same background and same personality. In my opinion, he will be back. And what he needs is an understanding and supportive general practitioner who will try to nurse him through the next medicalised crisis, avert hospital admission whenever possible, and try to protect him from unnecessary investigations. Forget the much abused "insight" and other terms that negatively imply that it is all in the patient's mind. It may have a psychological basis, but his pain and suffering are real.

He is clearly a high achiever, with good grades and peer recognition at school, and someone who is already showing leadership skills. He is likely to be successful in his chosen profession. But no one has everything. You can give it a nice medical title if you wish, but it is just the way he is. As he gets older, it is possible that he will, at different times, be anxious about various lumps and bumps, have different types of chest pain, worry about his bowels, and have many investigations. If that happens, a good general practitioner will be there to listen. What is most frightening about patients with this sort of recurrent presentation is that some day they will have something serious and, in all the medical clutter, it might be missed.

Competing interests: None declared.

1 Fox M, Young A, Anggiansah R, Anggiansah A, Sanderson J. A 22 year old man with persistent regurgitation and vomiting: case outcome. *BMJ* 2006;333:133.

Commentary: A clinical challenge

Robert Logan

Several learning points arise from Mr Neville's case.[1] The most important relates to the diagnostic approach when we are challenged with pieces of a clinical puzzle that do not neatly fit together.

Gastro-oesophageal reflux disease usually poses few diagnostic challenges, especially when there is a good symptomatic response to empirical anti-secretory therapy. However, in this case, Mr Neville's poor response to treatment and persistent symptoms led to further investigation and several protracted stays in hospital. The normal oesophageal manometry and lower oesophageal sphincter pressures were an appropriate trigger for further investigations to eliminate underlying organic disease, especially distal obstructing lesions or intermittent torsion of a hiatus hernia (although symptoms are more typically episodic with a hernia).

As with difficult to diagnose diarrhoea, admission to hospital provided the main clue to the final correct functional diagnosis. The importance of the careful clinical observations made while Mr Neville was eating cannot be emphasised enough. It is difficult to judge to what extent the possible underlying psychological components confounded the diagnosis, but seeking a second opinion from a fresh perspective is often very helpful when faced with a diagnostic challenge. More generally, patients and their doctors often mistakenly refer to regurgitation as vomiting, without recognising the importance of differentiating between the effortless nature of the former in contrast to most causes of vomiting.

Managing patients with psychological disorders

The other important learning point illustrated by this case is how to deal with patients who have potentially insoluble problems. One approach is to ask patients about their concerns or thoughts about the diagnosis. Another, not possible in this case, is to offer to review and repeat tests at some future time. Although it is essential always to be sympathetic and understanding, adopting the most appropriate approach to patients in whom underlying psychological problems may be contributing to their symptoms is fraught with difficulties and is a real challenge for the clinician.

A useful approach is to mention the importance of the "brain-gut axis" in functional gastrointestinal disorders at the outset. In this case, sharing the results of the impedance measurements together with getting Mr Neville to place his hand on his abdomen was a neat method of providing the patient with an opportunity to gain immediate insight into his problems. I suspect that the patient's sense of relief as his symptoms resolved and his weight increased was similar to that of his doctors.

Competing interests: None declared.

1 Fox M, Young A, Anggiansah R, Anggiansah A, Sanderson J. A 22 year old man with persistent regurgitation and vomiting: case outcome. *BMJ* 2006;333:133.

Department of Gastroenterology, King's Mill Hospital, Sutton-in-Ashton NG17 4JL
Robert Logan *consultant*
robert.logan@nottingham.ac.uk

Corrections and clarifications

Minerva

Several readers spotted Minerva's assertion, in her second item in the 17 June issue, that lithium is a divalent ion (*BMJ* 2006;332:1460). It is in fact a monovalent ion (unlike calcium, which, as she said, is divalent).

Rational prescribing for children

An authors' oversight in this editorial by Alastair G Sutcliffe and Ian Chi Kei Wong (*BMJ* 2006;332:1464-5, 24 Jun) led to Dr Sutcliffe having the wrong email address: this should have been a.sutcliffe@medsch.ucl.ac.uk.

Review of NICE's recommendations, 1999-2005

Our editing of the author's comments on assessment of non-drug technologies made them more definitive than intended and not strictly true (*BMJ* 2006;332:1266-8; 27 May). The published article, by James Raftery, said that Australia did not have a body that assessed health technologies. In fact, the Medical Services Advisory Committee in Australia and the New Zealand Health Technology Assessment Unit both have some form of assessment of non-drug technologies.

Obituary

We managed to make a nonsense of the date of death for Helen Ann Adam (*BMJ* 2006;332:1456, 17 Jun). She did die on 26 December, but in 2005, not in 2006.

Editor's choice

In her column in the *BMJ* issue of 24 June, the journal's editor, Fiona Godlee, slipped up in her assertion that a recent *BMJ* study showed that "One in 10 [patients aged over 45 who developed new rectal bleeding] had colon cancer." In fact, 1 in 10 of the patients developed bowel neoplasia, and about half of these neoplasms were cancer. The study was by Jennifer du Toit and colleagues (doi:10.1136/bmj.38846.684850.2F).