This case illustrates the recently coined BRASH syndrome (Bradycardia, Renal failure, AV-node blockers, Shock and Hyperkalaemia). This describes a series of events in a patient with CKD taking AV nodal blockers where an initial insult (such as dehydration or nephrotoxic medication) triggers a cascade of events where AV nodal suppression impairs the normal compensatory response to renal hypoperfusion thus causing renal decompensation resulting in worsening hyperkalaemia. The synergistic effect of hyperkalaemia and B-blockade on AV nodal function causes further decompensation resulting in a pathological downward spiral of events.1,2

This is an under-recognised cause of CHB and renal failure which may be refractory to initial conventional treatment measures. ECG changes may not be characteristic of classical hyperkalaemia, occur at lower than expected serum potassium levels and remain refractory to conventional treatment.3,4

Co-morbid elderly patients on multiple medications are at high risk of developing this syndrome therefore as physicians we must be cognisant of prescribing AV nodal blockers or indeed additional nephrotoxic agents, so as to not incite the pathological cascade of events leading to BRASH syndrome.
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Keywords: BRASH Syndrome, Hyperkalaemia, complete heart block, pacing, polypharmacy, elderly care medicine, cardiology, nephrology

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DEGLUTITION SYNCOPE – A CASE REPORT

Editor,

A 38-year-old woman was referred to hospital for investigation following a three-year history of lightheadedness, dizziness and poor balance associated with eating. During this period, she had one episode of loss of consciousness. Symptoms were associated with flushing of the face which resolved spontaneously within 15 seconds. She reported that she could have up to fifteen episodes per week. She denied headaches and did not have any autonomic problems with her bladder or bowels. She had no significant past medical history. She did not take any regular medication and had no known allergies.

Blood pressure and heart rate were within normal ranges and she had no postural hypotension. A 12-lead ECG showed normal sinus rhythm with QTc interval within normal limits at 400ms. MRI brain and EEG were unremarkable. A 24-hour ambulatory ECG showed episodes of Mobitz Type 2 second degree atrioventricular block of which the patient was symptomatic, all occurring whilst she was eating (Figure 1 (a) and (b)). A diagnosis of swallow or deglutition syncope was made. Permanent pacemaker was implanted with complete resolution of symptoms.

DISCUSSION

Swallow syncope is a rare disorder thought to be due to a vagus nerve-mediated reflex. An increase in afferent