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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
vagal activity from the oesophageal plexus to the nucleus solitarius in the medulla is associated with swallowing food. Efferent parasympathetic fibres to trigger peristalsis have a cardioinhibitory effect and lead to bradycardia, hypotension and vasodilatation. Severe cardiac conduction disturbance may cause loss of consciousness. Over one hundred cases have been described in the literature, despite having been first reported in 1793.

The management of swallowing syncope should include the withdrawal of any medication that slows the rate of cardiac conduction or causes vasodepression. Anticholinergic medications such as atropine have been trialed with a view to prevent bradycardia by inhibiting vagal tone. However, results have been inconsistent, and many drugs have undesirable side effects and are therefore poorly tolerated.

Eighty-five percent of reported cases of swallowing syncope had either sinus bradycardia, sinus arrest, SA block or AV block. Implantation of a permanent pacemaker is increasingly used for patients with swallowing syncope. Whilst permanent pacemaker implantation does not correct the cause of the condition, it has been demonstrated to be an effective treatment.

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4. Figure 1 (a) and (b) showing 2nd degree heart block. On both occasions, the patient had documented that she had been eating a meal.

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FOLLICULAR LYMPHOMA OF THE RECTUM

Editor,

Non-Hodgkin’s lymphoma compromises a diverse group of malignant neoplasms, rarely involving the colorectum. Follicular lymphoma is a common subtype and constitutes 1%–3% of all primary gastrointestinal tract lymphomas. There are very few cases reported of recurrence of follicular lymphoma in the rectum. Rectal follicular lymphoma is difficult to diagnose due to limited available data, low clinical suspicion and non-specific symptoms. It also has variable growth pattern and ill-defined histopathological picture, making it difficult to distinguish from benign proliferative lymphoid lesions.

This 67-year-old lady presented in January 2010 with a right neck mass. Initially she was managed with watchful waiting for putative atypical lymphoproliferative disorder, but in August 2011 histopathology confirmed follicular non-Hodgkin’s lymphoma which was treated successfully with chemotherapy. In May 2016 she presented with worsening faecal incontinence and a palpable rectal mass. Clinically, this appeared to be a low rectal adenocarcinoma. Magnetic resonance imaging (MRI) and computed tomography (CT) confirmed this rectal tumour extending to the anorectal junction with a radiological staging offered at T3N1Mx. The initial biopsy showed a probable high-grade lymphoma, but two subsequent biopsies demonstrated only chronic inflammation. Another biopsy in December 2016 confirmed the presence of a low-grade follicular lymphoma. The patient was clinically stable and given the locality of the disease and the significant risks of chemo/radiotherapy a ‘watch and wait’ approach was chosen. However, her symptoms progressed and in January 2018 she had low-dose radiotherapy in the pelvis. As of September 2018, the patient has had a relapse confirmed and is under the ongoing care of haematology/oncology.

Gastrointestinal tract follicular lymphomas have usually inert clinical course. Patients can present with various non-