CASE REPORT

HUGE TRICHOBEZOAR IN THE STOMACH OF A YOUNG FEMALE PATIENT

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ABSTRACT

A young lady of 24 years age presented with upper abdominal mass of 10 years duration. The provisional diagnosis was cyst with calcified walls following history, clinical examination and ultrasound abdomen until exploratory laparotomy was done that revealed it to be a huge trichobezoar in the stomach.

KEY WORDS: Trichobezoar; Abdominal mass; Trichotillomania.

This article may be cited as: Falah SQ, Amanullah A. Huge trichobezoar in the stomach of a young female patient. Gomal J Med Sci 2016; 14: 118-9.

INTRODUCTION

Trichobezoar is a rare disorder consisting of a hairball in the proximal gastrointestinal tract that almost exclusively affects young women.[1-9] Most patients with trichobezoar suffer from psychiatric disorders including trichotillomania (pulling out of their own hair) and trichophagia (eating of hair).[6,7,10] The site of hair pulling is most commonly from the scalp, but can occur from the eyelashes, eye-brows and pubic area.[7,8] Rarely these patients chew hair from other sources including hair from wigs.[10] Human hair is resistant to digestion as well as peristalsis due to its smooth surface. Therefore, it accumulates between the mucosal folds of the stomach. Over a period of time, continuous ingestion of hair leads to the impaction of hair together with mucus and food, causing the formation of a trichobezoar. In most cases, the trichobezoar is confined within the stomach. In some cases, however, it extends through the pylorus into the jejunum, ileum or even colon. This condition is called Rapunzel syndrome, first described by Vaughan Jr et al in 1968.[6-8,10]

Affected patients remain asymptomatic for many years. Symptoms develop as the bezoar increases in size. The most common presentations are abdominal pain, nausea/vomiting, obstruction and peritonitis. Less often, the patients present with weight loss, anorexia, hematemesis and intussusception. Complications by a large eroding or obstructing trichobezoar additionally include gastric ulceration, obstructive jaundice, acute pancreatitis and gastric emphysema[10-12] Malabsorption related complications include protein losing enteropathy, iron deficiency and megaloblastic anemia.

Different treatment options have been employed to treat this condition, including laparotomy, endoscopic removal and laparoscopic removal.

CASE REPORT

A 24 years old female patient was admitted through OPD with history of upper abdominal mass for 10 years. Examination revealed a mass in the upper abdomen, more to the right of midline. Mass was big in size, hard, smooth-surfaced and mobile. Rest of the abdominal examination was unremarkable.

Hematological and biochemical investigations were within normal limits. Ultrasound examination showed a large mass in the upper abdomen having thick calcified walls. It mentioned that interior of the lesion was totally obscured and that the smooth

Figure 1: Huge trichobezoar removed from the stomach of a female patient.

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Date Submitted: 8-05-2016

Date Accepted: 18-06-2016

and calcified walls favoured a calcified cyst. Mass was declared as clear from viscera such as liver, gallbladder, pancreas, kidneys, urinary bladder and spleen. CT scan abdomen could not be performed due to affordability problem.

Laparotomy was undertaken after necessary preoperative measures. A 23 centimeters long huge trichobezoar was removed from the stomach through anterior gastrotomy incision. Stomach was closed in two layers with vicryl 2/0 suture. A drain was placed in the right sub-hepatic space that was removed on second postoperative day. Patient fared well after surgery and was discharged on sixth post-operative day.

DISCUSSION

It is well understood that there is an underlying psychiatric condition responsible for the development of trichobezoar in most of the patients[6,7,10]. In our case, the patient denied eating hairs and so did her husband and in-laws. This patient may have habit of eating hair in her childhood and so her parents could give some information but they were not accompanying the patient. All such patients should have psychiatric evaluation.

As far as the treatment options of trichobezoar are concerned, laparotomy has been found to be the most favoured management choice with highest rate of success. Gorter et al[6] in a retrospective review of 108 cases of trichobezoar noted that whereas 5% of attempted endoscopic removals were successful, 75% of attempted laparoscopies were successful. However, laparotomy was 100% successful. We also performed laparotomy, whereby we removed trichobezoar quite easily and postoperative recovery was also excellent.

CONCLUSION

Trichobezoars should be considered as a differential diagnosis in young female patient with a mobile epigastric mass. Removal of such large trichobezoar is best possible by laparotomy.

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CONFLICT OF INTEREST
Authors declare no conflict of interest.
GRANT SUPPORT AND FINANCIAL DISCLOSURE
None declared.