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Summary

Rumination syndrome

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UEG Week Barcelona 2026 | Presentation

Small Intestine & Nutrition | Surgery | Neurogastroenterology & Motility

October 19, 2026

Rumination syndrome is frequently missed because clinicians do not specifically ask about the characteristic pattern of effortless, repetitive regurgitation starting within minutes of eating, leading to years of unsuccessful treatment for misdiagnosed reflux or gastroparesis.

KEY POINTS

- The speaker recommends diagnosing rumination primarily through targeted history-taking, asking specifically about effortless post-meal regurgitation that patients can re-swallow, which distinguishes it from vomiting or GERD.
- The speaker reported that approximately 20% of PPI non-responders and 55% of confirmed GERD patients who failed PPI therapy also showed rumination in studies.
- Postprandial high-resolution impedance manometry can confirm diagnosis when history is uncertain or overlap syndromes are suspected, using a standardized meal with at least 30-60 minutes of postprandial recording.
- The speaker stated that diaphragmatic breathing is the best-supported first-line behavioral treatment, working as a competing motor response to interrupt the learned abdominal contraction pattern.
- The speaker noted that 93% of rumination patients have at least one psychiatric comorbidity and overlap with other disorders of gut-brain interaction is common, requiring multidisciplinary management.
- Baclofen three times daily may be added when behavioral therapy alone is insufficient, according to the speaker, while neuromodulators are reserved for treating overlapping functional GI disorders rather than the rumination mechanism itself.

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