

Gastroparesis

APRIL 2019

TO THE EDITOR: We read with great pleasure the article by Sharayah et al about acute gastroparesis in a patient with diabetic ketoacidosis.¹ However, in the case description, the authors reached a diagnosis of gastroparesis secondary to diabetic ketoacidosis without aptly ruling out some of its most common causes such as hypokalemia and other electrolyte imbalances seen in diabetic patients (in the setting of recurrent vomiting).

The authors also did not include the patient's duration of diabetes or hemoglobin A_{1c} level, both of which are linked with gastroparesis in diabetic patients.² Pertinent biochemical information that can help readers formulate a rational approach and journey to making a diagnosis appears elusive in their article.

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■ REFERENCES

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IN REPLY: We thank the readers for their letter. Our patient's laboratory values at the time of presentation were as follows:

- Corrected sodium 142 mmol/L
- Potassium 5.5 mmol/L
- Phosphorus 6.6 mmol/L.

The rest of the electrolyte levels were within normal limits.

These reported electrolyte levels were unlikely to cause such gastroparesis. The patient's hemoglobin A_{1c} was 8.7% at the time of presentation, with no previous values available. However, since abdominal computed tomography done 1 year before this presentation did not show stomach dilation and the patient was asymptomatic, his gastroparesis was presumed to be acute.

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