Please treat me with metoclopramide

Dimitrios-Anestis Moutzouris, Stylianos Manetas, Stavros E Mountantonakis, Matthew E Falagas

Severe peptic ulcer resulting in hypertrophic pyloric stenosis is a rare clinical problem nowadays. Symptoms include vomiting, nausea, early satiety, weight loss, epigastric pain especially after eating. The physical examination may not be helpful because the pyloric mass is difficult to palpate. We report a case of a 43-year-old man who presented to the emergency department complaining of vomiting. He asked for metoclopramide, refusing initially further investigation and gastrointestinal endoscopy. Finally, he agreed to undergo a barium meal examination, which showed severe pyloric stenosis. He underwent vagotomy and enteroanastomosis. The biopsy of the removed segment of the stomach did not show any malignant changes.

A 43-year-old man presented to the emergency department complaining of vomiting. He refused persistently to give any more details. He asked for an intramuscular injection of metoclopramide, refusing further investigation, since "he already knew his problem" ("recurrent gastritis"). However, he was convinced to undergo an electrocardiogram in our attempt to rule out vomiting of cardiac origin, which showed ST changes and minimal U wave, suggestive of hypokalaemia (fig 1). The physical examination on presentation was unremarkable except for epigastric tenderness. Routine laboratory testing on admission was unremarkable except for low serum potassium (2.1 mmol/l). The arterial blood gas tests showed metabolic alkalosis (pH 7.66, bicarbonate 55.2 mmol/l, P_{CO_2} 49 mm Hg, PO_2 63 mm Hg, saturation O_2 96%).

Since his symptoms persisted, the patient agreed to be admitted. During his hospitalisation, he revealed that he had experienced upper gastrointestinal bleeding 4 years earlier but had not undergone further investigation. Since then he has been complaining of occasional vomiting that was empirically managed with metoclopramide. He did not report chest pain, headache, fever, weight loss, or other symptoms. He was afraid of hospitals and doctors

and he avoided visiting his family physician. During the 2 weeks before his admission his condition deteriorated. His other past medical history was unremarkable and he received no medications, except for the occasional dose of metoclopramide.

Initially, he was treated with intravenous fluids containing potassium. The patient refused to undergo gastrointestinal endoscopy, but agreed to undergo a barium meal examination, which showed severe pyloric stenosis (fig 2). Computed tomography of the abdomen showed severe stomach dilatation without masses or other abnormal findings (fig 3). He underwent vagotomy and enteroanastomosis. The biopsy of the removed segment of the stomach did not show any malignant changes.

DISCUSSION

Severe peptic ulcer resulting in hypertrophic pyloric stenosis is a rare clinical problem nowadays. Symptoms include vomiting, nausea, early satiety, weight loss and epigastric pain, especially after eating. The physical examination may not be helpful because the pyloric mass is difficult to palpate. On contrast radiography, the elongated narrow pylorus is again apparent; gastric emptying is delayed and the stomach may be dilated. Ultrasonography is the

Figure 2 Barium meal examination showing severe pyloric stenosis. D, duodenum; S, stomach; arrow, pyloric stenosis.

screening procedure of choice, whereas upper endoscopy is indicated to differentiate idiopathic hypertrophic pyloric stenosis from carcinoma or chronic peptic ulcer disease.¹ Medical management of peptic ulcer has limited its complications and decreased the need for surgical treatment. Surgery (either by resective or non-resective gastric procedures) may be the treatment of choice in selected patients with complications of peptic ulcer.^{2,3}

In conclusion, since a clinical diagnosis based upon vomiting and dyspepsia remains unreliable, alarming features such as dysphagia, weight loss, anaemia or predisposing and risk factors for organic diseases indicate patients at higher risk for serious disease who should undergo further evaluation without delay.⁴

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Figure 1 Electrocardiogram of the patient showing ST changes and minimal U wave, suggestive of hypokalaemia.

Figure 3 Computed tomography of the abdomen showing severe stomach dilatation without masses. K, kidneys; L, liver; S, stomach.

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REFERENCES

- 1 Redel C, Zwiener RJ. Anatomy and anomalies of the stomach and duodenum. In: *Sleisenger and Fordtran's gastrointestinal and liver disease*, 6th ed. Philadelphia: WB Saunders, 1998:567-8.
- 2 Chang TM, Chen TH, Shih CM, et al. Partial or complete circular duodenectomy with highly selective vagotomy for severe obstructing duodenal ulcer disease: an initial experience. *Arch Surg* 1998;**133**:998-1001.
- 3 Wang CS, Tzen KY, Chen PC, et al. Effects of highly selective vagotomy and additional procedures in gastric emptying in patients with obstructing duodenal ulcer. *World J Surg* 1994;**18**:131-8.
- 4 Kapoor N, Bassi A, Sturgess R, et al. Predictive value of alarm features in a rapid access upper gastrointestinal cancer service. *Gut* 2005;**54**:40-5.

IMAGES IN EMERGENCY MEDICINE

Wood tick

David Utting, Nigel Harrison

A 46-year-old man presented to the emergency department having noticed in the shower that morning an itchy black spot with some

surrounding erythema on his genitals. Further enquiry revealed he had been enjoying the summer heat in shorts while walking in Hutt Wood, Southampton, the

day before. Examination revealed a 2 mm live tick burrowed in the dorsum of his penis (figs 1 and 2). The tick was removed with splinter forceps and the patient was prescribed chloramphenicol ointment for local use. The Microbiology Reference Laboratory identified the insect as a wood tick (*Dermacentor variabilis*). Vaseline and dressings are thought to be ineffective in removing the mandible; caustic applications can damage surrounding skin.

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Figure 1 Live tick burrowed in the dorsum of the patient's penis. Informed consent was obtained for publication of this figure.

Figure 2 Close up of tick. Informed consent was obtained for publication of this figure.