

## A Rare Case of Gastric outlet Obstruction In A Young Girl: Trichobezoar\*

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**Abstract:** Trichobezoars are an uncommon form of bezoars formed from consumption of hair. They are more common in young females with history of trichotillomania. It can occur in young children which makes the diagnosis difficult.

Here we report a case of a 6-year-old girl with a history of abdominal pain, distension, weight loss, and attacks of vomiting. Upper gastrointestinal endoscopy showed a trichobezoar occupying almost the whole gastric cavity, which was managed by laparotomy. Gastric Trichobezoar is exceptional in young children and can lead to gastric outlet obstruction. After definitive surgical or endoscopic treatment, consultation of pediatric psychiatrist should be opted for any mental illness and further recurrence should be prevented

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### I. Introduction:

Trichobezoar is a hair ball commonly seen in female psychiatric patients who swallow hair. True incidence is unknown and they occur rarely.

Trichobezoars are seen in women between the ages of 13 - 20. They are often associated with learning disabilities and psychiatric illness. These bezoars are typically found in the stomach. They are also seen in the small intestine or large intestine

Trichobezoars have varied presentation with chronic anorexia and failure to thrive, pain abdomen, vomitings, and acute gastric obstruction. Trichobezoar can be treated endoscopically or laparoscopically.

If trichobezoar is large, it can be removed by gastrotomy and enterotomy. Postoperative psychotherapy/psychiatric input is required to prevent recurrence

Here we report the case of a female patient aged about 6 years having a gastric outlet obstruction with stunting due to a huge gastric trichobezoar. We discuss methods of diagnosis and management of the condition.

### II. Case Report:

A 6-year-old girl attended the department of surgery with a history of pain abdomen, distension, weight loss, and episodes of vomitings since 6 months

The pain increased in severity, more in the epigastric area. It was associated with vomitings. On examination, weight of the patient was 14kg and 103cm in height; There was no alopecia. Per abdomen examination revealed a non-tender smooth abdominal mass in the left upper quadrant extending from the left costal margin to the midline.

Upper gastrointestinal endoscopy showed a trichobezoar which occupied the whole gastric cavity. Unable to remove trichobezoar endoscopically and it was possible to pull only few fibers of huge trichobezoar. Laparotomy was done by giving upper midline incision. On longitudinal anterior gastrotomy, J shaped trichobezoar of size 18 × 4 cm, which was foul-smelling and weighed about 200 g, was retrieved (Figure 1). There were no daughter bezoars. Patient was given general diet on 5th day after the surgery and was discharged on 7th postoperative day. Psychiatric consultation was advised and the child was followed up for a period of 1 year. No recurrence occurred.

### III. Discussion:

Trichobezoars are an uncommon form of bezoars formed from hair ingestion. Young females commonly present with an underlying psychiatric disorder, mainly trichophagia. The ingested hair gets collected in the stomach and it forms a mass in the stomach and mostly these masses do not dislodge. Hair strands are slippery to be propelled and are retained in the mucosal folds of the stomach. They become enmeshed over a period of time. Trichobezoars appear black due to denaturation of protein by the action of acid. They appear glistening due to retained mucus and foul smelling from degradation of food residue trapped within it. Sometimes trichobezoar pass through the duodenum into the intestine and may

cause ulceration, partial or total obstruction, intestinal perforation, and peritonitis .Trichobezoar usually present late, becoz of low index suspicion by the surgoen. Trichobezar present as palpable abdominal massin 87.7%, painabdomen in 70.2%, vomitings in 64.9%, weakness and loss of weight in 38.1%, constipation or diarrhea in 32%, and hematemesi in 6.1% . In thepresent case, the patient was very young ; it affected the nutritional status of the child, leading to stunting, and it made the diagnosis difficult.



**Figure 1** HUGE TRICHOBEZOAR IN STOMACH ATTAINED THE SHAPE OF THE STOMACH

Ultrasonography and computed tomography (CT) scan are best methods for diagnosing gastrointestinal tract bezoars .Recently, magnetic resonance imaging (MRI) is also recommended for the diagnosis. MRI useful in locating the site and the cause of obstructions in small bowel. In MRI bezoar appear as a mass containing mottled and confluent low signal intensities on both T1 and T2images .

The diagnostic procedure of choice is the upper gastrointestinal endoscopy, andthis is also used for retrieval of proximal minor trichobezoars . Inthe early stages of the condition, endoscopic removal is not without risk of bowel perforation and should be resolved for small trichobezoars only . Surgical therapysould be reserved for patients having acute abdominal conditions or

Largebezoars. Laparoscopic surgery is becoming popular and bezoars can be milked into the caecum before removal .

Laparotomy is still the corner stone of large trichobezoar removal, especially if it has an extension into the bowel, which is often missed. Recurrences have also been reported, especially in women and psychiatric follow-up is necessary to prevent recurrences . A follow-up contrast study or endoscopy may also be advised if trichotillomania is suspected, as the patient usually never gives a positive history. Many of these patients report having parental discontent, bereavement, or other family problems. Parental or spousecounseling is also be advised as a regular part of treatmentto prevent recurrence. The patient’s long-term prognosis is excellent if behavioral therapy is used to control trichophagia, and psychological/psychiatric follow-up is maintained

#### **IV. Conclusion**

Trichobezoars are concentrations of hair which occur morefrequently in young women with long hair and adolescents, usually resulting from trichotillomania, causing pain from gastric ulceration and fullness from gastric outlet obstruction.It can rarely occur in children leading to a gastric outlet obstruction and stunting and making the presentation of trichobezoar late. After definitive surgical or endoscopic treatment, individuals with trichophagy require psychiatric care because recurrent bezor formation iscommon

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