Case reports in abdominal pain

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Abstract: Abdominal epilepsy is an uncommon syndrome in which gastrointestinal complaint results from seizure activity (1). It is well documented among children but is recognized only infrequently in adults (2). Abdominal symptoms are one of the most common initial symptoms of complex partial seizures. The cortical representation of autonomic innervation is usually localized in the insula. Epileptic focus in this locality can very rarely cause epileptic seizures with abdominal symptoms without any other features typical of epilepsy (3). Three cases of abdominal epilepsy in adults were reported in my private clinic. The diagnosis was based on detailed history, proper clinical examination and exclusion of any underling organic cause, after several investigations including EEG test. All three cases responded to anticonvulsant therapy without any recurrence of symptoms for several months.

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Case 1

An eighteen years old boy presented to my private clinic complaining of sever central abdominal pain, diffuse and continuous, and was associated with nausea and vomiting. His condition has been recurring for 10 years, during which he consulted with many doctors with no successful diagnosis.

I gave him antiemetic and Tramadol 100mg by intramuscular injection to relieve his condition, but with little benefit. A thorough examination and appropriate tests were done, including general urine examination (GUE), general stool examination (GSE) blood sugar, and ultrasound (U/S) examination. All results were negative (-ve).

At the beginning I thought that he might have familial Mediterranean fever (F.M.F) and kept him on colchicine 1mg/daily. I followed him for one month, but his condition recurred, without any improvement.

While examining his detailed history, his mother stated that her son's condition usually occurs either at the beginning or at the 10_{th} day of each month. This rhythm of attack with the same type of pain renders a diagnosis of abdominal epilepsy more likely. Hence, I sent him for electroencephalography (EEG), but the result was (–ve). In spite of this result, I put the patient on valproic acid 200mg X2daily and followed him for one month. The condition has completely disappeared and did not recur for the past 8 months.

Case 2

A twenty four years old female checked-in with an acute attack of periumbilical pain cramping and persistent, associated with nausea and vomiting. Patient's history reveals that she has some psychological related insomnia. Diagnostic procedures were performed, including (U/S) of the abdomen, but were all -ve.

Initially, I diagnosed the patient as psychogenesisdyspepsia and gave her some sedative drug.

A week later, the patient came back with the same cramping abdominal pain. A detailed examination of her history revealed that the pain usually occurs in the evening or at midnight, and recurs 1-3 times per week. It also suggests that the severity is not consistent with psychogenic dyspepsia.

I sent her for (EEG) but she did not do the test until several days later. The EEG result depicts a characteristic epileptic seizure.

I gave her valproic acid 200mgx2/day and had her under observation for 2 weeks. The condition totally disappeared and did not recur since 3 months. The patient became well and fully recovered.

Case 3

A 22 years old boy came with cramping abdominal pain without vomiting. The pain lasts for 15 min. then, disappears spontaneously. The condition occurs once or twice a month. Some physicians diagnosed his condition as abdominal spasm or psychogenic dyspepsia but with no response to treatment.

Results of all investigations were normal, but the previous 2 cases remind me of abdominal epilepsy. Therefore, I sent the patient for EEG which showed a characteristic pattern of epileptically seizure. I prescribed anti convulsing with valproic

acid 200mg twice daily which cured him completely with no recurrence for the past 4 months.

Conclusions

Abdominal epilepsy is not a rare disease and should be considered in differential diagnosis of recurrent abdominal pain without any underling organic disease especially if the pain recurs with the same severity and quality. Patient should be sent for EEG. However, even if the EEG result is normal, it remains better to give a therapeutic trial of anticonvulsant therapy in order to exclude abdominal epilepsy.

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