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Case Report

Trichobezoar: A Surgical Case Report

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Abstract

Trichobezoars, or a foreign body mass containing hair, are found in the gastrointestinal tract and are generally formed from the ingestion of hair. Frequently, such cases present in young women with history of trichotillomania and other psychiatric illnesses. They can also present during states of gastric dysmotility and previous gastric surgery. Though it is an uncommon condition, gastric trichobezoars must be regarded among the differential diagnoses in females presenting with vague epigastric pain. In this case report, we have incidence of a trichobezoar found in a 15-year-old teenage girl, having history of trichotillomania and trichophagia.

Keywords: *Trichobezoar, Bezoar, Trichotillomania.*

Introduction

Gastrointestinal (GI) bezoars are collections of undigested food or inedible material that have been discovered within the gastrointestinal tract. For countless years, bezoars have been found within the GI tracts of both animals and humans, most commonly within the stomach. Meaning counter poison or antidote, the term “bezoar” is a derivative of the Arabic word “badzehr” or the Persian word “panzehr”. Accordingly, these bezoars from animal stomachs were considered to possess medicinal and magical properties and were thereby used in ancient times as antidotes to various poisons and diseases. (1)

Currently, the term “Bezoar” is used to describe collections of non-digestible foreign material that often accumulates in the stomach and can extend till the small bowel. Trichobezoars are unusual conglomerates of hair that are typically found in young females with psychiatric history, who often have trichotillomania or trichophagia. Around one third of patients with trichophagia develop trichobezoars. All forms of stomach dysmotility, including diabetes mellitus, gastroparesis, prior gastric surgery and vagotomies, neurological disorders, peptic ulcer disease, gastric cancer, and hypothyroidism, are additional risk factors for the development of bezoars. (2)

In early stages, trichobezoars can lead to non-specific symptoms and later on cause symptoms of chronic abdominal pain, stomach ulceration or perforation, bleeding, intussusception and even obstruction. (3)

Trichobezoars remain to be an uncommon medico-surgical condition. In various case series, they reflect a prevalence that ranging from 0.4% to 0.6%. (2)

Case Report

A 15-year-old teenage girl was admitted with complaints of acute epigastric pain for 2 days duration and multiple episodes of vomiting on the day of admission. No history of bowel complaints or fever. She gave history of on and off epigastric pain and occasional vomiting for 1 year for which she started taking a proton pump inhibitor, Pantoprazole, after visiting a local private clinic.

Her parents provided additional history, stating that since the age of 7 to 8 years, after she shifted to a different school, the patient underwent a bit of stress and had since then been pulling hair from her scalp and was occasionally seen to be eating her hair. The parents noticed an area of baldness on one side of her scalp. In order to hide this fact from her parents, the patient began pulling hair from multiple different areas on her head so as to not raise the suspicion of continuing trichotillomania.

On examination, the patient was vitally stable, though appeared pale. Abdominal examination revealed soft and lax abdomen with tenderness in the epigastric region, negative rebound tenderness, with no abdominal distension and audible bowel sounds. No pathologic findings were detected in the patient's laboratory findings, except for iron deficiency anemia and elevated total bilirubin.

Contrast-enhanced computed tomography (CT) scan of the abdomen showed “Notable distension of the stomach harbouring intraluminal large mass of heterogenous material possibly combination of hair and entrapped food suggesting gastric bezoar”. (Figure 1)

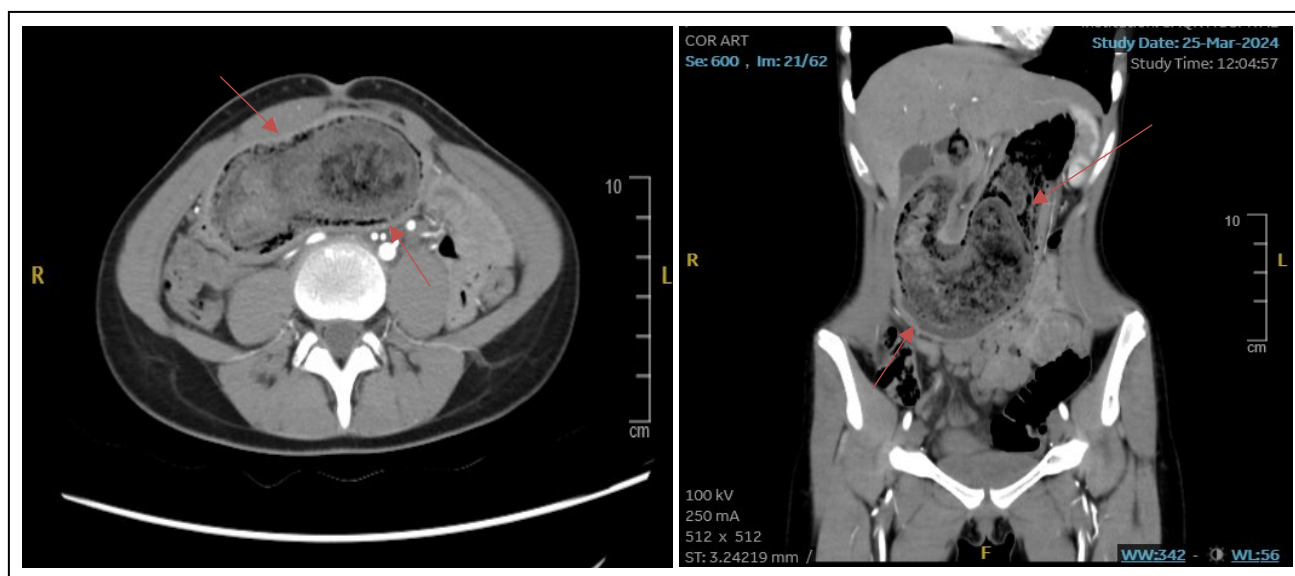


Figure 1: CT with contrast of the abdomen showing gastric bezoar (orange arrows)

Upper gastrointestinal endoscopy, under general anaesthesia, was carried out twice in order to evacuate the gastric bezoar, with failure of complete removal. (Figure 2) Only 10 percent of it could be extracted. On endoscopy, the bezoar was found to be large extending till the duodenum. It was then decided that the patient required surgical removal of the bezoar.

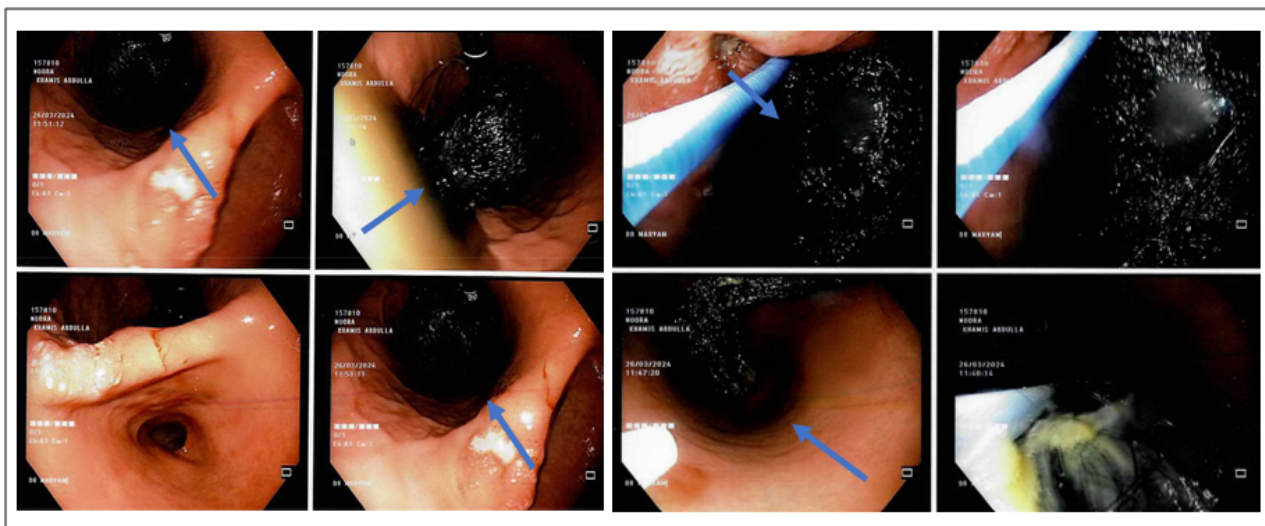


Figure 2: Upper Gastrointestinal Endoscopy showing the gastric trichobezoar. (indicated by blue arrows)

The patient was also referred for a psychiatric evaluation. History from the mother revealed that her Trichotillomania problem was more evident from 2019 onwards, and she had asked for psychological help before but never actually visited a psychiatrist. However, the parents refused a referral to CHAMPS (child and adolescent clinic).

4 days post admission, the patient underwent an explorative laparotomy. At the time of operation, a midline incision 5cm above the middle third of the distance between the umbilicus and the xiphoid was made. Once the stomach was identified in the abdominal cavity, the gastric bezoar was exposed. Careful dissection was performed to separate the bezoar from the surrounding tissue, ensuring preservation of the gastric wall integrity. The bezoar was then removed through the initial incision made. (Figure 3) No post-operative complications were noted during follow up checks. Patient was discharge on a three-day course of antibiotics, pain killers and a month course of a proton pump inhibitor, along with a psychiatric referral.



Figure 3: Surgical laparotomy for trichobezoar extraction

Discussion

A bezoar is a ball of undigested foreign material, aggregated by gastric fluid in the stomach, most often composed of hair or fibre. It collects in the stomach and fails to pass through the intestines. Previously, ancient people believed that bezoars were a type of medicine or an antidote against poisons. In the modern age, bezoars are known to be harmful and must be extracted. (4)

Bezoars rarely occur. The risk of developing a bezoar is higher in children and young females with psychological disorders. 90% of cases occur between the ages of 13 and 20 years along with trichotillomania and trichophagia. (5,6)

Additionally, bezoars or trichobezoars can be accompanied by other psychiatric diseases such as depression, anorexia nervosa, pica, obsessive compulsive disorder and pica. Untreated cases lead to deadly complications. If an early diagnosis is not established, a trichobezoar could grow continuously leading to the formation of gastric ulcers, perforation, intussusception, protein-loss enteropathy, obstructive jaundice, pancreatitis and even death. (7)

During the examination, a mass may be palpable in the upper abdomen especially if the patient has an especially large trichobezoar. An abdominal computed tomography (CT) scan demonstrates high accuracy in the diagnosis of trichobezoars and a definite confirmation can be achieved with endoscopic imaging. (8)

Bezoar extraction using either mechanical or chemical disintegration is the preferred type of treatment. For patients with milder symptoms, a trial of chemical dissolution can be initiated. If the bezoar fails to respond to the treatment or if the patient has moderate to severe symptoms, then endoscopic therapy and with gradual fragmentation can be considered. Small bezoars may be removed by non-surgically by endoscopy while larger ones require laparoscopy or laparotomy. Other therapies include ESWL (extracorporeal shock wave lithotripsy), Nd:YAG laser removal and intragastric enzyme administration however these methods are reported with varying results. (9,10)

The majority of bezoars are on the larger side and so laparotomy is considered as the treatment of choice owing to its high success rates, fairly low complication rates, and low complexity. Furthermore, the entire gastrointestinal tract can be evaluated for satellites in a short stretch of time. (11)

To prevent further episodes of bezoar formation, strict post operative precautions need to be undertaken including physical protections and psychological evaluations. Majority of these patients have underlying psychiatric or social disorders and therefore, the treatment of co-existing psychiatric illness is of utmost importance. There is a strong recommendation for frequent periodic follow up for psychiatric evaluation. (12) Reviewing the current case, our 15-year-old patient presented with history of trichotillomania and trichophagia. The trial of endoscopic retrieval presented the opportunity to visualize the regions of the gastrointestinal tract as the trichobezoar was being removed. Upon failure, an explorative laparotomy was carried out successfully with an uneventful post-operative period. Like many similar cases, this patient was also referred for regular follow ups and was given a psychiatric referral.

In conclusion, a patient coming with trichobezoar secondary to trichotillomania are generally accompanied by an underlying psychiatric disorder, and should be managed with the appropriate choice of surgical treatment along with the initiation of treatment for the psychiatric disorder.

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