Poster Abstracts

PO-27

DELAYED RECOGNITION OF CANNABINOID HYPEREMESIS SYNDROME: AN EIGHT-YEAR JOURNEY

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INTRODUCTION: Cannabis hyperemesis syndrome (CHS) is unfamiliar in medical practice worldwide. We report a Thai chronic cannabis smoker with delayed CHS diagnosis who received excessive invasive investigations and unnecessary treatments.

CASE REPORT: A 27-year-old Thai man with history of chronic cannabis smoking presented to our hospital with abdominal pain, refractory vomiting, hypokalemia and hypertension 8 years ago. His symptoms were not improved and occasionally got worse so he underwent esophagogastroduodenoscopy (EGD) 3 times despite negative findings. He was diagnosed as irritable bowel syndrome (IBS) for one year but his symptoms were not responsive to standard medications for IBS. Eventually he developed severe colicky abdominal pain, diarrhea and had lost 3 kilograms within a month hence he was admitted. His physical examinations were normal except low body mass index (17.99 kg/m^2). Laboratory results demonstrated hypokalemia (2.9 mmol/L), hypochloremia (90 mmol/L), HCO_3 25 mmol/L, anion gap 20 mmol/L, high urine specific gravity (1.021), ketonuria and proteinuria. Urine toxicology screening was positive for cannabinoid but negative for amphetamine and opiates. He admitted that he had smoked cannabis more intensively for few months and the last usage was 3 days before arrival. He was diagnosed cyclical vomiting syndrome (CVS) and depressive disorder, however the attending physician consulted to our poison center as CHS was suspicious. The patient received intravenous fluid, analgesics and antiemetics. His symptoms were gradually improved and he was discharged on hospital day 9 with oral antiemetics as home medication. He felt better but after he returned home for 3 weeks, his symptoms were relapsed briefly but intensively that required medical attention at out-patient unit. He denied using cannabis and cannabinoid was negative in urine. He completed recovery at 6 weeks and gained weight up to normal body mass index.

DISCUSSION: Our patient's symptoms were consistent with CHS supported by the temporality and full recovery after cannabis cessation for 6 weeks. The diagnosis was not suspicious hence he underwent unnecessary invasive investigations during the past 8 years. CHS's diagnosis is done by exclusion. Patients will improve clinically within days after cannabis cessation and symptomatic treatment. Multidisciplinary approach is recommended as long term cannabis cessation is the main objective of treatment.

CONCLUSION: CHS has been described and reported in medical literature, however it is unknown amongst healthcare professionals resulting in delayed diagnosis and management as well as unnecessary invasive investigations.