peripheric blood cells. Improving diagnostic accuracy, and more elaborate assessment of the clinical features may help in better understanding of the inflammatory mechanism involved in the pathophysiology of depressive states.

Key words: Major depressive disorder - Bipolar disorder; Inflammation; Immunology; Neutrophil-lymphocyte ratio; Platelet-lymphocyte ratio; Bio-marker

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DEPRESSION AND COGNITIVE DISORDERS IN POST-STROKE PATIENTS

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Introduction: To analyze the clinical features of depressive disorders and cognitive impairment in poststroke patients.

Materials and methods: We studied 40 patients with ischemic stroke located in the medical rehabilitation department. The study used the Brief Mental Status Scale (MMSE); Hospital Anxiety and Depression Scale (HADS).

Results: According to HADS at the time of hospitalization 26 people. did not experience depression (65%), but 10 of them were at the lower limit of the norm (25% of the total number of respondents); 10 pax (25%) experienced subclinical depression, and 4 (10%) had signs of severe depression. The ratio of "men: women" was ~ 1: 2, respectively. Among the women, 12 out of 20 had signs of depression, and two were clinically depressed.

The frequency of depression with damage to the left hemisphere was ~ 66.7% (the remaining 33.3% scored points corresponding to the lower limit of the norm); the frequency of depression with lesions of the right hemisphere was ~ 9.1% (taking into account patients who scored the number of points corresponding to the lower limit of the norm - 27.3%), which is significantly lower than with lesions of the left hemisphere.

According to MMSE results, only 20% of people had no cognitive impairment. Most of the subjects had moderate cognitive impairment - 70% of the subjects, and 10% - mild dementia. The main problems were associated with the performance of numerical manipulations, a violation of concentration and violation of mnestic functions.

Conclusions: Cognitive impairment, psycho-emotional impairment, and insomnia are common in stroke patients and require appropriate therapeutic measures.

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EARLY SCREENING FOR RISKS OF BIPOLAR DISORDER AT THE PRECLINICAL STAGE

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Introduction: Bipolar disorder (BD) is characterized by a high rate of prevalence in the general population varying from 0.6% to 5.84% (Yildiz 2015). BD is one of the leading causes of disability and mortality from suicide and comorbid diseases (Johnson et al. 2017). Individual symptoms of the disease in the form of cyclothymia-like mood fluctuations can be detected in adolescence and have potential for predicting risk for BD (Tijssen et al. 2010). The key issue here is untimely diagnosis of BD (Mosolov et al. 2014, Bardenshteyn et al. 2016). Early screening for risks of bipolar disorder at the preclinical stage.

Subjects and methods: The study involved 137 students aged from 18 to 20 years (mean age 18.93±0.09). The clinical-psychopathological method as well as the screening method of research were used: the Mini-International Neuropsychiatric Interview (M.I.N.I.), (Sheehan et al. 1998), the Hamilton Depression Rating Scale (HDRS 1960), the Mood Disorder Questionnaire (MDQ) (Hirschfeld 2000). The statistical data processing included descriptive statistical methods (p<0.05).

Results: Clinical diagnostics of the responders using ICD-10 (WHO, 1992, Chapter V [F00-F99]) excluded the diagnosis of bipolar disorder. The MDQ screening method revealed a statistically significant excess of the average values for hypomania throughout the sample (M±m: 6.46±0.44; p<0.05). The total score of 64 interviewees (46.7%; 95% CI: 38.1–55.3) exceeded the threshold value (≥7). 68 responders (49.6%; 95% CI 41.0–55.3) showed one-stage manifestation of certain signs of mood rise. 72 interviewees (52.6%; 95% CI 43.9–58.3) reported absence of mood rise, associated with conflict behaviour, family problems etc.

According to the HDRS scale, 45 responders (32.85%; 95% CI: 24.14-40.95) showed signs of mild depression (M±m: 6.51±0.39; p<0.05). Also, a group of responders (18.2%; 95% CI: 11.78–24.72) manifested exceeding indicators both for hypomania and depression.

Conclusions: According to the MDQ scale, 46.7% of the responders showed threshold values exceeding; with the one-stage manifestation of hypomania signs in 49.6% of the respondents. 32.85% of the responders showed signs of mild depression (the HAMD scale). 18.2% of the interviewees exceeded threshold values for both hypomania and depression. The discovered cyclothymia-like conditions at the preclinical stage have potential for predicting risk for their transformation to bipolar disorder which directs further outpatient clinical and dynamic observation.

Key words: bipolar disorder - early screening - hypomania

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COMORBIDITY IN BIPOLAR DISORDER- CASE REPORT

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Bipolar disorder (BD) is an affective disorder characterized by the exchange of periods of depression and mania. BD is commonly in comorbidity with mental and somatic diseases. This report presents a 59-year-old female patient in treatment for BD comorbid with Generalised anxiety disorder (GAD) and somatic diseases (psoriasis, diabetes mellitus type 2, hypothyroidism). The development of clinical signs of BD began in January 2016. when she was first hospitalized for depression symptoms. Later that year, she was hospitalized for the second time with acute mania symptoms. During this period, she had caused significant financial loss spending all of her family savings. Symptoms were reduced using the combination of psychotropic medications (mood stabilizer, antipsychotic, anxiolytic, hypnotic). During the second hospitalization elevated blood sugar and altered levels of thyroid hormones were noted and the patient was diagnosed with diabetes mellitus type 2 and hypothyroidism. Insulin therapy and thyroid hormones substitute were introduced. After discharge from the hospital the patient noticed skin changes and was diagnosed with psoriasis. A year later (2017) she was re-hospitalized for the actualization of BD and GAD symptoms, and the clinical condition was further aggravated by changes in her physical appearance caused by psoriasis. Since her last hospitalization, the patient is in regular outpatient psychiatric, endocrinological and dermatological treatment and regularly takes prescribed medication. She is in a stable mood, functional in all spheres of life and is in state of solid symptom remission. In order to achieve optimal treatment outcomes, it is important to recognize comorbidities on time and treat them through an individualized interdisciplinary approach.

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