



EDITOR'S
CHOICE

A hiccup in holiday plans

Mark Goldin,¹ Zachary Hahn²

¹North Shore-LIJ Health System, New Hyde Park, New York, USA

²Hofstra North Shore-LIJ School of Medicine, Hempstead, New York, USA

Correspondence to
Dr Mark Goldin,
mgoldin@nshs.edu

Accepted 6 December 2015

DESCRIPTION

A 35-year-old man presented with 5 days of persistent hiccups and vomiting just prior to a major holiday. Twice in the past month he had visited the hospital for hiccups and had experienced no relief with chlorpromazine. This time he noted left-sided paraesthesias, previously attributed to existing C3–5 disc herniation. Physical examination revealed left-sided pronator drift, left index finger past-pointing, left upper extremity numbness and inability to ambulate due to imbalance. Routine laboratory studies were normal, although head CT and subsequent MRI revealed a C2 intramedullary mass with associated cystic structure extending from the fourth ventricle to C7 (figure 1). Over the holiday he developed blurry vision, dysphagia and night sweats. Expedited neurosurgery led to removal of a grossly orange tumour at C2 with decompression of cystic structures. The patient ambulated on postoperative day 1 and was discharged home with outpatient occupational therapy on postoperative day 4. Pathology was consistent with a diagnosis of haemangioblastoma (figure 2). Three-month follow-up MRI showed no recurrence, with resolution of postoperative changes.

Stimulation/irritation of any component of the hiccup reflex arc (phrenic and vagus afferents to phrenic and central midbrain nuclei, then phrenic efferents to respiratory muscles) will produce

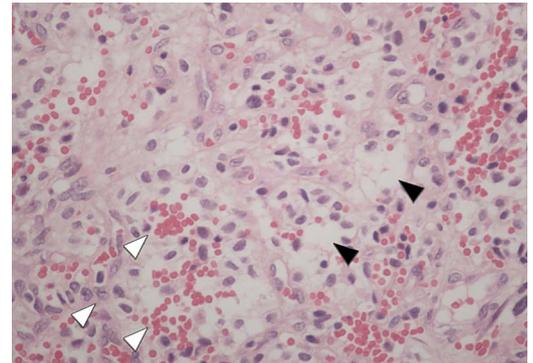


Figure 2 Pathology specimen consistent with a diagnosis of haemangioblastoma. Whit arrowheads indicate a mixture of spindle and clear cells with rich vascular network. Black arrowheads indicate clear cell features due to high cellular lipid content. Must rule out metastatic renal cell carcinoma.

hiccups, and thus a broad differential must be considered.^{1–3} Metabolic derangements, nerve compression/irritation, central nervous system lesions and medications can be triggers. It is important to recognise that short bouts of hiccups are benign; however, protracted (>48 h) or intractable (>1 month) hiccups almost always have an underlying pathology and can be associated with significant morbidity or death.^{2–3}

Contributors The authors contributed equally to the preparation of this manuscript. MG was the physician of record who managed this case, and he will serve as guarantor for the manuscript.

Competing interests None declared.

Patient consent Obtained.

Provenance and peer review Not commissioned; externally peer reviewed.

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Figure 1 T1-weighted MRI, midline sagittal cut; arrow indicates solid tissue nodule of the haemangioblastoma (left). T2-weighted MRI, midline sagittal cut; arrows indicate extensive cystic structure of haemangioblastoma (right).



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To cite: Goldin M, Hahn Z. *BMJ Case Rep* Published online: [please include Day Month Year] doi:10.1136/bcr-2015-213288

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