Results: A 71 year old man presented to hospital with a 3 week history of persistent hiccoughs. The onset was initially intermittent, but had become continuous with disturbance of sleep. He also reported a maculopapular purpuric rash which had appeared one week earlier on the medial aspect of the right knee and had progressed to involve both thighs and lower abdominal wall. He was haemodynamically stable and apyrexic. His background was of adult onset asthma (diagnosed aged 39 years, lifelong non-smoker), bronchiectasis, nasal polyposis and progressive hearing loss with bilateral myringotomies and hearing aid provision 7 years prior to this presentation. He had been discharged from the acute medical unit 5 weeks earlier after an episode of fast atrial fibrillation, congestive heart failure and lower respiratory tract infection. An echocardiogram at that stage detected a pericardial effusion and severely impaired right ventricular function. Left ventricular function was satisfactory. Blood investigations showed elevated inflammatory markers (ESR 44 mm/h, CRP 10.7 mg/l). He had a leucocytosis of 29 x 10^9/l with 70% eosinophils (20 x 10^9/l). Normochromic normocytic anaemia, haemoglobin 83 g/l. Normal serum creatinine. Blood and protein detected on dipstick urinalysis. ANCA negative. The rash was biopsied confirming eosinophil rich leucocytoclastic vasculitis. CT of chest, abdomen and pelvis detected scattered mediastinal lymph nodes and chronic bronchiectasis but no new pulmonary infiltrate. A diagnosis of eosinophilic granulomatosis was made and he was commenced on oral prednisolone 40 mg/day. He responded swiftly with gradual resolution of the rash over the next 7 days. His hiccoughs, which were intractable by that stage; ceased completely within 48 hours. Follow up echocardiogram showed resolution of pericardial effusion and recovery of right ventricular function. Two weeks after commencing corticosteroid therapy he also noted a marked improvement in his hearing. Peripheral eosinophil count had fallen to 0.02 x 10^9/l.

Conclusion: A hiccough is an involuntary, intermittent, spasmodic contraction of the diaphragm and intercostal muscles. Several neural pathways are involved. Causes of persistent hiccoughs include CNS disorders and irritation of the phrenic and vagus nerve. The onset of hiccoughs in this case occurred alongside marked serum eosinophilia, vasculitic rash and cardiomyopathy and must be considered a heralding symptom of acute EGPA. This is further supported by rapid response to induction corticosteroid therapy.

Disclosure statement: The authors have declared no conflicts of interest.

2. A CURIOUS CASE OF HICCUGHS: UNUSUAL PRESENTATION OF EOSINOPHILIC GRANULOMATOSIS WITH POLYANGITIS

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Background: We report a case of eosinophilic GPA (EGPA) presenting with persistent hiccoughs. The diagnosis was based on clinical and histological findings. Induction treatment with corticosteroids led to clinical improvement and rapid resolution of hiccoughs. Hiccoughing has never before been associated with acute EGPA and may reflect involvement of the phrenic and/or vagus nerves.

Methods: We describe the acute hospital admission and follow up.