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# Bipolar Disorder Association and Neuro-Behçet: What links? About a clinical case
# BipolarDisorder and Neuro-Behçetdisease: What links? A case report

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**ABSTRACT**
*Behcet's diseaseisis an idiopathic chronicrelapsing multisystem vascular-inflammatory disease of unknown origin. It affects mainly young patients and evolves in spurts. Its prevalenceis variable. Psychiatric symptoms have been reported in half of patients with neuro-Behçet.*
*These symptoms are nonspecific and insufficiently studied. We report a 40 year old patient without psychiatric history, who presented anacute mania. During the initial management, exploration of new-onset neurological symptoms pose the diagnosis of Neuro-Behçet. We discuss twoh ypothesis: the fortuitous association with bipolar disorder and Behçet's disease versus a maniac episode induced by this systemic disease.*
**Keywords:** Bipolar disorder, Neuro-Behçet etiologic link

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## INTRODUCTION

Behcet's disease is a multisystem vasculitis of unknown etiology relapsing and usually affecting young subjects [1]. Its prevalence is variable; it remains particulièrementélevée in Eastern Mediterranean, North Africa, Iran and Japan [2,3]. Its diagnosis is purely clinical, meeting critèresdéfinis by the International Study Group on Behcet's Disease [4]. Although not part of the diagnostic criteria, psychiatric manifestations are common. These events are non-specific, polymorphic and very little studied. They are dominated by mood disorders including dépressifs[5,6]. Some studies report manic symptoms and délirants[5,7]. We report the case of an adult with a manic episode who discover a Neuro-Behçet.

## MATERIALS AND METHOD

**Clinical observation:**

Mr. R is Moroccan and 40 years old. A career soldier, he is married with two children. He has no staff or family psychiatric history. It is amenépar his family, running his annual leave to reception and emergencies. "It has become abnormal, said his wife, for three weeks, I no longer recognize." She explained that her behavior gradually changed. He became insomniac and very talkative. He spent his days talking about several projects and to contact relatives and friends, sometimes at late hours of the night. And in recent days, his sexual advances have inquiétéla neighboring family who led "by force" in the hospital.

The examination on admission found a vigilant and well oriented in time and space patient. He is talkative, cheerful countenance and hypermimique. Contact was easy, but remained superficial. Étaitdébraillée his outfit. His speech was loud, with about familiar, caustic, interspersed with jokes and songs. The mood étaitexaltée with tachypsychie and flight of ideas. Étaitdécousu speech with a passage from one subject to another. At the proposal of hospitalization, he became irritable, said he was at his best and asked aggressively from. He then followed up with about megalomaniac, identified several heroes and described himself as invincible and able at any time to escape from the hospital. He got up frequently during the interview for us flaunt his muscles in a rather playful dimension, referring to projects that require them to not stay in the hospital. Throughout the interview, he is less reluctant to care and eventually, collapsing in tears, to accept hospitalization. Research carried toxic to the emergency department was révéléenégative.

The diagnosis of mania was made [8,9], care setting was explained and psychotropic medication was started: mood stabilizer initially associated with neuroleptic treatment viséesédative.

The clinical course showed a fluctuating table in the first days of hospitalization. One week after admission, discrete neurological symptoms including impaired balance, suggestive initially side effects of psychotropic drugs, coinciding with the period of evolution with the existence of mild hypotension orthostatic blood. The persistence of these symptoms prompted the request for an expert opinion. Neurological examination revealed a cérébelleuxstato-kinetic syndrome with tétrapyramidale irritation. The mucocutaneous review noted a scar genital aphthous lesions and pseudofolliculitis upper limbs. Lumbar puncture revealed lymphocytic meningitis. Cerebral angiography MRI revealed hyper-signals in the thalamus and the periventricular white matter. Ophthalmologic examination showed no lesions of uveitis. Laboratory tests showed a moderate inflammatory with VS 35mm syndrome and CRP 26,2mg / l. The diagnosis of neuro-Behçet was selected. The patient was treated with corticosteroids and antiplatelet agents with a progressively increasing remission.

## RESULTS AND DISCUSSION

This observation is an illustration of the clinical situations that psychiatrists are usually faced with the emergency department of a general hospital. Indeed, these are généralementsollicités for patients with acute psychiatric symptoms without organic cause found in the context of emergency. In our case, the symptoms presented by the patient meet the diagnostic criteria for a manic episode.

On the other hand, calling in particular neurological signs were absent registry, physical examination, though laborious, was normal, a éventuelleiatrogénie was discarded and the search for toxic was negative. Given these data and at this stage of the game with our patient, the diagnosis of mania and therefore bipolar disorder type I [9],a been retained, and the possibility of an organic nature whose thinking is always there was not privileged.

That said, the distinction between primary and secondary bipolar disorder really has no reason to be: in fact, apart from the age of onset, later for secondary bipolar disorder, presentation and

evolution of thymic primary or secondary disorders are stackable [10]. Family history of mood disorders or modality of treatment response would be so bad discriminating factors. Our patient is 40 years old, he has no personal or family psychiatric history, military benefiting each year visit a so-called routine annual medical examination (VSA): these two criteria we have no incentive to seek further tests complementary. It was only after the onset of neurological symptoms, set at the beginning of the side effects of psychotropic drugs account and their persistence despite lower dosages and the implementation of corrective treatments, that the possibility of organicity was raised. This expert judgment allowed, through a anamnèsedétaillée and a complete physical examination and a much more extensive complementary balance sheet, the diagnosis of Neuro-Behçet.

This raises the question of the etiologic relationship between the two diseases. And whether it is bipolar disorder fortuitously associated with Behçet's disease or a manic episode induced neuro Behçet.

The first premise is possible, but very unlikely for the following reasons: the patient has no family history or psychiatric personnel, in particular thymic order; age occurring disorder is late, there is no psychosocial stressor that could be a trigger and the manic symptoms were followed by neurological symptoms.

As for the inclusion of this disorder in the field of psychiatric manifestations of Behçet's disease, this assumption is favored. Although these events are poorly studied, according to some studies, they are polymorphic and nonspecific: half of patients with Behçet's disease show changes in personality, and 5-10% develop avérées[11] psychiatric disorders that are dominated by depression and anxiety states [12]. Some studies report manic symptoms, as is the case of our patient, or délirants[7,11]. Other events are rare; it is confusional states and dementia that fit within the psycho-organic syndrome or as some addictive behavior. The mental impairment may be inaugural accompany flares or occur during periods of remission. The onset can be as variable, ranging from a few weeks to several années[13].

The psychiatric involvement stems from the same physical signs that etiopathogenic process and accompanying parenchymal lesions of the central nervous system. The prevalence of neurological involvement in Behçet's disease varies widely across studies between 5.3 and 35% [14]. This neurological condition makes the severity of the disease as it hypothèquelourdement functional prognosis and remains a cause of death. It occurs during the quatrièmedécennie four to five years after diagnosis, but may, in 7.5% of cases, be concomitant [11] or in 3% of cases, precede other signs of 1 to 10 years.

Although parenchymal lesions in lymph généralementdétectées brainstem, thalamus and basal skull on MRI, they can êtreobservées all sites [15] central nervous system. The limbo-thalamic-cortical circuit and the limbo-striato-pallido-cortical system have long been implicated in the pathogenesis of bipolar spectrum disorders [16]. Manic symptoms in our case could be due to a secondary dysfunction of these two circuits.

Therapeutically, despite the lack of specificity of the treatment of neuro-Behçet and protocol standard codified certain substances have proven effective (corticosteroids, immunosuppressants, anticoagulants) and must êtreproposées in combination with psychotropic symptomatic treatment manic episode.

## CONCLUSION

This case raises the existence of manic symptoms in Behçet's disease. These symptoms are a factor in disease severity as they are the corollary of neurological involvement. It also questions the complexity of the etiologic relationship between the two diseases and finally stresses the need for

careful diagnostic approach, and close collaboration between different practitioners in the care of such patients.

**Conflict of Interest:**
The authors declare no conflict of interest.

**Author Contributions**:
All authors contributed to the care of patients and in the writing of this manuscript. All authors read and approved the final manuscript.

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