suppl. 48), s120–s124

International clinical practice guidelines for early psychosis

INTERNATIONAL EARLY PSYCHOSIS ASSOCIATION WRITING GROUP[1]

- The prepsychotic phase is often prolonged and characterised by subtle and confusing symptoms. Much of the disability associated with the psychotic disorders is established and accumulates in this phase.

International Early Psychosis Association

An international network for the study and treatment of early psychosis

- The first psychotic episode and the critical period of the early years following initial diagnosis deserves optimal, comprehensive and phase-specific treatment with continuity of care guaranteed.

A systematic review and meta-analysis of recovery in schizophrenia

Erika Jääskeläinen[*,1,6], Pauliina Juola[1], Noora Hirvonen[1,2], John J. McGrath[3,4], Sukanta Saha[3], Matti Isohanni[1], Juha Veijola[1], and Jouko Miettunen[1,5,6]

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[6]These authors contributed equally to the article.

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Conclusions:

Based on the best available data, approximately, 1 in 7 individuals with schizophrenia met our criteria for recovery. Despite major changes in treatment options in recent decades, the proportion of recovered cases has not increased

Jääskeläinen et al. Schizophr Bull 2013;39(6):1296–1306

BJPsych | The British Journal of Psychiatry (2010)
196, 92–95. doi: 10.1192/bjp.bp.109.073429

Reappraisal

The Kraepelinian dichotomy – going, going . . . but still not gone

Nick Craddock and Michael J. Owen

Summary

Recent genetic studies reinforce the view that current approaches to the diagnosis and classification of major psychiatric illness are inadequate. These findings challenge the distinction between schizophrenia and bipolar disorder, and suggest that more attention should be given to the relationship between the functional psychoses and neurodevelopmental disorders such as autism. We are entering a transitional period of several years during which psychiatry will need to move from using traditional descriptive diagnoses to clinical entities (categories and/or dimensions) that relate more closely to the underlying workings of the brain.

Declaration of interest

None.

Etiologic, Phenomenologic, and Endophenotypic Overlap of Schizophrenia and Bipolar Disorder

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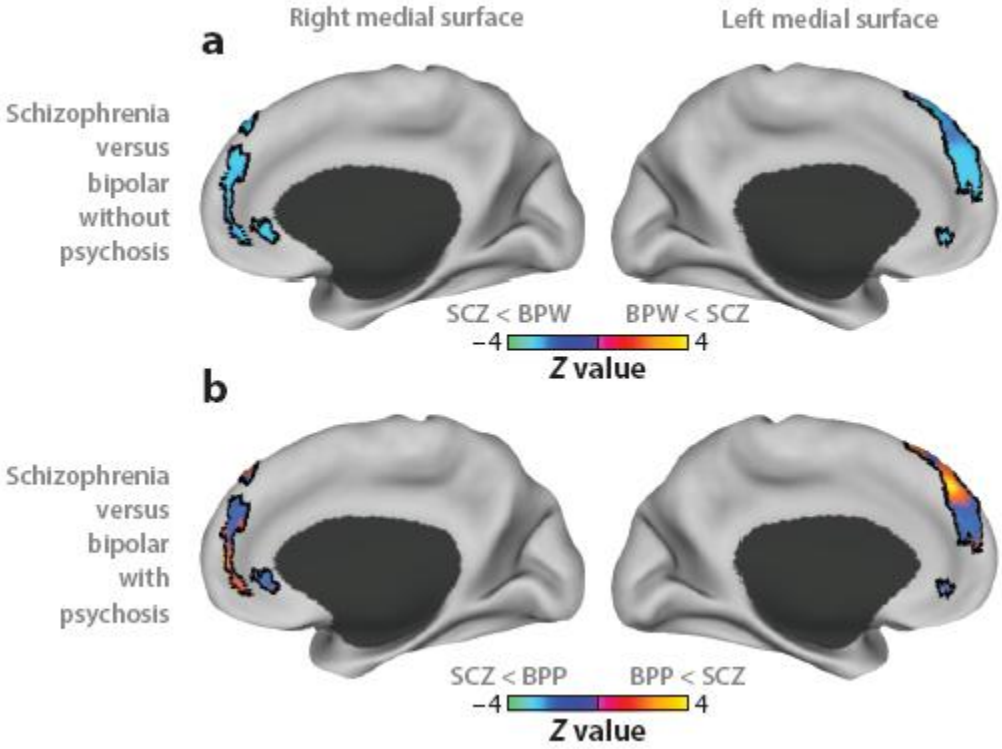
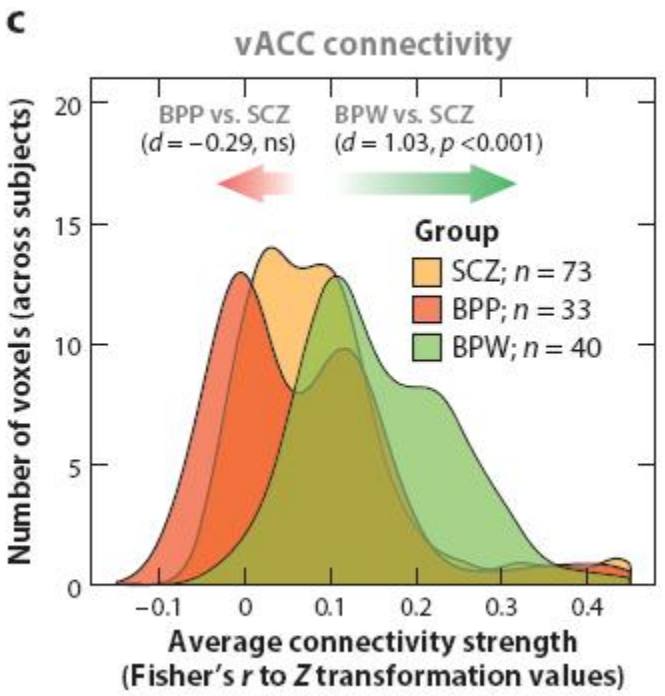
This review examines the history of psychiatric nosology, with particular reference to the nineteenth-century origins of the concepts of manic-depressive illness and schizophrenia as distinct clinical syndromes and their evolution and diagnostic refinement over time. I document how the terminology applied to these entities has generated controversy, and discuss the ways in which the resulting diagnostic entities as defined by pure phenomenological symptom descriptors fail to capture discrete diagnostic distinctions, leading some researchers to posit an illness continuum rather than separate disorders. Furthermore, the two syndromes overlap substantially on multiple biologic measures, and clarity is lacking as to the underlying etiology and pathology necessary to move from descriptions of clinical syndromes to diseases. I next examine how biologically based classifications agnostic to conventional diagnostic schemes may be useful and how these are being implemented in practice, and conclude by summarizing where such approaches are likely to lead.

Annu. Rev. Clin. Psychol. 2015. 11:251–81





Annu. Rev. Clin. Psychol. 2015. 11:251–81

Molecular Psychiatry (2009) 14, 252–260

Table 4 Number of significant genes observed to overlap in schizophrenia (SZ) and bipolar (BD) datasets

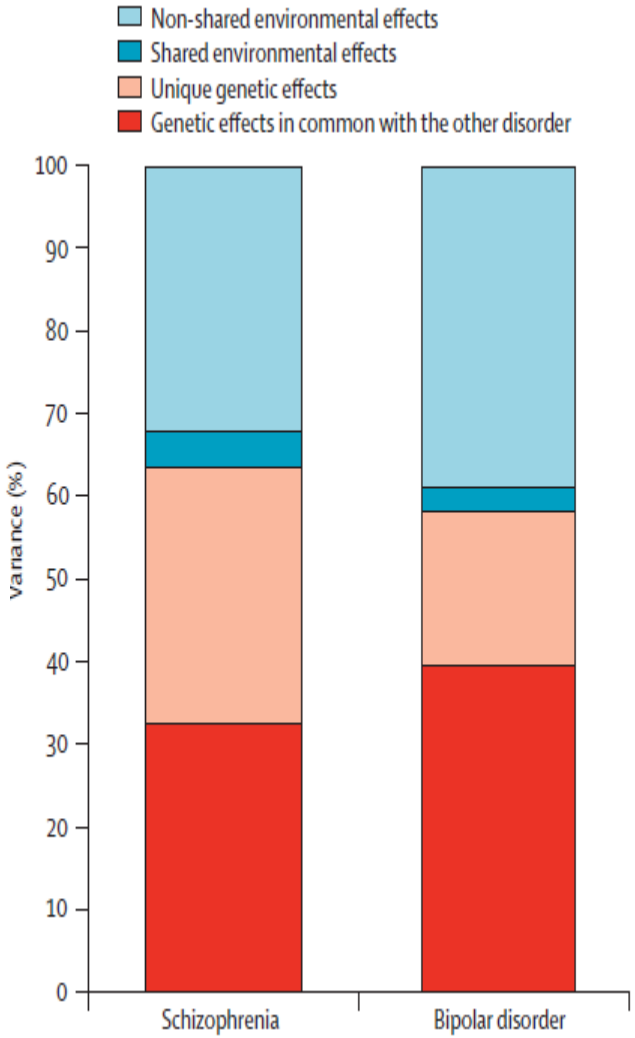
	Smallest P-*value per gene*			*Product of* P *truncation* ⩽*0.01*			*Product of* P *truncation* ⩽*0.001*		
	$\alpha = 0.05$	$\alpha = 0.01$	$\alpha = 0.001$	$\alpha = 0.05$	$\alpha = 0.01$	$\alpha = 0.001$	$\alpha = 0.05$	$\alpha = 0.01$	$\alpha = 0.001$
SZ	703	175	41	425	140	39	98	75	30
BD	790	197	41	445	159	30	94	63	24
Overlap	85	14	1	37	11	2	5	2	0
Number of overlapping genes (1000 permutations with shared controls)									
Median	60	5	0	33	4	0	2	1	0
Min	27	0	0	12	0	0	0	0	0
Max	93	16	5	60	18	5	8	7	3
Empirical *P*-value[a]	0.014	0.007	0.402	0.305	0.017	0.09	0.063	0.415	NA

the main results, at several thresholds, we observed an excess of associated genes common to schizophrenia and bipolar disorder. These findings support the specific hypothesis that some genes influence risk beyond traditional diagnostic boundaries.

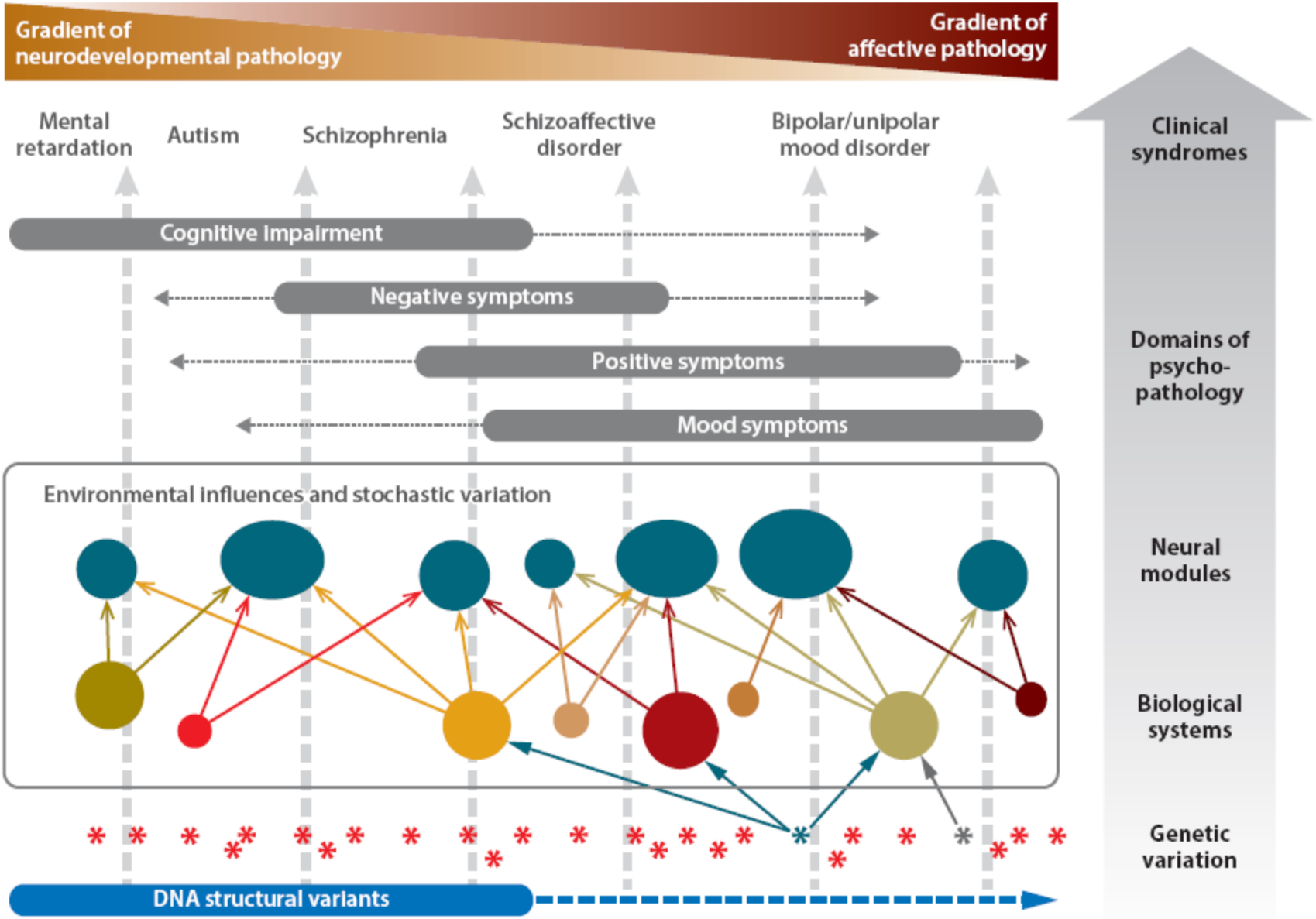
Lancet 2009; 373: 234–39

Discussion

In this study of more than 2 million Swedish families, we found evidence of a substantial genetic association between schizophrenia and bipolar disorder. All classes



Interpretation Similar to molecular genetic studies, we showed evidence that schizophrenia and bipolar disorder partly share a common genetic cause. These results challenge the current nosological dichotomy between schizophrenia and bipolar disorder, and are consistent with a reappraisal of these disorders as distinct diagnostic entities.



Annu. Rev. Clin. Psychol. 2015. 11:251–81

Neuroscience and Biobehavioral Reviews 45 (2014) 134–141

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Review

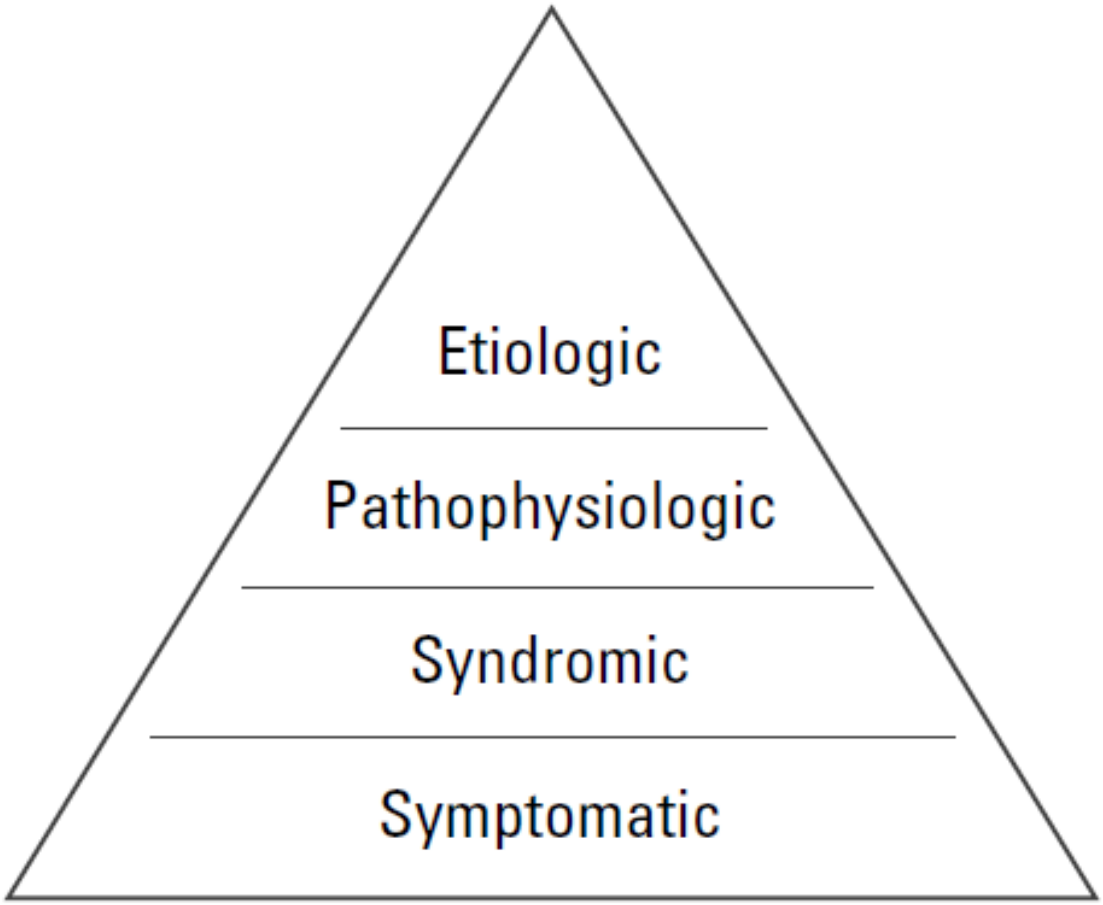
Clinically meaningful biomarkers for psychosis: A systematic and quantitative review

Diana Prata*, Andrea Mechelli, Shitij Kapur

A B S T R A C T

Despite five decades of search for clinically meaningful 'biomarkers' in schizophrenia there are still no common tests to inform diagnosis or treatment. Our aim was to understand why it has been so difficult to convert biological findings into clinical tests. We categorized all PubMed-indexed articles investigating psychosis-related biomarkers to date (over 3200). Studies showed an evident publication bias, a confusing array of terminology, and few systematic efforts at longitudinal evaluation or external validation. Fewer than 200 studies investigated biomarkers, longitudinally, for prediction of illness course and treatment response. These biomarkers were then evaluated in terms of their statistical reliability and clinical effect size. Only *one* passed our *a priori* threshold for clinical applicability. This is a modest record. In order to promote real progress, the field needs: (a) consistent use of terminology so that studies can be compared; (b) a system of standardized universal reporting to overcome the existing publication bias; and (c) practical criteria [a prototype is suggested here] for assessing the clinical applicability of the findings.

Figure 1. Diagnostic criteria pyramid



Levels of Diagnostic Sophistication

Schizophrenia Research 128 (2011) 5–6

- “what we call schizophrenia is likely a meta-syndrome with multiple disease entities, multiple etiological factors, multiple relevant pathophysiological processes, multiple symptom dimensions, multiple protective and pathoplastic factors, all of which interact with the different current treatments to generate multiple different illness courses and individual outcomes.”