Adult Cyclic Vomiting Syndrome Is Easy to Miss

BY AMY ROTHAMAN SCHONFELD

BOSTON — Cyclic vomiting syndrome in adults often goes unrecognized for years after onset, despite its severe and disabling consequences.

The disorder may be the cause of repeated visits to emergency departments, unnec-
sary surgeries and diagnostic tests, and substance abuse, according to participants at the first-ever symposium devoted to cyclic vomiting syndrome (CVS) in adults. The gathering was held as a satellite meet-
ing following a meeting on neurogastro-
terology and motility.

Diagnosis of CVS in adults is complic-
ted by the variability in age of onset and pattern of symptoms. The result is that the average delay in making the diagnosis is 8 years from the time symptoms first appeared. Of 50 U.S. Li, director of the Center for CVS at the Medical College of Wisconsin, Milwaukee, in a presenta-
tion at the meeting.

“Where are we? How did we miss these folks?” Dr. Richard McCallum of the Kansas University Medical Center, Kansas City, rhetorically asked the audi-
ence, composed of physicians, patients, and family members.

As the director of the first center for CVS in adults, Dr. McCallum said, “We’re getting a continued trickle of patients coming to us,” a avalanche of phone calls from patients and physicians from around the world.”

According to the Rome 3 criteria H1b, the definition of CVS is two or more pe-
riods of intense nausea or unremitting vomiting or retching lasting hours to days, with a return to the usual state of health lasting weeks to months (J. Gastro. Liver Dis. 2006;15:237-41). In its mildest form, the symptoms of CVS do not interfere with a patient’s ability to work or attend school, said Dr. David Fleisher of the Uni-
versity of Missouri, Columbia, who has treated more than 350 pediatric and adult CV

CVS patients often undergo batteries of tests, including upper GI series, abdominal ultrasound and CT scan, colorocoloscopy, bar-
tium enema, endoscopy, MRI of the head, sinus radiography, EEG, and lab work, usually with negative results.

In Dr. Fleisher’s series, the 41 patients underwent almost 100 diagnostic stud-
ies—one of which was indicative of an organic etiology for CVS. Recent findings suggest that about 75% of patients with CVS show rapid gastric emptying on elec-
trogastrograms, and this may help distin-
guish CVS from other vomiting disorders (Neurogastroenterol. Motil. 2006;18:728 [abstract 200]).

Unnecessary surgeries are also common. Of the 41 patients in the series, 10 had un-
diagnosed cholecystectomies, 2 had append-
dectomies, 5 had laparoscopies, 1 had a hys-
terectomy, and others had undergone other procedures. Rate of procedures relieved the CVS symptoms.

Part of the problem is the lack of con-
tinuity of care for these patients, especial-
ly those who present repeatedly to hospi-
tal emergency departments. Dr. Fleisher suggests that more CVS centers should be created and staffed by two to three physi-
cians available 24/7, as well as by nurses and mental health professionals. A patient can be managed routinely by his primary care physician, and then referred when necessary to a CVS center cognizant of his history, he added.

The Cyclic Vomiting Syndrome Association (www.cvsonline.org) is establishing a referral network and provides resources for physi-
cians who want to learn more about the syndrome.

Knowledge, Patience Key to Managing the Four Phases of Cyclic Vomiting Syndrome

A physician must be knowledgeable, accessible, pa-
ient, nonjudgmental, and quick to respond when treating adults with cyclic vomiting syndrome, Dr. Fleisher said, and follow a rational treatment plan, tai-
ored to the phase of the disease, that includes seda-
tion when symptoms rage uncontrollably.

The CVS cycle has four phases, said Dr. Fleisher, who has treated more than 350 pediatric and adult CV

The physician should help the patient regain a sense of being in control, rather than being at the mercy of CV

The symptoms to those of an “adrenergic storm” seen in patients with pheochromocytoma. Patients begin to fall into a vicious cycle of anticipatory anxiety, whereby the worry about having a CVS episode in-
creases the likelihood of another attack.

Some CVS patients have a propensity to both mi-
grenes and anxiety/panic attacks. A careful medical history can help physicians recognize the pathogenic factors specific for each patient, leading to an ap-
propriate preventive strategy.

In the prodromal phase, the physician and patient have the chance to abort the emetic phase. In Dr. Fleisher’s group, 93% had recognizable prodromes; common symptoms included nausea, sweating, epi-
gastic pain or pressure, fatigue or weakness, feeling hot or cold, cramping urge to defecate, abdominal pain, shivering or shakiness, insomnia, food aversion, pal-
pitations, irritability, and panic.

Depending on the symptom, appropriate medica-
tions during the prodrome include lorazepam, alper-
zolam, and/or ondansetron orally or sublingually for nausea, analgesics for abdominal pain, antianxiety medica-
tions for anxiety, and a triptan for headaches. Sleep may also be beneficial.

During the emetic phase, the goal is to rapidly ter-
minate the episode, preferably within 1 hour of onset. In a sample of 39 adults with CVS, more than half had vomited emetic episodes lasting 3 days or more. Steps to take include prevention of dehydration with IV fluids, and IV administration of antiepileptics, antianxiety agents, and H2-receptor blockers or pro-
to-pump inhibitors. In some cases, IV opiates are necessary for pain control. Patients should be checked for electrolyte depletion, ketany, herniation, and se-
cretion of inappropriate antidiuretic hormone.

If the CVS episode cannot be terminated, Dr. Fleisher recommends sedating the patient in a dimly lit and quiet room until the episode passes. A CVS patient needs to know there is an escape hatch that gets them out of their misery. Without that, the more they will suffer and the more they will coalesce,” Dr. Fleisher said, referring to the process in which CVS episodes become more and more frequent. He rec-
mends chlorpromazine (0.5-1.0 mg/kg) plus diphen-
hydratine (0.5-1.0 mg/kg) in normal saline over 15 minutes, which can be repeated as often as every 3-4 hours if needed.

The duration of the recovery period reflects the ad-
equacy of management of the emetic phase. Patients with severe fluid or electrolyte deficits will have a more difficult and prolonged recovery. Some patients can tolerate a normal diet soon after the emetic phase passes, while others will tolerate only clear liquids.

“Long waits in emergency rooms, encounters with caregivers who are unfamiliar with CVS, receiving im-
possible diagnoses, the repetition of di-
gnostic procedures, and stopgap intravenous hydration followed by being sent home still sick are common ex-
periences that reinforce patients’ feelings of being out of control of an illness that no one understands or can treat,” Dr. Fleisher wrote in a 2005 report on the 41 pa-
tients (see www.biomedcentral.com/1741-7015/3/20).