Adult rumination syndrome: Differentiation from psychogenic intractable vomiting

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INTRODUCTION
Repetitive effortless vomiting is termed as rumination syndrome and is common in infants and mentally retarded individuals. It is associated with considerable morbidity in children who frequently miss the school, have history of multiple hospitalizations, and also suffer significant psychiatric morbidity. Unfortunately, before reaching a correct diagnosis, a number of patients undergo unnecessary invasive testing and surgical treatments. Symptoms are often confused with that of gastric motility disorders and diagnosis is often delayed due to poor awareness regarding adult rumination syndrome among physicians. Here we are presenting a case that posed diagnostic confusion as already mentioned and showed improvement soon after the correct diagnosis was made. The main factors that helped in remission of symptoms were supportive psychotherapy and the firm attitude of the physician.

CASE REPORT
A 26-year-old lady presented with her husband and mother with the complaints of recurrent and intractable vomiting since past 2 years. The vomiting was regular, occurring throughout the day, and it used to increase after meals. For the past 6 months, she was not able to hold even the liquid diet to the extent that few sips of water were sufficient to induce vomiting. Along with vomiting, she also complained of episodic loss of consciousness, which she used to regain after 1-2 h. These episodes of unconsciousness specifically occurred when she was under some stress. Besides this, she was not having any other complaint, e.g., abdomen pain, fullness in the stomach after having meals, diarrhea or constipation, or swallowing difficulties. Her history did not suggest any cardiac problem, focal neurological deficits, or convulsions. At the time of presentation, she was pregnant (second trimester) with normal fetal growth. Her family history was unremarkable except that she had strained relations with her parents-in-law. Though her husband was very supportive but for almost 1 year she was staying at her mother’s house due to this illness.

Since the onset of illness, she was taken to many physicians,
gastroenterologists, neurologists, and psychiatrists. She underwent extensive laboratory investigations including upper gastro-intestinal endoscopy, barium meal, and MRI brain but any of the tests did not reveal any finding that could explain the symptoms. Results of her liver and kidney function tests were within normal limits since the onset of illness.

In the past, she was treated with a number of drugs including antidepressants, antipsychotics, promethazine, proton-pump inhibitors, and prokinetics for optimal periods without any relief. Her husband also took her for a vacation when suggested by a physician, but it also did not improve the situation.

Looking at such a long history, multiple consultations, and extensive laboratory work-up, she was interviewed in the presence of her husband. Then it became clear that her vomiting was effortless; in other words, she used to stand in front of a wash basin and without putting any finger or anything else in the mouth, used to expel all the food (liquid or solid) that she had. The vomiting act was not associated with lacrimation, salivation, cramping of the abdomen, cessation of respiration followed by hyperventilation, and the “gag sound” that is otherwise common during true vomiting. The vomitus was always small in amount and comprised of the ingested food. It never tasted bitter to the patient. It always took her about half an hour to expel the food. To make the information clearer, she was made to drink a glassful of water and her vomiting was observed which confirmed the information provided by her husband.

Her general physical examination showed pale conjunctiva but we did not find any signs of induced vomiting. Mental status examination disclosed the presence of depressed mood since the past 3 years. However, she was not meeting all criteria for the major depressive disorder according to DSM-IV TR. Factitious disorder and eating disorders were also ruled out during the interview.

A diagnosis of adult rumination syndrome with conversion disorder was made. Looking at the concern of her family members and her pregnancy, she was hospitalized and reassured. She was asked to improve the oral intake and hematinics were started. When she did not improve even after 2 days, in view of her pregnancy, oral feeding from a naso-gastric tube was started. To our surprise, she improved within few hours and started taking liquids orally without “vomiting” them. She also insisted on the removal of the naso-gastric tube, but due to our concerns for the maintenance of feeding, it was kept for 2 days. She kept on taking liquid diet orally as well as through the tube and the symptoms did not recur. Now her tube was removed and she was insisted to have solid food. For the next 2 days, she even had solid food without “vomiting” anything; at this juncture, supportive psychotherapy was started. She was discharged after 3 days with the advice to attend regular supportive psychotherapy sessions.

**DISCUSSION**

Rumination syndrome is common in infancy and among intellectually impaired persons. The diagnosis often poses a challenge to the physicians, especially when encountered in adults with normal intelligence and is often confused with gastroparesis and gastroesophageal reflux. In these adults, it is commonly associated with psychiatric morbidity in themselves or in their family members. One common psychiatric problem is personality disturbances with high scores on hypochondriasis and depression sub-scales. This supports the presence of persistence stress in our case.

Previous literature suggests that these patients often show multiple physician consultations and diagnosis is often delayed by years, and the food is usually expelled within few minutes of having it. Similar features were found in this case.

Manometric studies suggest abnormal esophageal pressure but reports vary with respect to the prevalence. O’Brian et al. could find manometric abnormality only in one-third of patients while Levine et al. reported manometric abnormality in even lesser number of subjects. Subjects with manometric abnormality may show higher gastric sensitivity and greater lower esophageal relaxation. However, the diagnosis is often clinical and manometry is usually unnecessary. In this the present case, gastroscopy, barium meal and MR Scan of head were done before presenting to us. However, none of them showed any abnormality. In view of the available literature and her pregnancy, we did not subject the patient to any of the invasive tests.

The treatment of adult rumination syndrome consists of reassurance, behavior therapy, psychotherapy, and relaxation therapies. These may improve a number of patients while others suffer persistence of symptoms. Nissen fundoplication has been reported to provide complete relief in the symptoms in one report. This patient was also shown to a number of physicians and was given all kinds of medical treatment including gastrokinetics, antacids, antidepressants, and benzodiazepines without any improvement. The relief was obtained with reassurance, supportive psychotherapy, and our firm attitude to take care of the patient’s health.

In conclusion, adult rumination syndrome may be more prevalent than it appears and adequate knowledge of this syndrome among the physicians is necessary to reach to a diagnosis and early intervention. In addition, further studies are required to assess therapeutic benefits of various modalities in this entity.
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