Your chronic GI patients: Don't overlook this key dietary history detail

Written by The Life Science Feed Editorial Team · Published 7 August 2026 · Edited by Mara Voss

> Clinicians routinely encounter patients presenting with chronic, debilitating symptoms that defy conventional diagnosis and treatment. The diagnostic journey often involves extensive investigations, specialist referrals, and a careful review of lifestyle factors. But what happens when the root cause is not a rare disease or an elusive pathogen, but a deliberate, if misguided, personal choice?
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> This case, widely discussed in medical circles, illustrates a physician's protracted struggle with severe gastrointestinal symptoms, ultimately traced back to a dietary habit maintained for an unusual and frankly, unappetizing, reason.

KEY TAKEAWAYS

- The Pivot: A physician's chronic, severe gastrointestinal symptoms were self-induced by a specific, unusual dietary habit.
- The Data: The patient's symptoms resolved completely upon cessation of the offending dietary practice.
- The Action: Thorough dietary history, including seemingly unusual practices, is critical in diagnosing chronic GI complaints, even in medical professionals.

Chronic gastrointestinal complaints represent a significant burden on healthcare systems and individual patients, often leading to a cascade of investigations, specialist consultations, and empirical treatments. Conditions such as irritable bowel syndrome, inflammatory bowel disease, and various malabsorption syndromes are common culprits, each requiring a systematic diagnostic approach. The challenge intensifies when standard diagnostic pathways yield no clear answers, pushing clinicians to explore more nuanced aspects of a patient's life, including dietary habits, stress levels, and medication use.

This particular case involved a physician, a male in his 40s, who presented with a constellation of severe and persistent gastrointestinal symptoms. His complaints included chronic abdominal pain, severe bloating, recurrent episodes of nausea and vomiting, and significant changes in bowel habits, oscillating between intractable diarrhea and severe constipation. These symptoms had been ongoing for several years, progressively worsening to the point of significantly impairing his professional and personal life. He reported substantial weight loss and fatigue, further contributing to his overall debilitated state. The patient, being a medical professional himself, had initially attempted self-management and had undergone a series of preliminary investigations, all of which were unrevealing.

The Diagnostic Odyssey and Unconventional Habits

The patient's initial workup, performed by various gastroenterologists, was comprehensive. It included multiple upper endoscopies and colonoscopies, both with biopsies, which showed no evidence of inflammatory bowel disease, celiac disease, or malignancy. Imaging studies, such as abdominal CT scans and MRI enterography, were also unremarkable, ruling out structural abnormalities or significant inflammatory processes. Blood tests, including complete blood counts, inflammatory markers (ESR, CRP), liver function tests, pancreatic enzymes, and serological markers for celiac disease, were all within normal limits. Stool studies for infections, parasites, and occult blood were consistently negative.
Despite this extensive diagnostic effort, the patient's symptoms persisted, leading to increasing frustration and a sense of diagnostic futility for both the patient and his treating physicians.
Given the lack of objective findings, the focus shifted to functional gastrointestinal disorders, such as irritable bowel syndrome (IBS). However, the severity and relentless progression of his symptoms, coupled with significant weight loss, made a pure functional diagnosis less convincing. The patient had been prescribed various symptomatic treatments, including antispasmodics, antiemetics, and laxatives, with minimal and transient relief. Dietary modifications, such as a low-FODMAP diet, had also been attempted without sustained improvement, further deepening the diagnostic conundrum. The patient's medical history was otherwise unremarkable, with no significant comorbidities or regular medications that could explain his symptoms.
During a particularly detailed history-taking session, a new physician, frustrated by the lack of progress, pressed the patient on every conceivable aspect of his daily routine, including highly specific dietary practices. It was during this exhaustive inquiry that the patient reluctantly revealed a peculiar habit. For several years, he had been consuming a significant quantity of his own nasal mucus, describing it as a 'gross' but deeply ingrained habit. He admitted to doing this multiple times a day, often without conscious thought, and had never considered it relevant to his gastrointestinal symptoms, nor had he ever disclosed it to previous clinicians due to embarrassment.

The Mechanism of Self-Induced Illness

The revelation of this unusual dietary intake immediately provided a plausible, albeit unconventional, explanation for his chronic symptoms. Nasal mucus, while primarily composed of water, mucins, proteins, and salts, also contains a host of other substances. These include trapped environmental particles, allergens, bacteria, viruses, and inflammatory mediators. The sheer volume of mucus ingested daily, combined with its variable composition, could plausibly irritate the gastrointestinal tract. The stomach, designed to handle food and digest pathogens, might be overwhelmed by a constant influx of this material, particularly if it contained a high bacterial load or irritants.
The mechanical irritation from the mucinous material itself could contribute to abdominal discomfort and bloating. Furthermore, the presence of various microorganisms, even commensals from the nasal cavity, could disrupt the delicate balance of the gut microbiome, leading to dysbiosis. This dysbiosis, characterized by an imbalance of beneficial and harmful bacteria, is increasingly recognized as a contributor to a wide range of gastrointestinal symptoms, including pain, bloating, and altered bowel habits. The continuous ingestion of potentially inflammatory substances could also trigger a low-grade inflammatory response within the gut, contributing to the chronic nature of his symptoms.
The patient's symptoms, including nausea and vomiting, could be a direct consequence of gastric irritation or a reflex response to the ingested material. The alternating diarrhea and constipation could be explained by the fluctuating impact on gut motility and water absorption, influenced by the volume and composition of the ingested mucus. The weight loss, a concerning symptom, could be attributed to malabsorption secondary to chronic gut irritation, reduced appetite due to

persistent nausea, or simply the body's increased metabolic demand in response to chronic inflammation or irritation. The patient's own medical knowledge, ironically, may have led him to dismiss this habit as a cause, focusing instead on more conventional pathologies.

Resolution and Clinical Takeaways

Upon understanding the potential link between his habit and his symptoms, the patient was advised to immediately cease the ingestion of nasal mucus. This intervention, while seemingly simple, required significant effort from the patient to break a long-standing habit. He was provided with strategies to manage nasal secretions, including saline rinses and behavioral techniques to interrupt the habit. The patient was also offered psychological support to address the underlying reasons for maintaining such a habit, though he declined, stating that the motivation to alleviate his debilitating symptoms was sufficient.

The results were striking. Within weeks of discontinuing the habit, the patient reported a significant reduction in his abdominal pain, bloating, and nausea. His bowel habits began to normalize, and the episodes of vomiting ceased entirely. Over the next few months, his symptoms continued to improve, eventually resolving completely. He regained the weight he had lost and reported a dramatic improvement in his energy levels and overall quality of life. This rapid and complete resolution upon cessation of the habit provided compelling evidence that the ingested nasal mucus was indeed the primary driver of his prolonged and severe gastrointestinal distress.

This case underscores several critical points for clinical practice. First, a thorough and non-judgmental history-taking process is paramount, particularly when faced with chronic, unexplained symptoms. Clinicians must be prepared to ask about unusual habits, even those that patients may find embarrassing or irrelevant. Second, the human body's response to chronic, low-level irritation or unusual dietary inputs can be profound and mimic more serious pathologies. The gut microbiome's sensitivity to external factors means that even seemingly innocuous substances, when consumed consistently and in quantity, can have significant effects. Finally, this case serves as a reminder that even medical professionals, with their inherent understanding of physiology and disease, can fall prey to self-induced conditions, often due to a blind spot regarding their own habits or an unwillingness to disclose them. For a comprehensive understanding of such intricate cases, a reliable clinical reference like the Oxford Handbook of Clinical Medicine can be invaluable.

> **CLINICAL IMPLICATIONS**
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> This case is a stark reminder that the most obvious answers are sometimes the ones patients, and even clinicians, are most reluctant to acknowledge. It highlights the critical importance of a truly exhaustive history, pushing beyond the standard questions to uncover habits that might seem irrelevant or embarrassing to the patient. The diagnostic yield of a thorough, non-judgmental inquiry often far surpasses that of expensive, invasive investigations.
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> For general practitioners and specialists alike, the lesson is clear: when faced with intractable symptoms and negative workups, the problem may not be an obscure pathology but rather an unusual, self-imposed exposure. This requires a level of trust and rapport that allows patients to disclose even their most 'gross' habits without fear of judgment. It is a testament to the fact that sometimes, the simplest intervention, once identified, can yield the most profound results.
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> The patient's professional background as a physician adds another layer of complexity. Even those with

> medical knowledge can develop blind spots regarding their own health, or perhaps, a reluctance to admit to behaviors they know are unconventional. This case should prompt clinicians to consider that even their most informed patients might be withholding crucial information, not out of malice, but out of shame or a genuine misunderstanding of its relevance.

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