Response to "Desperate for a Hot Shower"

Abstract:

Sir,

We read with interest the recent letter by Conway et al regarding cannabinoid hyperemesis1. We have recently had a patient in his late twenties under our care that we believe may also have been suffering from this syndrome.

The patient presented to the Emergency Department with a two day history of severe periumbilical pain, associated with persistent bilious vomiting. He was afebrile and haemodynamically stable. Inflammatory markers were within normal limits. He admitted to a recent alcohol binge but denied using illicit drugs. Examination revealed tenderness in the right upper quadrant and epigastric with mild guarding. Following a similar episode of pain two years prior to this presentation the patient had been diagnosed with gastritis and treated with a short course of proton pump inhibitors (PPI). Five weeks prior to the index admission, he had been admitted overnight with periumbilical pain and bilious vomiting that had resolved following PPI administration.

On this admission, it was suspected that the patient might have pancreatitis or a duodenal perforation, however computed tomography of the abdomen was reported as normal, revealing no evidence to support these diagnoses. Mild oesophagogastritis was found at upper gastrointestinal endoscopy. Intravenous PPI therapy was commenced. His symptoms improved over the following three days and he was discharged with an appointment for repeat endoscopy six weeks later.

The patient re-presented the following day as his symptoms had returned. An erect plain film of the chest again failed to support a diagnosis of perforation. His symptoms continued unabated for the following week. Nasogastric feeding was commenced. MR enteroclysis ruled out small bowel pathology. Computed tomography of the brain failed to reveal a lesion that might have prompted his symptoms. The patients next of kin was contacted in order to determine if there were any psychosocial factors that might have induced his symptoms. It was revealed that the patient was a habitual user of cannabis, smoking on an almost daily basis. It was also brought to our attention that the patient showered multiple times per day, as he found that this relieved his symptoms, a feature also noted in the case described by Conway et al1. A working diagnosis of cannabis withdrawal was suspected, which was revised on reading the aforementioned case report. The patients symptoms gradually improved and he was discharged, after an almost three week long in-patient stay.

Our case, and that described by Conway et al, highlight the difficulties in managing these patients. As noted in both cases, while symptoms are sufficiently robust and intractable to necessitate multiple investigations, these will typically be normal or reveal mild upper gastrointestinal inflammation out of keeping with symptom severity. Given the prevalence of cannabis use in Ireland, it is likely that a significant proportion of patients suffering from cannabinoid hyperemesis are misdiagnosed and consequently over-investigated. Although it will likely remain a diagnosis of exclusion, careful history-taking, including collateral histories from family members, and peers, and recognition of tell-tale symptom relief by showering, might prevent unnecessary diagnostic studies1.

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References