Commentary: Power of the mind

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I hadn't heard of rumination syndrome before reading Mr Neville's story.¹ My first thought on hearing about his repeated presentation, negative findings, and distress was that this was a case of somatoform disorder.² His deterioration after a difficult meeting with a staff member supported that view.

Is rumination syndrome a distinct syndrome or is it an example of a functional somatic syndrome?³ It is unfortunate that mind-body dualism still dominates clinical discussions and management. To me, this sounds like a condition with psychogenic aetiology but physical manifestation. His symptoms are not "all in the mind," they are "all in the stomach"; understandably Mr Neville and his general practitioner sought advice from gastroenterologists.

Psychological support

Mr Neville started to feel better when he was given an explanation of his symptoms and learnt how to suppress contractions. Explanations that are tangible remove blame and involve patients in managing their illness and improve wellbeing. They are also associated with patient satisfaction.⁴ A psychoeducational approach could be helpful in explaining to Mr Neville that abdominal wall contraction is under his control and assist in reducing frequency of these contractions. Cognitive behavioural therapy is effective in patients with somatoform disorder as it gives them enhanced coping skills, reduces worries about illness, reduces the frequency of avoidant behaviour, and imparts a sense of control.⁵

This case also reminds us of the importance of working with families. Mr Neville's mother, described as "highly protective," was almost certainly anxious about her son's four year history of unexplained and upsetting symptoms. Her thoughts, feeling, and actions will have a bearing on Mr Neville's prognosis.

Psychological or pathological?

What will psychiatrists learn from Mr Neville's case? On the one hand, we could consider rumination syndrome as a possible differential diagnosis in children and young people presenting with weight loss or school refusal. However, I am more likely to remember Mr Neville's story, rather than his label, and what he has taught us. Child and adolescent psychiatrists in community clinics are well placed to identify and intervene before abnormal illness behaviour becomes entrenched.

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Commentary: A fairytale ending?

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"And they all lived happily ever after," happens only in fairy tales. The clever hospital doctors have made a fascinating physiological diagnosis, and the patient has stopped vomiting and returned to normal life. Cured. Wouldn't it be great if life was like this all the time? Most general practitioners will suppress a wry smile, knowing that this is likely to describe a chapter in Mr Neville's life.¹ His general practice file is already substantial, and his hospital notes bulging. The pattern of morbidity leading up to this admission is perhaps likely to continue long into the future.

Our hospital colleagues can enjoy the triumph of their diagnosis aided by the latest technological advances: manometry and multichannel intraluminal impedance. We would not have made the correct diagnosis. Of course not. But most general practitioners would have spotted the warning signs that there was

something not quite right. The phrase, "He was discharged despite strong objections" resonates. Most young people and their relatives are so relieved that nothing serious has been found that they cannot wait to get out of hospital. If they don't want to leave, there is a reason. And so, when he appeared unwell at Christmas time, there was no alternative but admission. But what do you write on the referral to accident and emergency? Can you imagine the response if the general practitioner had written that he or she thought there was "something not quite right." The howls of derision would have been heard across the city.

Ongoing support

And yet, whatever diagnostic term was written on the hospital discharge letter, this is still the real diagnosis. The patient is still the same person, with the