Outcome of Boufée Délirante A Retrospective Study

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The French concept of bouffée délirante refers to a clinical picture characterised by sudden onset of polymorphic delusions, with relative frequence of hallucinations, mood and behaviour disturbance and confusion. After the episode, the patient classically returns to his/her premorbid level of adapation. Such episodes are often recurrent.

Twenty patients diagnosed clinically as bouffée délirante were evaluated to determine the outcome over a 2-5 year period. The clinical picture generally conformed with that described in the literature, Outcome was diverse: single or recurrent episodes, schizophrenia, manic depressive illness, schizoaffective disorder. The question of the nosological and structural specifity of bouffée délirante is discussed.

(Egypt.J. Psychiat.,1992,15:234-241).

The French concept of bouffée délirante was first introduced by Magnan in 1893. It refers to a clinical picture characterised by the acute onset of multiple, polymorphic and variable delusions. These are experienced with an intensity which leads to a dramatic change in the patient's perception of the world. Hallucinations are frequent. Mood changes, especially anxiety are common and the state of consciousness is often altered. The clinical picture is variable and may change during the same episode (Samuel - Lajeunesse, 1985).

A typical B.D. totally clears up in an average of 4-5 weeks, but recurrences are common. Henry Ey (1954) postulated that, psychopathologically, B.D. corresponds to a level of destructuration of consciousness between manic-depressive psychosis and oneroid - confusional states. According to Lacan (1981), the presence of delusions and hallucinations does not necessarily designate a psychosis; it is the premorbid structure which defines the nature of the episode.

As regards nosology, B.D. can be said to correspond, to a certain degree, to DSM-III-R.: schizophreniform psychosis or brief reactive psychosis (Pichot, 1979: Singer et al., 1986); ICD-9: acute paranoid reaction; DMP-I: acute or subacute paranoid episode. It can be seen that the concept of B.D. is perhaps neither clear cut nor accepted by other than French psychiatrists from a study carried out by Johnson Sabine et al. (1983). 21 lengthy case summaries of patients diagnosed by French psychiatrists as a B. D. were rediagnosed according to ICD-9 by English psychiatrists. No patient was given a diagnosis of acute paranoid reaction (298.3) and only 2 were diagnosed as psychogenic paranoid psychosis (298.4). 10 were diagnosed as schizophrenia, 8 as manic-depressive illness and 4 were given various other diagnoses.

The main question posed by different

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authors as regards a B.D. is whether or not it is to be considered an independent entity or merely an atypical form of schizophrenia, manic-depressive illness or a diagnosis of "wait and see". One way of answering this question has been to trace the outcome of the acute episode diagnosed as B.D. for varying periods. Ey et al. (1957) compared between two groups of patients presenting with B.D., before and after the advent of biological treatment. In the group of 13 cases which received treatment 3 (23%) had a single episode, 3 (23%) died and 7 (54%) had a chronic course (schizophrenia or a chronic paranoid state). Guilloux (1987) studied the evolution of 98 patients over a 1 to 5 year period of follow-up. He stated his findings as follows: 36 patients had a single episode; 22 had a recurrence after a period of normality; 11 had recurrences with a schizophrenic outcome; 5 became chronic schizophrenics; 4 became chronic paranoid states; 16 had an evolution towards manic depressive episodes; 1 became demented and 3 patients died. In the preliminary results of a recent study by Metzeger et al., (1990) concerning 273 cases of B.D., the authors report that 57.1% had a single episode; 18.6% had recurrences of the same type; 4.7% were schizophrenics; 3.3% were manic-depressives; and 14.6% presented with other psychiatric episodes. Coreau-Guillier (1990) studied 14 cases of B.D. occurring during adolescence, with a two year follow up, and found that 7 had a favourable outcome with treatment and 7 had a favourable outcome without treatment. Peraud et al. (1975) observed that there is a considerable difference in evolution between a case of B.D. and another of schizophrenia, especially if academic or professional achievement are taken into consideration. The same finding was shown by Singer et al., (1986) on comparison of a group of B.D. and another of schizophrenics over a 10 year period. The level of adaptation at work was significantly better for the former group.

In an earlier study by Singer et al., (1980), these authors stated that if the diagnosis of B.D. is made according to the restrictive criteria proposed by Pull: age of 18 to 45 years, sudden onset, episode characterised by polymorphic delusions, hallucinations, abnormal affect, adequate premorbid personality, absence of positive past history for psychiatric disorders other than similar episodes with a return to baseline between episodes, absence of organic etiology or iatrogenic factors, the diagnosis of a genuine B.D. is more probable. Consequently, the prognosis of such episodes is more favourable and they do not end as chronic psychoses. If deterioration does occur, a milder form of chronic psychosis is the result. In their study, for example, 45 cases were diagnosed according to the above criteria. 20 of these cases (50%) had a single episode or recurrences of the same type. Thus, the authors concluded that the existence of such (20) cases may be considered as a proof that B.D. exists as an independent nosological entity, even if relatively rare (20 cases out of a total of 4171 admissions in a psychiatric hospital over a 3-year period).

The present retrospective study is a trial to evaluate patients diagnosed clinically as B.D. without specific criteria and to follow their outcome over a 2 to 5 year period.

Subjects and Method

The files of patients hospitalized in a department (sector G07) in the Centre Hospitalier Specialisé de Rennes (Specialised Psychiatric Centre) between 1985 and 1988 were consulted. 20 cases clearly diagnosed as B.D. by clinicians with 5 to 35 years of experience were

chosen for this study. The clinical records of these patients were examined and relevant data extracted. Outcome was determined by questionning the clinician in charge of follow-up (either a psychiatrist or a family doctor).

Results

Our 20 patients had an age range of 18 to 52 years with a mean of 30.95 years (table 1), a majority of females: 14 (70%), males were 6 (30%). 10 patients were single (50%), 7 were married (35%) and 3 divorced (15%) (table 2). 12 patients were employed (60%), 1 was a student (5%), 2 were housewives (10%) and 5 were unemployed (25%) at the time of episode (table 3). One patient was Senegalese and the rest were French.

Family history was positive for psychiatric disorders in 11 cases, with one or more members of the family affected: 7 family members had depressive episodes, 5 were alcoholics, one was schizophrenic, one had unspecified psychotic disorder, one was homosexual and one had unspecified psychiatric illness.

Table 1
Age of patients

Age	No. of Patients	%
-20yrs.	2	10
20-30	7	35
30-40	9	45
40-50	1	5
+50	1	5
Total	20	100

Table 2
Marital Status of Patients

Marital Status	No. of Patients	%
Single	10	50
Married	7	35
Divorced	3	15
Total	20	100

Table 3
Occupational Status of the Patients at the Time of the Episode

Occupational Status	No. of Patients	%
Employed	12	60
Unemployed	5	25
Housewife	2	10
Student	1	5
Total	20	100

Table 4
Symptoms According to Frequency

Symptom	No. of Patients	%
Delusion	20	100
Anxiety	12	60
Aud. hallucin.	11	55
Psychomotor agitation	9	45
Mood fluctuations	6	30
(Depersonalisation)	6	30
Confusion	5	25
Visual hallucin.	5	25
Depressed mood	3	15
Exaltation	3	15
Perplexity	3	15
Logorrhea	3	15
Anorexia	2	10
Derealisation	2	10
Ambivalence	1	5
Incoherence	1	5
Déja vu phenomenon	1	5

Table 5
No of Delusional Themes

No. of Delusional Themes	No. of Patients	%
1	2	10
2	7	35
3	5	25
4	5	25
5	1	5

Table 6
Delusional Themes According to Frequency

Delusional Theme	No. of Patients	%
Persecution	15	75
Mystic	7	35
Grandeur	5	25
Influence	5	25
Thought reading	3	15
Telepathy	3	15
Bewitchment	3	15
Erotic	3	15
Impending death	2	10
Misidentification	2	10
Body transformation	2	10
Possession	1	5
Loss of self-unity	1	5
Loss of self-identity	1	5
Hypochondriacal	1	5
Communication with a dead son	1	5

Table 7
Treatment During the Episode

Treatment	No. of Patients	%
Neuroleptics	12	60
Neuroleptics + anti-dep.	3	15
Neuroleptics + lithium	1	5
Neuroleptics + Tegretol	1	5
Neuroleptics + E.C.T.	1	5
Neuroleptics + anti-dep. + E.C.T.	1	5
Neuroleptics + anti-dep. + lithium + E.C.T.	1	5

Past history was positive in 12 cases (40%): a similar episode or episodes in 5 cases, depressive episodes in 3 cases, psychotherapy for neurotic traits in 2 cases, a suicidal attempt in one case and scholastic block in one case.

The premorbid personality was described in 8 cases (40%):4 were described as immature, hysterical; 2 as schizoid; one as passive and one as obsessive.

Precipitating factors were mentioned in 12 (60%) cases: marital problems in 3 cases, puerpurium in 2 cases, loss of job in 2 cases, fatigue in 2 cases and physical health problems in one case.

The onset of the episode was described as 'sudden' in 10 cases (50%). A precise date was given in 2 cases. It was possible to estimate the duration of the episode in 14 cases with a range of 4 weeks to 5 months and a mean of 12 weeks.

According to the records, the symptoms most frequently encountered during the episode of B.D. in question were delusions in all cases (100%), anxiety in 12 cases (60%), auditory hallucinations in 11 cases (55%), psychomotor agitation in 9 cases (45%), mood fluctuations in 6 cases (30%), depersonalisation in 6 cases (30%), confusion in 5 cases (25%) and visual hallucinations in 5 cases (25%). Other symptoms found were depressed mood in 3 cases (15%), exaltation an 3 cases (15%), perplexity in 3 cases (15%). logorrhea in 3 cases (15%), derealisation in 2 cases (10%), anorexia in 2 cases (10%), ambivalence in one case (5%), incoherence in one case (5%) and déja-vu phenomenon in one (5%) (table 4).

It is interesting to mention that French authors frequently consider hallucination as a delusional mechanism and not as an independent phenomenon (Porot, 1989).

Im most cases, the delusional themes were polymorphic:most frequently 2 themes in 7 cases (35%), 3 themes in 5 cases (25%), 4 themes also in 5 cases (25%), only one theme in 2 cases (10%) and 5 themes in one case (5%) (table 5).

As shown in table 6, the more frequent delusional themes were those of persecution (15 cases: 75%), mysticism (7 cases: 35%), telepathy (3cases: 15%), bewitchment (3 case: 15%), eroticism (3 cases: 15%), impending death (2 cases: 10%), misidentification (2 cases: 10%), body transformation (2 cases: 10%), possession (1 case: 5%), hypochondriasis (1 case: 5%), and communication with a dead son (1 case: 5%).

Treatment was by neuroleptics alone in 12 cases (1 patient received long acting neuroleptics), and a combination of neuroleptics and other psychotropics in 5 cases: anti-depressants in 3 cases, lithium in 1 case, tegretol in 1 case. 3 patients received electroconvulsive therapy: 1 associated with neuroleptics alone, 1 with a combination of neuroleptics and antidepressant, and 1 with a combination of neuroleptics, antidepressants and lithium (table 7).

In one case, it was specified that the patients passed through a depressive phase before remission.

Follow up was evaluated for a period of 2 to 5 years: 4 patients for 2 years, 5 for 3 years, 6 for 4 years and 4 for 5 years. One patient died of cancer cervix of the uterus shortly after the episode studied. The outcome in relation to the number of years of follow-up is shown in table 8. The outcome was specified by taking into consideration the patient's past history as well as the opinion of the clinician in charge of follow-up:

- A single episode of B.D.: 5 patients (25%)

-Recurrent similar episodes: 5 patients (25%)

-Schizophrenia: 5 patients (25%)

-Manic-depressive illness: 2 patients (10%)

-Schizoaffective disorder: 1 patient (5%)

-Death: 1 patient (5%)

-Unclassifiable: 1 patient who had a depressive episode one year after the B.D.

On reviewing these results, no factor was found to be predictive of the outcome as favourable or not.

At the time of this study, most of the patients were still consulting a physician except 2 of the 5 patients who had a single episode of B.D. and who returned to an adequate level of premorbid functionning.

Table 8

Outcome in Relation to No. of Years of Follow-up

No. of Years of Follow-up	Single Episode	Recurrence	Schizoph.	M.D. Illness	Schizo-aff.	Death
2	2		1	1		
3	2		2	1		
4		4	2			1
5	1	1			1	
Total No. of patients	5	5	5	2	1	1

Discussion

The results of our study show that the concept of B.D. is relatively clear cut, at least from a clinical point of view. The clinical picture warranting such a diagnosis in our 20 cases was more or less conforming with that described in the literature: delusions, usually multiple, with or without hallucinations and with frequent anxiety or other mood changes. The onset was mostly sudden and the outcome was diverse: 50% with either complete resolution or recurrent episodes with a return to premorbid functionning and otherwise an evolution towards schizophrenia, schizoaffective or manic-depressive illness.

In one case the use of this diagnosis was unorthodox: a patient already diagnosed as schizophrenic was accorded the diagnosis of B.D. during an episode which probably represented an acute exacerbation of symptoms.

In the light of our results, we will attempt to discuss the position of B.D.. It has been postulated that it may be a specific presentation of a unitary psychosis, an acute schizophrenia or a type of manic depressive illness. It may also be considered an independent entity or finally a group of disorders, clinically similar but psychopathologically heterogenous.

It seems that from our study we can find certain evidence which can favour this latter possibility, especially if the longitudinal dimension is taken into consideration. The differences in premorbid personality and level of adaptation, the presence or absence of precipitating factors, the evolution towards a superior or inferior level of adaptation may show that the psychopathological significance of each episode is different and should be taken into account during therapy. We can assume that the lacanien point of view that the presence of delusions and hallucinations does not necessarily indicate a 'psychotic' structure has its value. The B.D. can be seen as an 'activity' in a previously established process. The symptoms can have different functional value as regards to psychological development and maturation. The symptoms may reflect a premature developmental failure, a transient reversible breakdown, or the intensification of defensive strategies. Each functional level requires appropriate therapeutic measures. In this respect, it is interesting to note that in transcultural studies, a higher frequency of B.D. is commonly observed in primitive cultures as opposed to schizophrenia in western societies. In such primitive societies, the outcome of these episodes in commonly in the direction of restitution and better integration (Sizaret et al., 1987).

As regards nosography, the position of B.D. raises questions as to the logic behind existing nosological systems. As long as they are qualified as descriptive, a B.D. appears to merit its place as an independent entity and not merely a form of acute schizophrenia. However, if a more psychopathological or functional dimension were taken into consideration, the nosological system in general would require re-evaluation.

References

Americain Psychiatric Association (1987) *Diagnostic and Statistical Manual of Mental Disorders*. Revision of 3rd ed. Washigton D.C.

Coreau-Guillier S. (1990) Les Etats Psychotiques Aigus de l'Adolescent. *Thesis*. Univ. de Rennes

Egyptian Psychiatric Association (1979) *Diagnostic Manual of Psychiatry-I* (DMP-I). Cairo.

Ey H. (1954) *Etudes Psychiatriques. Vol. III.* Paris. Desclée de Brouwer.

Ey H., Igert C., Rappard Ph. (1957) Psychoses Aigues et Evolutions Schizophréniques dans un Service de 1930 á 1956. *Annales Médico-psychologiques.*115:2,231- 240.

Guilloux J. (1987) Les Bouffées Délirantes Aigues un Siécle Aprés Magnan. *Actes de la Journée Psychiatriques du Val de Loire.* 25-35.

Johnson-Sabine E.C., Mann A.H., Jacoby R.J., Wood K.H., Peron Magnan P., Olié J.P., Deniker P. (1983) Bouffée délirante: An Examination of its Current Status. *Psychological Medicine.* 13, 771-778.

Lacan J. (1981) Le Séminaire. Livre III. *Les Psychoses.* Paris. Ed. du Seuil.

Metzger J.Y., Weibel H., Baldauf A., Sichel J.P. (1990) Bouffée délirante et/ou Schizophrénie Aigue. *Revue Française de Psychiatrie.* 8:7, 34-37.

Peraud M.C., Danon-Boileau H., Lab P. (1975) Le Devenir de Mille Malades Etudiants Hospitalisés Entre 1956 et 1966. Enquête Catamnestique. *Annales Médico-psychologiques.* 133:1, 1-50.

Pichot P. (1979) Les Bouffées Délirantes et Les Délires chroniques. Deux Concepts Nosologiques Français. *Annales Médico - psychologiques.* 137:1, 52-58.

Porot M. (1989) Approche d'une Classification Française des Délires. *Annales Médico-psycholgiques.* 147:3, 374-378.

Samuel-Lajeunesse B. (1985) Psychoses Délirantes Aigues. *Encyclopédie Médicale Chirurgical.* Paris. Psychiatrie 37230 A10.

Singer L., Ebtinger R., Mantz H. (1980) Le Devenir des Bouffées Délirantes. Etude Catamnestique de 74 Cas. *Annales Médico-psychologiques.* 138:9, 1097-1106.

Singer L., Roos L., Danion J.M., Heidet S. (1986) Bouffées Délirantes et Schizophrénie. Etude Catamnestique Comparative de Deux Groupes de Patients. *Annales Médico - psychologiques.* 144: 10, 1029 - 1043.

Sizaret P., Degiovanni A., Faure M. (1987) Bouffée Délirantes et culture. *Annales Médico-psychologiques.* 145:9, 753-762.

World Health Organization. (1978) *International Classification of Diseases. (Mental disorders). 9th Revision.* Geneva: W.H.O.

Le Devenir Des Bouffées Délirantes: Une Etude Rétrospective

Le tableau clinique de la bouffé délirante est caractérisé par un début soudain d'un délire plymorphe, souvent associé à des hallucinations, des troubles de l'humeur et du comportement ainsi qu'un état confusionnel. Après l'accés, le patient, classiquement, retrouve son niveau d'adaptation premorbide. Les récidives sont fréquentes. Notre étude rétrospective a porté sur 20 patients ayant le diagnostic clinique de bouffée délirante, en vue de connaitre leur évolution au bout de deux à cinq ans. Le tableau clinique décrit dans les dossiers de ces patients était conforme aves les descriptions classiques des bouffées délirantes. L'évolution a, par contre, divergé: un accés unique ou des récidives semblables, psychose maniaco-dépressive, trouble schizo-affectif, et schizophrénie. Une hypothèse quant à la specificité nosologique et structurale des bouffées délirantes est proposée.

مصير النفخة الضلالية

يشير المفهوم الفرنسي للنفخه الضلالية – إلى صورة إكلينيكية تتميز بالبداية المفاجئة – لضلالات متنوعة كثيراً ما تصاحبها الهلاوس واضطرابات المزاج والسلوك والوعي. وفي المعتاد يعود المريض بعد النفخة الضلالية إلى حالة قبل المرض وكثيراً ما تعاوده هذه النوبات.

وقد درسنا عشرين حالة شخصوا إكلينيكياً بنفخة ضلالية لتحدد ما آلوا إليه بعد فترة تتراوح بين سنتين وخمس سنوات. وقد وجدنا إن الصورة الإكلينيكية مطابقة للموصوفة وبالنسبة إلى ما آلو إليه هؤلاء المرضى متنوع. إما نوبة واحده أو نوبات متكررة إما فصام أو اضطراب الهوس والاكتئاب أو الفصام الوجداني. وقد ناقشنا الخصوصية التصنيفية والتركيبية للنفخة الضلالية.