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RESEARCH ARTICLE

A RARE CASE OF TRICHO BEZOAR PRESENTING AS PAIN ABDOMEN TO THE EMERGENCY

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ABSTRACT

A trichobezoar is a mass of undigested hair within the gastrointestinal tract. Trichobezoars are often associated with trichotillomania (hair pulling), and trichophagia (hair swallowing). Trichotillomania may be unconsciously or unintentionally done and is part of the DSM IV psychiatric classification of impulse control disorders (Gastrointestinal Bezoars, 1991; Trichobezoar, 1972). In up to 18% of patients with trichotillomania, trichophagia occurs; one third of patients with trichophagia develop trichobezoars (Sood, 2000). Trichobezoars most commonly occur in adolescent females (Lamerton, 1984). The site of hair pulling is most commonly from the scalp, but can occur from the eyelashes, eyebrows, and pubic area (Taylor, 1975). Trichobezoars commonly occur in adolescent females, often with an underlying psychiatric or social problem. Clinical presentation of these patients may be confusing as often they are not forthcoming with a history of trichophagia either due to embarrassment or the unintentional nature of the problem. Although this is a rare condition, numerous case reports and series have been reported as high mortality may follow complications associated with this condition. Trichobezoars in humans were first described from a post mortem by Swain in 1854 (Ratcliffe, 1982). The postulated reason for formation in the stomach is that hair is undigestible and due to its smooth nature cannot be propelled with peristalsis and over time forms a bezoar within the stomach. Presentation ranges from nonspecific abdominal or epigastric pain, to a range of complications as mentioned. In 5% patients diagnosed with Trichobezoars, attempted endoscopic removals were successful and in 75% of patients attempted laparoscopies were successful. However, laparotomy was 100% successful and thus favored as their management of choice.

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INTRODUCTION

A trichobezoar is a mass of undigested hair within the gastrointestinal tract. Trichobezoars are often associated with trichotillomania (hair pulling), and trichophagia (hair swallowing). Trichotillomania may be unconsciously or unintentionally done and is part of the DSM IV psychiatric classification of impulse control disorders (Gastrointestinal Bezoars, 1991; Trichobezoar, 1972). In up to 18% of patients with trichotillomania, trichophagia occurs; one third of patients with trichophagia develop trichobezoars (Sood, 2000). Trichobezoars most commonly occur in adolescent females (Lamerton, 1984). The site of hair pulling is most commonly from the scalp, but can occur from the eyelashes, eyebrows, and pubic area (Taylor, 1975). Trichobezoars commonly occur in adolescent females, often with an underlying psychiatric or social problem.

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Presentation ranges from nonspecific abdominal or epigastric pain, to a range of complications as mentioned. Clinical examination often reveals a large mobile epigastric mass that may be indentable, the so-called Lamerton's sign (Baker *et al.*, 1998). Endoscopy is usually diagnostic. The hair appears black (despite the normal hair colour) due to denaturing of the hair protein by the acid. The most common diagnostic tool used in the literature is a CT scan, with a typical image showing a well-defined intraluminal ovoid heterogeneous mass with interspersed gas (Taylor, 1975; Ratcliffe, 1982). Management options include endoscopic removal, laparoscopic removal, or via laparotomy. Gorter *et al.*, in a retrospective review of 108 cases of trichobezoar, evaluated the available management options; it was noted that whereas 5% of attempted endoscopic removals were successful, 75% of attempted laparoscopies were successful. However, laparotomy was 100% successful and thus favoured as their management of choice.

CASE DETAIL

23 yrs old female presented in ER with c/o pain abdomen since 5 days along with persistent vomiting since 5 days. It was associated with high grade fever. No other complaints. No previous comorbidities. The pain is dull aching and over the whole of abdomen and no aggravating and relieving factors. There is no history of any trauma. The pain score is 5/10. There is no associated hematuria or hematochezia or hematemesis.

O/E:

Primary survey:

Airway: patent
Breathing: RR: 20/min
Spo2: 99%
Circulation: PR: 120b/min
Peripheral pulses: normal
Temperature: 99 F

Secondary survey

HEENT: dehydration present
Pallor: present
Icterus: absent
Cyanosis: absent
Clubbing: absent

CHEST: B/L AIR ENTRY PRESENT

CVS: S1 S2 PRESENT

ABDOMEN: Soft lump palpable in epigastric and umbilical region

No guarding
No rigidity
BS present
CNS: conscious and oriented

Treatment given in emergency

Inj Pantop 40 mg iv

Inj Metrogl 100ml iv
Inj Oflox 400mg iv
Inj Emset 4mg iv
Inj. Diclofenac 75mg iv stat
Inj. Paracetamol 1000 mg iv stat
IVF NS 500ML bolus fb 80 ml /hr
CBC: HB: 8.2
WBC: 12.42
PCV 28.2
MCV: 69.5
MCH 20.2
PLATELET: 660

Peripheral Smear: Mild anaemia, microcytic hypochromic type

NEUTROPHILIC LEUCOCYTOSIS
THROMBOCYTOSIS
RETICULOCYTE COUNT: 5%
VIRAL MARKERS: NON REACTIVE
TYPHI DOT: NEGATIVE
NS1: NEGATIVE
LFT: NOTHING SIGNIFICANT
KFT: NOTHING SIGNIFICANT
URINE R/M : NOTHING SIGNIFICANT
Usg whole abdomen: showed multiple fluid distended bowel loops scattered all over abdomen.





Cect whole abdomen: S/O massive distention of the stomach and duodenum with bezoars within distended duodenum was impressing on the IVC, gall bladder, and pancreatic head. No free fluid in the peritoneal cavity.

Gastro-Duodenoscopy: large trichobezoars (two in number) in stomach and duodenum (third part)
Multiple circumferential ulcers (D2)

Procedure done: diagnostic laparoscopy+ exploratory laprotomy+ anterior gastrotomy+ removal of trichobezoar+ intra OP gastroscopy+ feeding jejunostomy+ drains done under GA. Patient was discharged from the hospital in stable condition and had a follow up after 2 weeks with good recovery.

Conclusion: Any patient presenting the emergency with pain abdomen thorough examination is important along with detailed history taking. The medical and psychiatric sequelae of trichotillomania should not be underestimated and early diagnosis and treatment is of utmost importance to save the patient's life and prevent recurrence. Although laparotomy is still considered an excellent treatment option, pharmacotherapy and behavioral assessment play a useful role in patient management.

REFERENCES

- Baker D., Trichobezoar. 2001. Medical and Paediatric Oncology. 1998; 16(5):341-343
O'Sullivan MJ, McGreal G, Walsh JG. Trichobezoar. Journal of the Royal Society of Medicine. 94
- Gastrointestinal Bezoars. 1991. Journal of the Indian Medical Association, 89(12):338-9
Bholla SS, Gurjit S
Trichobezoar. *Journal of Indian Medical Association.*
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2856853>
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3946194>
- Lamerton AJ. 1984. Trichobezoar: Two Case Reports- A New Physical Sign. *American Journal of Gastroenterology.*, 79:354-6
- Pandeya NK. Trichobezoar, 1974. A case report of recurrence in same patient, Journal AOA.
- Ratcliffe JF. 1982. The ultrasonographic appearance of a trichobezoar. *British Journal of Radiology.*, 5:166-167.
- Sood AK., Bahl L., Kaushal BK. 2000. Childhood Trichobezoar. *Indian Journal of Paediatrics.*, 67(5):390-1.
- Taylor TV., Bruce Torrance H. 1975. Trichobezoar presenting as an unusual mass, *Journal R. Coll Surg. Edin.*, 20(2):128-129.
- Trichobezoar (A Case Report). Journal of the Association of Physicians of India 1972; 20(4):339-41.
