Emotions, aerophagia and severe abdominal distension in an elderly person

SIR—Excessive air-swallowing and severe abdominal distension may occur in association with several medical conditions [1] but is mostly seen in mentally retarded patients. It is unusual as a manifestation of self-injurious behaviour in older people.

A widowed 71-year-old patient was admitted to the geriatric ward with a suspected vertebrobasilar stroke. He had mild Parkinson's disease controlled by amantadine, moderate cognitive impairment and mild depression treated with doxepin and sulpiride. He complained of dizziness and unsteadiness. Neurological evaluation was normal except for extrapyramidal signs, as was a brain computed tomography scan. Doxepin and sulpiride were stopped as they may have been aggravating his symptoms. His condition improved, but he was unwilling to be discharged. Shortly after being asked to go home, he became restless and started stereotyped air-swallowing which resulted in severe abdominal distention (Figure 1). He was treated by fluids and a duodenal tube. This was removed 3 days later, but was re-inserted three times because of recurrent abdominal distention. During this period, the patient had spontaneous bowel movements.

Psychiatric evaluation revealed no depressive features, but an avoidant and antisocial personality disorder. Blood tests and a complete gastrointestinal tract investigation were normal. Passage of barium showed no delay, but very large amounts of air were observed. The doxepin and sulpiride were resumed and the patient reassured about his future placement. This resulted in rapid improvement of mood, cessation of swallowing movements and a resolution of abdominal distension.

We presume that this case of aerophagia was triggered by a functional psychiatric decompensation and stress associated with hospitalization, that ultimately resulted in this self-injurious abnormal behaviour pattern. This may also be supported by the fact that, despite re-administration of doxepin (with its known anticholinergic effects), there were no further

Figure 1. Severe gaseous distention involving stomach (left) and large bowel (right).


episodes of distention. We suggest that emotional distress and decompensation are carefully considered in elderly people presenting with gaseous abdominal distention.

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Still's disease in an 80-year-old woman

SIR—Adult-onset Still's disease (AOSD) was first described by Bywaters who reported 14 adult patients with features similar to the systemic form of juvenile rheumatoid arthritis [1]. Many case series have since been published [2-5]. The disease has an equal sex incidence and in most patients onset is between the ages of 16 and 35 years. The oldest reported patient with AOSD was a 75-year-old Japanese woman [6]. We report a patient who first presented with fever, arthritis, liver dysfunction, hepatosplenomegaly and leucocytosis at the age of 80. The diagnosis of AOSD was made after careful exclusion of malignant, granulomatous and infective causes.

The patient presented with intermittent fever and asymmetrical polyarthritis involving the left knee, right elbow, both wrists and the metacarpophalangeal joints. There was no sore throat, morning stiffness, or limb girdle symptoms. Three months earlier, she had had a transient rash over both shins which was diagnosed as erythema nodosum by a general practitioner. No skin biopsy was performed.

On admission, physical examination revealed mild synovitis of the involved joints. There was no rash, subcutaneous nodules or lymphadenopathy. Abdominal, cardiovascular and chest examination were unremarkable. She had had an intermittent fever. Repeated cultures of blood, urine and sputum were negative and paired viral titres, Weil-Felix and Widal tests were not informative. The chest X-ray was normal and sputum for acid-fast bacilli were negative. A Mantoux test was negative. Her blood counts, serum biochemistry and immune marker test results are shown in Table 1.

An ultrasound of the hepatobiliary system showed gall stones but normal bile ducts. An endoscopic retrograde cholangiopancreatogram was normal. A liver biopsy (to exclude granulomatous disease) was unremarkable. She was a non-drinker and her serology for hepatitis A, B and C was negative. Screening for underlying malignancies including a gynaecological and ear, nose and throat examination was negative. A computed tomography scan of the abdomen and pelvis showed radiological hepatomegaly and splenomegaly (12 cm) but no lymphadenopathy or mass lesions. A 24-h urine did not show any protein loss. A 5-day stool for α-1-antitrypsin clearance to exclude protein-losing enteropathy as a cause of the low serum albumin concentration was normal. Investigations for the cause of anaemia did not demonstrate any gastrointestinal blood loss or haemolysis. A bone marrow biopsy was performed because of the persistent fever and anaemia. The smear and culture of the marrow blood for acid-fast bacilli were negative and the marrow morphology favoured the diagnosis of anaemia of chronic disease. A gallium scan did not reveal any foci of increased uptake. X-rays of the involved joints did not show any erosions or bony ankylosis, although some degeneration with osteophyte formation was evident in both knees.

AOSD was diagnosed by exclusion and the patient was started on Naprosyn (250 mg three times daily). She responded dramatically with the subsidence of fever after the first dose and the arthritis gradually improved. She remained afebrile over the next few days and was discharged. There was no relapse of fever or arthritis on follow-up for 11 months and her C-reactive protein, erythrocyte sedimentation rate and ferritin concentrations returned to normal.

This patient presented with fever of unknown origin, arthritis, hepatosplenomegaly, leucocytosis and liver function abnormalities. Extensive investigations did not identify any haematological malignancies or infective causes. Follow-up for 11 months did not reveal any conversion to an autoimmune disorder or the development of malignancy. Although the presentation was atypical, we believe that the diagnosis of AOSD was correct because she fulfilled the diagnostic criteria proposed by Yamaguchi et al. [7] (with five features). Differential diagnoses include polymyalgia rheumatica and seronegative rheumatoid arthritis. The absence of girdle stiffness or coexisting temporal arteritis, and the marked response to Naprosyn, made the former unlikely. Moreover, the patient did not meet the American College of Rheumatology criteria for rheumatoid arthritis [8]. Serum ferritin concentration has been described as a useful diagnostic tool for AOSD [9]. Very high ferritin concentration can be detected in patients with AOSD during the active phase of the disease. Our patient was indeed hyperferritinaemic but the ferritin concentration was only 3-4 times normal. The ferritin concentration and other markers of the acute phase response returned to normal on subsequent visits.

This is the oldest person with AOSD reported in literature. AOSD in elderly patients may present atypically. A rash may not be present, the fever may