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FREQUÊNCIA DOS TRANSTORNOS DE PERSONALIDADE EM PACIENTES BIPOLARES AVALIADOS EM ESTADO DE EUTIMIA: UMA REVISÃO SISTEMÁTICA

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Dissertação apresentada ao Programa de Pós-graduação em Medicina e Saúde, da Faculdade de Medicina da Bahia, Universidade Federal da Bahia, como requisito para a obtenção do grau de Mestre em Medicina e Saúde.

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Coorientadora: Drª. Amanda Galvão de Almeida

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Frequência dos Transtornos de personalidade em pacientes bipolares eutímicos: uma revisão sistemática

RESUMO

Contexto: Uma revisão sistemática foi realizada para identificar a frequência de comorbidade entre Transtornos de Personalidade (TP) e Transtorno Bipolar (TB) avaliando estudos apenas com pacientes bipolares eutímicos. **Métodos:** Foram pesquisados artigos publicados no período 1997-2013 nas seguintes bases de dados *PubMed, SciELO e PsycINFO*. Após a triagem de 1.249 artigos, dois revisores independentes identificaram 3 artigos que avaliaram a frequência de TP em pacientes com transtorno bipolar avaliados em estado de eutimia. **Resultados:** A amostra total foi de 376 pacientes bipolares eutímicos, dos quais 155 (41,2%) tiveram pelo menos um diagnóstico de TP comórbido. Entre eles encontramos 87 (23,1%) no grupo B, 55 (14,6%) no grupo C, e 25 (6,6%) no grupo A. As frequências dos subtipos de TP foram: *Borderline* 38 (10,1%), histriônico 29 (7,7%), obsessivo-compulsivo 28 (7,4%), dependente 19 (5%), narcisista 17 (4,5%), esquizóide, esquizotípico e esquiva cada um com 11 (2,95%), paranoico 5 (1,3%) e antissocial 3 (0,79%). **Conclusão:** A frequência de comorbidade com TP foi elevada entre os pacientes bipolares eutímicos. Nessa população, os TP mais comuns foram os do grupo B, e o subtipo mais frequente foi *borderline*, seguido por histriônico e obsessivo-compulsivo.

Palavras-chave: Transtorno Bipolar, Transtorno Afetivo, Transtorno de Humor, Transtornos de Personalidade e Comorbidade.

Personality disorders in euthymic bipolar patients: a systematic review

ABSTRACT

Background: A systematic review was conducted to identify the frequency with comorbid personality disorders (PD) have been assessed in studies of euthymic bipolar patients. **Methods:** PubMed, SCIELO and PsychINFO databases were searched for eligible articles published in the period 1997–2013. After screening 1,249 empirical papers, two independents reviewers identified 3 articles evaluating the frequency of PD in patients with bipolar disorders assessed in a state of euthymia. **Results:** The total sample was 376 euthy mic bipolar patients, of which 155 (41.2%) had at least one comorbid PD. Among them, we found 87 (23.1%) in cluster B, 55 (14.6%) in cluster C, and 25 (6.6%) in cluster A. The frequencies of subtypes of PD were: borderline 38 (10.1%), histrionic 29 (7.7%), obsessive-compulsive 28 (7.4%), dependent 19 (5%), narcissistic 17 (4.5%), schizoid, schizotypal and avoidant each with 11 (2.95%), paranoid 5 (1.3%) and antisocial 3 (0.79%). **Conclusion:** The frequency of comorbid PD was high across the euthymic bipolar patients. In this population, the most common were the PD of cluster B, and the most frequent subtype PD was borderline, followed by histrionic and obsessive-compulsive.

Keywords: Bipolar disorder, Affective disorder, Mood disorder, Personality disorders, and Comorbidity.

LISTA DE FIGURAS E TABELAS

LISTA DE ABREVIATURAS E SIGLAS

APA - *American Psychiatric Association*. Associação de Psiquiatria Americana.

BD - Bipolar Disorders.

CAPES - Coordenação de Aperfeiçoamento de Pessoal de Nível Superior.

CETHA - Centro de Estudos de Transtornos de Humor e Ansiedade.

CID-10 - Classificação Internacional de Doenças, 10º versão.

Complexo-HUPES - Complexo Hospitalar Universitário Professor Edgard Santos.

DSM-III-R - *Diagnostic and Statistical Manual of Mental Disorders, 3rd ed, Revised*. Manual Diagnóstico e Estatístico de Transtornos Mentais. Terceira edição revisada.

DSM-IV - *Diagnostic and Statistical Manual of Mental Disorders. 4th edition*. Manual Diagnóstico e Estatístico **de** Transtornos Mentais. Quarta edição.

DSM-IV-R - *Diagnostic and Statistical Manual of Mental Disorders, 4rd ed, Revised*. Manual **Diagnóstico** e Estatístico de Transtornos Mentais. Quarta edição revisada.

DSM-5 - *Diagnostic and Statistical Manual of Mental Disorders. 5th edition*. Manual Diagnóstico e *Estatístico* de Transtornos Mentais. Quinta edição.

HAM-D - *Hamilton Rating Scale for Depression*.

IC - Intervalo de Confiança.

MEDLINE - *Medical Literature Analysis and Retrieval System Online*.

NOS - *Not Otherwise Specified*.

PD - *Personality Disorder*.

PsycINFO - *Psychological information*.

PPgMS - Programa de Pós-graduação em Medicina e Saúde.

PRISMA - *Preferred Reporting Items for Systematic Reviews and Meta-Analyses*.

SCID-I - *Structured Clinical Interview for DSM-IV Axis I*.

SCID-II - *Structured Clinical Interview for DSM-IV Axis II Personality Disorders*.

SCIELO - *Scientific Electronic Library Online*.

SOE - Sem Outra Especificação.

STEP-BD - *Systematic Treatment Enhancement Program for Bipolar Disorder*.

TB - Transtorno Bipolar.

TP - Transtorno de Personalidade.

UFBA - Universidade Federal da Bahia.

UEFS - Universidade Estadual de Feira de Santana

YMRS - *Young Mania Rating Scale*.

SUMÁRIO

1. INTRODUÇÃO

O Transtorno Bipolar (TB) é uma doença crônica e recorrente com oscilações patológicas do humor. A prevalência, ao longo da vida, na população mundial dos tipos I e II é de aproximadamente 2%, e das formas subsindrômicas é mais de 2%. Pacientes com TB apresentam sintomas depressivos residuais, em média, em um terço dos dias de sua vida, além de experimentarem comprometimento funcional em diferentes aspectos, baixos índices de qualidade de vida (QV) e a possibilidade de serem estigmatizados.

Parte dos prejuízos que os pacientes com TB sofrem se deve a altas taxas de comorbidade com transtornos psiquiátricos do eixo I e II com implicações diagnósticas, terapêuticas e prognósticas diversas. Dentre as comorbidades de maior impacto nos pacientes bipolares, encontram-se os Transtornos de Personalidade (TP) que segundo a quarta e a quinta edição do Manual Diagnóstico e Estatístico de Transtornos Mentais (respectivamente, DSM-IV e DSM-5), podem ser divididos em três grupos, com base em semelhanças descritivas: Grupo A (paranoide, esquizoide e esquizotípico), Grupo B (antissocial, *borderline*, histriônico e narcisista) e Grupo C (esquiva, dependente e obsessivo-compulsivo).

Apesar de estarem entre os transtornos mentais de maior prevalência no mundo, os TP continuam subinvestigados e grandes lacunas de informação persistem quanto ao seu perfil epidemiológico e sua relação com o TB. A prevalência desses transtornos na população geral é de 10-23%, mas em pacientes bipolares estas taxas chegam a 25-50%, segundo estudos mais recentes. A variabilidade destas taxas pode ser decorrente das diferenças metodológicas, dos instrumentos utilizados, das fases da doença nas quais os dados foram colhidos, dos critérios de eutimia estabelecidos, dentre outros fatores. De fato, estudos que avaliaram pacientes sintomáticos no momento da entrevista, mostraram que sintomas depressivos ou maníacos alteram a percepção de si mesmo, podendo gerar taxas equivocadas de comorbidades com TP.

Apesar das diferenças metodológicas dos diversos estudos, os resultados das pesquisas mostram que a coocorrência de TB e TP gera impacto negativo na resposta ao tratamento, redução da QV e aumento do comportamento suicida dos seus portadores.

Dessa forma, descrever a frequência de TP em pacientes bipolares avaliados com instrumentos adequados e livres de sintomatologia aguda, é de extrema importância, ainda mais se considerarmos a alta prevalência destes transtornos na população geral, as altas taxas de comorbidades entre eles e a grande diversidade de metodologias empregadas na avaliação destas populações.

2. OBJETIVO

Determinar a frequência de TP em pacientes bipolares avaliados em estado de eutimia, segundo os critérios diagnósticos do DSM-IV.

3. ARTIGO ORIGINAL

PERSONALITY DISORDER IN EUTHYMIC BIPOLAR PATIENTS: A SYSTEMATIC REVIEW

REVISTA: REVISTA BRASILEIRA DE PSIQUIATRIA

SITUAÇÃO: ACEITO

3.1. Personality disorders in euthymic bipolar patients: a systematic review.

Personality disorder in euthymic bipolar patients

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Abstract

Background: A systematic review was conducted to identify the frequency with comorbid personality disorders (PD) have been assessed in studies of euthymic bipolar patients.

Methods: PubMed, SCIELO and PsychoINFO databases were searched for eligible articles published in the period 1997–2013. After screening 1,249 empirical papers, two independents reviewers identified 3 articles evaluating the frequency of PD in patients with bipolar disorders assessed in a state of euthymia.

Results: The total sample was 376 euthimic bipolar patients, of which 155 (41.2%) had at least one comorbid PD. Among them, we found 87 (23.1%) in cluster B, 55 (14.6%) in cluster C, and 25 (6.6%) in cluster A. The frequencies of subtypes of PD were: borderline 38 (10.1%), histrionic 29 (7.7%), obsessive-compulsive 28 (7.4%), dependent 19 (5%), narcissistic 17 (4.5%), schizoid, schizotypal and avoidant each with 11 (2.95%), paranoid 5 (1.3%) and antisocial 3 (0.79%).

Conclusion: The frequency of comorbid PD was high across the euthymic bipolar patients. In this population, the most common were the PD of cluster B, and the most frequent subtype PD was borderline, followed by histrionic and obsessive-compulsive.

Keywords: Bipolar disorder, Affective disorder, Mood disorder, Personality disorders, and Comorbidity.

Introduction

Bipolar disorders (BD) are characterized as a group of chronic and recurrent diseases with pathological changes of mood. The prevalence of BD types I and II throughout life in the general population is approximately 2%, and subsyndromal forms of BD reach at least a further 2%.[1] Even with treatment, about 37% of patients experience recurrence of mania or depression within a year, and 60% within two years.[2] In the study Systematic Treatment Enhancement Program for Bipolar Disorder (STEP-BD), with a cohort of 1,469 participants, 58% of BD patients type I and II achieved full recovery, but 49% had recurrences in a 2-year interval. These relapses were twice as frequent in patients with negative polarity compared to those with positive polarity.[3] In fact, BD patients may have residual depressive symptoms during, on average, one-third of the days of their lives.[4]

Bipolar patients also experience functional impairment in various forms, low levels of quality of life and the possibility of being stigmatized.[5] Part of these losses is also due to high rates of comorbidity with psychiatric axis I and II disorders, with implications for therapeutic and prognostic issues.[6, 7] Among the comorbidities of greater impact in bipolar patients are personality disorders (PD). Several studies have shown that the co-occurrence of BD and PD generates a negative impact on response to treatment, increased suicidal behavior and reduced global functioning in bipolar patients.[8, 9, 10, 11]

According to both the fourth and the fifth editions of the Diagnostic and Statistical Manual of Mental Disorders (respectively, DSM-IV and DSM-5), PDs can be divided into three groups based on clinical similarities: group A (paranoid, schizoid, and schizotypical), group B (antisocial, borderline, histrionic, and narcissistic), and group C (avoidant, dependent and obsessive-compulsive).[12, 13] Despite being among the most prevalent mental disorders in the general population, ranging from 10% up to 23%,[14, 15] PDs continue to be under-investigated and large information gaps persist regarding its epidemiology and its relationship with BD.[11]

In general, rates of PD comorbidity in BD patients reach 25–50%[16, 17, 18, 19, 20] according to recent studies. Nevertheless, rates up to 73.6%[21, 22] have been found, especially when evaluating hospitalized or highly symptomatic patients. Additionally, variability may also be due to other methodological differences, such as instruments used, phase of the disease in which the data were collected, and the established criteria for euthymia. In fact, studies evaluating symptomatic patients have shown that depressive or manic symptoms alter one's self-perception, and therefore can generate misleading rates of comorbidity with PD.[23] Thus, to avoid diagnostic errors by misperception of certain personal characteristics or overlapping symptoms, the presence of psychiatric comorbidity in BD patients should preferably be evaluated while they are in a euthymic state.[24]

Despite the controversy over these issues, negative outcomes are worsened in bipolar patients with comorbid PD; therefore PD should be investigated in any treatment plan. Thus, in order to identify a more accurate frequency of PD in bipolar patients, a systematic literature review was conducted on the frequency of PD in BD type I, II, cyclothymia, or BD Not Otherwise Specified (NOS), restricted to assessments performed in a state of euthymia, according to diagnostic criteria of DSM-IV. In addition, these rates were then compared to PD rates in the general population to identify the differences between them.

Methodology

We performed, according to the PRISMA guidelines,[25] a systematic review of the literature on the frequency of PD in patients with BD assessed only in a state of euthymia, according to the criteria for complete remission found in DSM-IV.[12] A search of the electronic medical literature databases MEDLINE, SCIELO and PsychoINFO was conducted. The basic search strategy for MEDLINE was as follows: ("bipolar disorder" OR "affective disorder" OR "mood disorder") AND ("personality disorders" OR "axis II") AND ("comorbidity" OR "comorbid"). The searches conducted in the other databases were analogous. Furthermore, additional studies were obtained by checking the references of selected articles. The search was limited to articles in Portuguese, English, Spanish, and Italian, published between 1997, the year of publication of the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II), and 31 December 2013.

The eligibility criteria for the review were: studies that assessed the frequency of PD in adults and elderly patients (≥ 18 years old) of both genders with BD type I, II, cyclothymia or BD NOS, according to DSM-IV criteria, with a period of at least two months during which there was no sign or symptom of mania or depression. Clinical trials, cross-sectional, prospective and retrospective studies were included since frequency of PD in BD patients was one of the outcomes at any time of the work. To homogenize the diagnostic criteria for PD, we selected only articles that evaluated all 10 specific types of PD, and PD NOS using the SCID-II, considered the gold standard instrument for this purpose. Furthermore, studies had to use scales for rating the intensity of mood symptoms that indicated remission of symptoms at the time of evaluation (Hamilton rating scale for depression, HAM-D ≤ 8; Young mania rating scale, YMRS ≤ 7). We did not exclude studies on the basis of sample size.

Considering the eligibility criteria, two authors (SBF and FL) independently reviewed the titles and abstracts of the retrieved studies and selected items were which read in full. Divergent selection of items was resolved by consensus. The selected studies were evaluated with respect to study methods, type of study design, psychometric instruments, diagnostic criteria, subjects, setting, outcome variables, and results.

Characteristics of sample, and the frequency of bipolar patients with at least one PD, from each article, were collected. One author extracted the data (FL), and the other checked the extraction (SBF). Based on these data, the frequency of PD was calculated for the total sample. However, the frequencies of each PD were calculated separately, because patients could have more than one disorder.

Results

Searches of databases and bibliographies of relevant manuscripts yielded 1,249 citations of which 12 were potentially relevant articles. Further examination of these articles was performed, leaving a final set of 3 eligible articles. The remaining 9 articles were excluded because they did not meet inclusion criteria: 4 studies mixed inpatients and outpatients,[26, 27, 28, 29] 2 studies included only hospitalized patients,[20, 22] and in the other 3 studies the patients were ambulatory but not all in euthymia.[30, 31, 32] Most of these studies used diagnostic scales distinct from HAM-D and YMRS; while some used none. (See Figure1).

The 3 selected studies were conducted in outpatient services of European universities, on patients with BD type I, II and cyclothymia (See Table 1). No study of BD NOS was found. The total sample of patients was 376, of which 155 (41.2%) had at least one comorbid PD. Among them, 87 (23.1%) belonged to cluster B, 55 (14.6%) to cluster C, and 25 (6.6%) to cluster A. Regarding the subtypes of PD, the most frequent were: borderline 38 (10.1%), histrionic 29 (7.7%) and obsessive-compulsive 28 (7.4%), followed by dependent 19 (5%), narcissistic 17 (4.5%), schizoid, schizotypal, and avoidant each with 11 (2.95%), paranoid 5 (1.3%), and antisocial 3 (0.79%). The PD NOS showed 7 (1.86%) (See Table 2).

Discussion

To our knowledge, this is the first systematic review of the literature that describes the frequency of PD in patients with BD assessed only in a state of euthymia. In this review we noted that there is a vast literature on the association between PD and BD. However, there are few studies evaluating PD in bipolar patients in remission of symptoms using appropriate instruments for diagnosis of PD, in order to minimize potential measurement bias, such as interpreting affective symptoms as dysfunctional personality traits. Thus, the studies selected in this revision included only euthymic patients, according to DSM-IV, using scales of intensity of affective symptoms, which strongly suggest the absence of acute or subsyndromal states for personality assessment. Furthermore, to adequately characterize the PD, we chose those articles which used only the SCID-II and included all 10 specific types of PD, and PD NOS.

Despite the methodological accuracy in the selection of papers, this review showed a high frequency of Axis II disorders in BD subjects, since 41.2% of patients had at least one PD. This high percentage is similar to that found in a recent systematic review (42%) which includes

studies with patients in different symptomatic states and used different diagnostic methods.[33] However, that review includes many studies with outpatients, probably in a state of euthymia, which may have led to the similar rates of comorbidity. Likewise, similar rates were also described in the few previous studies that evaluated only euthymic patients, but were diagnosed with the version of the SCID-II based on DSM-III,[34] thereby preventing a similar characterization between the different types of PD.

The DSM-III contains 11 specific types of PD, 10 of which were maintained in DSM-IV and DSM-5. Specifically, passive-aggressive PD was placed under PD NOS. Moreover, there are significant differences from DSM-III in diagnostic criteria, especially in groups B and C. For example, in antisocial PD the total number of diagnostic criteria decreased from 10 to 7, and the minimum number of items for diagnosis was reduced from 5 to 3. In borderline PD, a ninth criterion was added: "transient, stress-related paranoid ideation or severe dissociative symptoms." Furthermore, the number of items to make the diagnosis of histrionic types were reduced from 5 to 4, along with other changes such as replacing the criterion: “is self-centered, actions being directed toward obtaining immediate satisfaction; has no tolerance for the frustration of delayed gratification” with "is suggestible (i.e., easily influenced by others or circumstances)”.[35, 12, 13]

With respect to cluster C, dependent and obsessive-compulsive PD were the only ones to undergo a conceptual change and a change in the number of diagnostic criteria.

In fact, according to Friborg et al., studies based on different classification systems influence the diagnosis of PD in patients with comorbid mood disorder. Those who used the DSM-III-R produced higher frequencies of PD than those based on DSM-IV, reinforcing the importance of the adoption of uniform criteria for diagnosis in the characterization of PD, as adopted in this review. [33]

Despite the changes mentioned in the diagnostic criteria of the DSM and the possible difference in the frequency of PD assessment with both versions, studies in euthymic patients using the DSM-III-R, found higher rates of PD: 25.6% to 47.7% of patients with BD type I,[17, 18] and 32.5% with BD type II.[19]

The studies selected for this work also offered differing results: Harnic et al. found 61.5% of PD patients with BD I, 15.3% with BD II, and 23% cyclothymic.[36] On the other hand, Rosso et al. showed no statistical difference in the frequency of PD between bipolar patients I and II (43.7% vs 41.7%).[23] The criteria for both studies were similar as to the time of euthymia,

but Rosso et al. used stricter criteria regarding the scales of affective symptoms (HAM-D ≤ 7, and YMRS ≤ 6 to euthymia), and this methodological difference could partially explain the difference between these results. The third study found a frequency of 31% of PD, but did not differentiate between the bipolar subtypes.[37]

Another important aspect concerns the subtypes of PD clusters. Fan and Hassell developed the hypothesis that due to the similarity of some symptoms, cluster B PD were more commonly found in bipolar patients than clusters A and C.[11] Regardless of the instruments used and the symptomatic state in which patients were evaluated, cluster B remains the most frequently reported.[22, 28, 33, 36] Also, in our review, 87 patients (23%) belong to this cluster, confirming the data in the literature.

It is challenging to distinguish between trait and state in the presence of affective episodes and hence define comorbidity with cluster B PD. In this aspect, the temporal delimitation of symptoms is crucial for the distinction. For example, symptoms such as impulsivity, aggression and reckless disregard for safety can be seen in both antisocial PD and in mixed states. Likewise, grandiosity and presumptuous behavior present in narcissist PD can be confused with symptoms of hypomania.[11] However, affective symptoms have limited duration, whereas dysfunctional personality traits begin early in adolescence and are persistent over time, regardless of the state of euthymia. Furthermore, the distinction between BD and borderline PD symptoms can be particularly difficult to identify. Since its introduction in DSM-III,[34] the overlap of diagnostic criteria and the presence of clinical similarities between borderline PD and BD has rendered the existence of the former controversial to some scholars.[38] A history of childhood abuse, self-harm, intermittent paranoia, mood instability, sleep disorders, and depressive episodes with atypical symptoms may be present in both disorders.[11, 39]

In our review, the rate of borderline PD was the most frequent in BD patients at 10%; 10 times higher than in the general population.[40] However, reported rates varied broadly, ranging from 6,2% to 30% in BD type I.[7, 19, 20, 21, 41] When referring to BD type II, borderline PD rates ranged from 12% to 23%.[16, 42, 43]

On the other hand, antisocial PD demonstrated a small frequency in our review (0.79%), and seems to be more frequent in BD type I than in type II.[40] In the general population, the prevalence can be up to 5 times higher (4.1%) than that found in this review.[44]

Although cluster A is the second most prevalent in the general population (1.6% to 6.2%),[44, 45, 46] it is less frequent among BD patients. Our review found a frequency of 6.6% for

this group, very similar to the prevalence in the general population. This fact may be attributable to there being little overlap between the diagnostic criteria in cluster A and BD, when evaluated in euthymia.

Cluster C is the most prevalent in the general population (2.4% to 6.8%), and also presents significant frequency in bipolar patients (14.6%). Among them, the obsessive-compulsive PD is one of the most common in both the general population (2.1% to 7.9%) and in BD patients (7.4%).[44, 45, 46]

However, Friborg et al. found almost twice the rates of clusters A and C as found in our results (cluster A: 13% vs 6.6%, cluster C: 26% vs 14.6%). Interestingly, in that review, avoidant and paranoid PD were among the most frequent, with rates 4 and 8 times higher, while being among the least frequent in our paper, (avoidant: 12 % vs 2.95%; paranoid: 11% vs 1.3%). Moreover, histrionic PD which ranking second in our analysis (7.7%) is in sixth place (10%) in the cited review.[33] These differences in the frequencies of some specific PDs, and in certain clusters, may be partially explained by methodological differences between studies.

Even with controversy over rates of comorbid mood disorders in PD, there is no denying its high frequency in bipolar patients and its negative impact on treatment and outcomes in this population since a PD may be implicated in self-harm, substance abuse, patient difficulty in recognizing own improvement of BD, and may influence the development of the therapeutic alliance in treatment compliance.[8, 47, 48, 49]

With respect to treatment, although antipsychotics and mood stabilizers seem to improve global functioning in patients with borderline and/or schizotypal PD,[50] few studies have addressed concurrent medical and psychological treatment in bipolar patients with comorbid PD. In this context, lamotrigine and valproate may alleviate symptoms of both BD and borderline PD,[51] and psychoeducation in the prophylaxis of BD with any comorbid PD seems useful as an adjunctive treatment.[37] Patients not receiving concurrent combination treatment, stabilization of mood episode should be followed by efficacious adjunctive treatment for the PD, such as dialectical behavior therapy or transference-focused therapy for borderline PD.[52, 49]

Therefore, even in the absence of clear evidence regarding the best therapeutic practice dealing with the association of each PD and BD, the presence of PD should be thoroughly investigated in any treatment plan, especially in patients who do not respond to first-line medical drugs for BD. Adequate medical and psychological assistance can help patients better

cope with their behavior and have a better prognosis, with the possibility of exhibiting less comorbidity through longitudinal follow-up.[49]

Limitations of the study

This review includes a small number of articles in the final analysis. The fact that they are exclusively of European origin impedes generalization of results.

Conclusion

Despite controversy about the comorbidity between PD and BD, this review showed a high frequency of PD (41.2%) assessed only in euthymic bipolar patients. In these patients, the most common PD was the cluster B (23.1%), followed by the C (14.6%) and A (6.6%), and the most frequent specific PD were the following: borderline (10.1%), histrionic (7.7%) and obsessive-compulsive (7.4%).

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Disclosure

The authors report no conflicts of interest.

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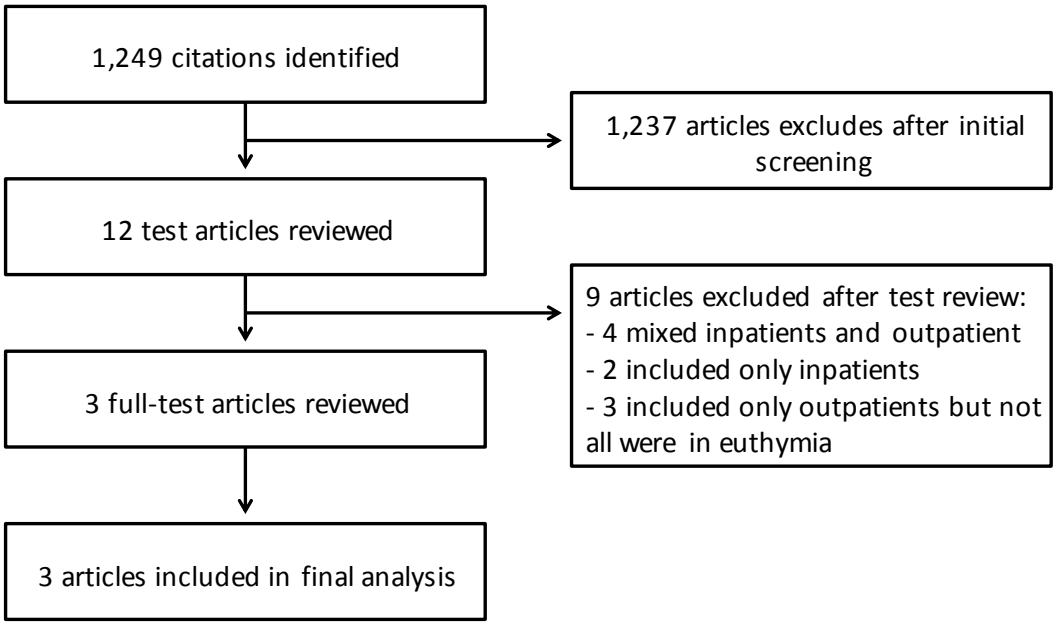

Figure 1. Flow chart to illustrate results of search strategy.

Table 1

Characteristics of included studies.

Article	n	Sample	Scales	Frequency	TP
Colom et al., 2004	120	BD type I, II	HAM-D ≤ 7 YMRS ≤ 5	31%	Borderline Histrionic OCPD
Rosso et al., 2009	186	BD type I, II	HAM-D ≤ 7 YMRS ≤ 6	42,5%	OCPD Borderline Narcissistic
Harnic et al., 2010	70	BD type I, II, cyclothymic	HAM-D ≤ 8 YMRS ≤ 7	55,7%	Borderline Histrionic Narcissistic

Abbreviations: BD, Bipolar Disorders; HAM-D, Hamilton Depression Rating Scale; YMRS, Young Mania Rating Scale; OCPD, Obsessive–compulsive personality disorder.

Table 2

Frequency of each PD in euthymic bipolar patient.

PD	N	%
Borderline	38	10,1
Histrionic	29	7,7
OCPD	28	7,4
Dependent	19	5,0
Narcissistic	17	4,5
Schizoid	11	2,9
Schizotypal	11	2,9
Avoidant	11	2,9
Paranoid	5	1,3
Antisocial	3	0,8
NOS	7	1,9

Abbreviations: PD, Personality Disorder; OCPD, Obsessive–compulsive personality disorder; NOS, Not Otherwise Specified.

Note: Numbers and percentages do not sum to total amounts because some subjects had more than one disorder.

4. CONCLUSÕES

1- Poucos estudos avaliaram pacientes bipolares com critérios de eutimia bem definidos e com instrumentos diagnósticos estruturados e adequados, por isto, apenas 3 estudos foram eleitos para esta revisão.

2- Existe uma elevada frequência de TP em pacientes bipolares (41,2%), mesmo quando avaliados segundo rígidos critérios de eutimia. Ainda assim, esta frequência é bem menor que a encontrada nos estudos que avaliam pacientes hospitalizados ou muito sintomáticos (essas taxas podem chegar até 73,6%).

3- O grupo B de TP foi o mais frequente (23,1%) e os TP específicos mais encontrados foram: *borderline* (10,1%), histriônico (7,7%) e obsessivo-compulsivo (7,4%).

5. CONSIDERAÇÕES FINAIS

O presente estudo teve como objetivo determinar a frequência de TP em pacientes bipolares avaliados em estado de eutimia a partir de uma revisão sistemática. Na literatura ainda existem lacunas no que se refere a prevalência desta comorbidade, devido a diferentes metodologias empregadas no diagnóstico de ambas as patologias. No entanto, apesar das controvérsias sobre os métodos empregados, nosso estudo permitiu corroborar a hipótese de que pacientes bipolares têm alta frequência de comorbidade com TP, avaliados segundo critérios rígidos de avaliação.

6. PERSPECTIVAS E PROPOSTAS DE ESTUDO

As observações clínicas deste estudo sugerem que essa linha de pesquisa deva ser ampliada, devido à importância do tema e a escassez de trabalhos neste campo. Com maior expansão do conhecimento nessa área, futuramente, será possível identificar a repercussão da presença de um TP em diferentes âmbitos da vida dos pacientes bipolares, com sua influência no comportamento suicida, na QV, no apoio social ou no desenvolvimento de determinadas características clínicas como ciclagem rápida, sintomas psicóticos, polaridade ou uso de polifarmácia nesta população. Nesse sentido, nosso grupo de pesquisa já iniciou coleta de dados sobre o comportamento suicida, características clínicas e sociodemográficas além da QV e apoio social em pacientes com transtorno bipolar portadores ou não de TP comórbido.

ANEXO

7.1. CÓPIA DA CONFIRMAÇÃO DE ACEITAÇÃO DO ARTIGO NA REVISTA BRASILEIRA DE PSIQUIATRIA.

Asunto:	Revista Brasileira de Psiquiatria - Decision on Manuscript ID RBP-2014-RA-1459.R2
De:	pedromaga2@gmail.com (pedromaga2@gmail.com)
Para:	sevbezerrafilho@yahoo.com;
Fecha:	Miércoles, 24 de septiembre, 2014 11:41:41

24-Sep-2014

Dear Dr. Bezerra-Filho:

We have completed our review of your manuscript "Personality disorders in euthymic bipolar patients: a systematic review." and are pleased to accept it for publication in Revista Brasileira de Psiquiatria.

Thank you for your contribution. We look forward to your continued contributions to the Journal.

Sincerely,
Dr. Pedro Magalhães
Editor, Revista Brasileira de Psiquiatria
pedromaga2@gmail.com