Interactive case report

A 22 year old man with persistent regurgitation and vomiting: case progression

Mark Fox, Alasdair Young, Roy Anggiansah, Angela Anggiansah, Jeremy Sanderson

This is the second of a three part case report where we invite readers to take part in considering the diagnosis and management of a real patient using the rapid response feature on bmj.com. In three weeks' time we will report the outcome and summarise the responses.

Oesophageal Laboratory, St Thomas' Hospital, London SE1 7EH
Mark Fox
specialist registrar
Roy Anggiansah
physiologist
Angela Anggiansah
director

Department of Gastroenterology, St Thomas' Hospital
Alasdair Young
senior house officer
Jeremy Sanderson
consultant

Correspondence to:
M Fox markfox@doctors.org.uk

BMJ 2006;332:1496

Last week (*BMJ* 2006;332:) we presented the case of Mr Neville, a 22 year old student with persistent severe epigastric pain and regurgitation and vomiting after meals. Investigation suggested gastro-oesophageal reflux disease, but treatment with acid suppression and prokinetics was only partially effective and he was readmitted to hospital with persistent symptoms and weight loss.

His persistent reflux symptoms were treated aggressively with oral esomeprazole 40 mg twice daily and later with intravenous pantoprazole. This reduced his epigastric pain and heartburn but not the regurgitation and vomiting. He did not tolerate conventional antiemetics, developing a dystonic reaction with prochlorperazine and mental agitation with metoclopramide and cyclizine. Regular ondansetron reduced the sensation of nausea but

Combined manometry and multichannel intraluminal impedance recorded after Mr Neville ingested a pureed meal. He takes a sharp intake of breath (pressure fall in the oesophageal sensors), immediately followed by contraction of the abdominal muscles producing a rise in gastric and oesophageal pressure (black arrow). Impedance increases sharply owing to the passage of air (white arrow) and is followed by a fall in impedance as the stomach contents pass up the oesophagus to the mouth. A swallow occurs after this (dashed arrow), and the impedance returns to baseline as the oesophagus is cleared

Questions

- 1 What is Mr Neville's diagnosis?
- 2 How would you present the results to him?
- 3 What issues does this case raise for the management of persistent reflux, regurgitation, and vomiting?

Please respond through bmj.com, remembering that Mr Neville is a real patient and that he and his carers will read the response

did not prevent postprandial regurgitation and vomiting. Small bowel follow-through; upper and lower gastrointestinal endoscopy (to exclude obstruction and inflammatory bowel disease); cranial, abdominal, and pelvic computed tomography (to exclude pancreatic disease and occult malignancy); gastric emptying studies; and small bowel manometry (to exclude gastrointestinal dysmotility) showed no abnormalities beyond those expected in severe under-nutrition.

After five months in hospital Mr Neville's weight had fallen from 68 kg to 52 kg (body mass index 20 to 14). He was increasingly bed bound and required high doses of analgesia for abdominal and back pain. He could tolerate only liquid nutrition and little was retained. The relationship between the patient, his mother, and the nursing and medical staff became very difficult. Psychiatric review detailed Mr Neville's background as an only child of a highly protective mother with multiple admissions for poorly defined illnesses during childhood. He did not have features of major depression or psychosis. The report commented on the "unhelpful relationship between mother and child," the secondary gain "met by hospital admission," and the possibility of fabricated or induced illness (FII). Mr Neville read the report and demanded a transfer.

On his arrival at our institution he was re-examined and carefully observed during a meal. The episodes described as regurgitation and vomiting followed a typical pattern. On eating even small volumes of food, Mr Neville experienced an unpleasant sensation of fullness in the upper abdomen shortly followed by belching and painless return of food to the mouth. He then spat out the food. He had combined oesophageal manometry with multichannel intraluminal impedance before and after a meal to assess the physiological basis of these events (figure).

Competing interest: None declared.

(Accepted 5 January 2006)