



CLINICAL CASE

Trichobezoar – A Rare Cause of Abdominal Mass and Gastric Outlet Obstruction



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Abstract The authors present the clinical case of a 14-year old girl with weight loss, anorexia, epigastric abdominal pain and postprandial vomiting with 5 months duration. There was a background of trichophagia for 2 years without evidence of alopecia or psychiatric history. The physical examination revealed an epigastric mass motionless, stony, with poorly defined limits, painful on palpation and about 7 cm diameter. Abdominal ultrasonography showed thickening of the gastric wall and antrum with gastric distension. The abdominal tomography scan and endoscopic examination revealed the presence of a bulky trichobezoar occupying almost the entire gastric lumen. It was decided to undergo gastrotomy and extraction of the bezoar. The postoperative period was uneventful.

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PALAVRAS-CHAVE

Abdómen;
Bezoares;
Obstrução Gástrica;
Tricotilomania

Tricobezoar – Uma Causa Rara de Massa Abdominal e Obstrução Gástrica

Resumo Apresentamos o caso clínico de uma adolescente de 14 anos com emagrecimento, anorexia, epigastralgia e vômitos pós-prandiais com 5 meses de evolução. Apurou-se história de tricofagia com 2 anos de evolução mas sem áreas de alopecia ou antecedentes psiquiátricos. Apresentava massa epigástrica imóvel, pétreo, de limites mal definidos, dolorosa à palpação e com cerca de 7 cm de diâmetro. A ecografia abdominal mostrou espessamento da parede gástrica e do antro com distensão gástrica. Realizou tomografia abdominal e endoscopia

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digestiva alta que revelaram a presença de volumoso tricobezoar ocupando quase a totalidade do lúmen gástrico. Foi decidido realizar gastrotomia e extração do bezoar. O pós-operatório decorreu sem incidentes.

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1. Introduction

Bezoars are concretions of undigested or partially digested foreign material in the gastrointestinal or genitourinary tract.¹

They are classified according to their composition. The major types are phytobezoars (composed of vegetable matter), trichobezoars (composed of hair) and pharmacobezoars (composed of ingested medications).¹⁻³ There are others composed of a variety of other substances as tissue paper, fungus, cement, vinyl gloves, milk curd.

Development of bezoars is usually associated with predisposing risk factors. They occur in patients with altered gastrointestinal motility and/or anatomy (previous gastric surgery, diabetes mellitus, neurological disorders). Psychiatric illness, suicidal tendencies and mental retardation are common associations with trichobezoar (hair bezoar).^{1,3} They begin as retained hairs between the gastric folds; the hair is then denatured by gastric acid, becomes black due to oxidation and combines with food to form an enmeshed mass. Trichobezoars subsequently become colonized by bacteria resulting in halitosis.

They are rare, with an estimated incidence of 0.3 percent on upper endoscopy.⁴ Trichobezoars are typically seen in women in their 20s and are often associated with psychiatric disorders.⁵

They cause nonspecific symptoms and are usually found incidentally in patients undergoing upper gastrointestinal endoscopy or imaging. The most common symptoms include abdominal pain, nausea, vomiting, early satiety, anorexia, and weight loss.^{3,5} They represent an uncommon cause of abdominal mass.

The bezoars although rare, when undiagnosed can lead to complications such as ulcers, gastric bleeding or perforation and obstruction.^{3,5} Although many bezoars become quite large, gastric outlet obstruction is an uncommon presentation.

2. Clinical case

A 14-year old girl was admitted to the Department of Pediatrics with weight loss (5 kg), anorexia, epigastric abdominal pain and postprandial vomiting with 5 months duration. She denied the presence of fever, altered bowel habits or visible blood loss. She had no distortion of body image or eating pattern changes.

Her history revealed significant trichophagia for 2 years without evidence of alopecia or psychiatric history.

On clinical examination she was pale and skinny. Her vital signs were within normal limits and the higher intellectual functions were normal. There was no dehydration, halitosis or lymphadenopathy. There was an epigastric mass of stony consistency, bulky, with poorly defined limits, painful on palpation and about 7 cm diameter.

Laboratory investigation revealed anemia (hemoglobin – 7.6 g/dL).

Abdomen radiograph showed marked gastric distension with gastric camera barely visible (Fig. 1).

On the abdominal ultrasonography there was thickening of the gastric wall and antrum with gastric distension.

It was then performed an abdominal tomography scan to exclude other bezoars in the small intestine that revealed the presence of a bulky bezoar difficult to characterize, occupying almost the entire gastric lumen and causing compression of neighboring structures (Figs. 2–4).

The endoscopy confirmed the diagnosis of a large volume trichobezoar not amenable for chemical dissolution or endoscopic fragmentation (Fig. 5).

Given the large mass causing gastric outlet obstruction and compression of neighboring structures it was decided to undergo laparotomy. Through the gastrotomy, a gastric



Figure 1 Abdominal radiograph. Marked gastric distension with gastric camera barely visible.

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