Journal of Medical Case Reports and Case Series ISSN: 2692-9880

Case Report Volume 5 Issue 13

A Huge Trichobezoar That Extends From The Stomach To The Transverse Colon, About A Case

I. Yazough[1*], H. Ouaya[2], A. Jbilou[1], A. Ahellat[1], Y. Agouri[1], A. Akjay[2], H. Meyiz[2], I. Mellouki[2], S. Ait laalim[1]

[1]Visceral and Endocrine Surgery Department, Mohammed VI University Hospital of Tangier

[2]Hepato-gastroenterology department, Mohammed VI University Hospital of Tangier

***Corresponding Author:** I. Yazough, 1Visceral and Endocrine Surgery Department, Mohammed VI University Hospital of Tangier.

Received date: 24 September 2024; **Accepted date:** 04 October 2024; **Published date:** 11 October 2024

Citation: Yazough I, Ouaya H, Jbilou A, Ahellat A, Agouri Y, et al. (2024) A Huge Trichobezoar That Extends From The Stomach To The Transverse Colon, About A Case. J Med Case Rep Case Series 5(13): https://doi.org/10.38207/JMCRCS/2024/OCT051302122

Abstract

Trichobezoar is a rare condition, most often asymptomatic, but easily diagnosed by esophageal gastroduodenal fibroscopy. The majority of cases described in the literature are limited to a part of the digestive tract; Treatment is most often surgical. A 19-year-old woman who was extracted by gastrotomy plus ileal enterotomy, without complications, was reported to have been observed with a trichobezoar extending from the stomach to the transverse colon. Psychiatric care was provided.

Introduction

Gastric blichezaza is a rare condition that refers to the unusual presence of hair, in the form of a solid mass, in the stomach. Most often asymptomatic, its diagnosis is essentially based on fibroscopy. Treatment is often surgical **[1]**. The aim of this work is to discuss through this case of the trichobezoar which extends from the stomach to the transverse colon the diagnostic difficulties and the different therapeutic methods.

Patient at observation

It is a 19-year-old woman, with no history, who consults for diffuse abdominal pain with vomiting and a cessation of materials without stopping gas evolving in a context of unquantified weight loss.

The clinical examination found a thin patient with a hard abdominal mass with no other associated signs.

The patient underwent an abdominal ultrasound showing a trichobezoar associated with intussusception, and a FOGD **(Figure 1)** was in favour of a trichobezoar.

The patient was admitted to the operating room in the exploration revealed a large trichobezord which occupies the entire stomach and extends to the transverse colon, the extraction was done by a gastrotomy associated with an enterotomy of the last ileal loop **(Figure 2)**; The postoperative follow-up was marked by an infection of the wall which was recovered under medical treatment with a twice-daily change of passenger. Psychiatric care was carried out.

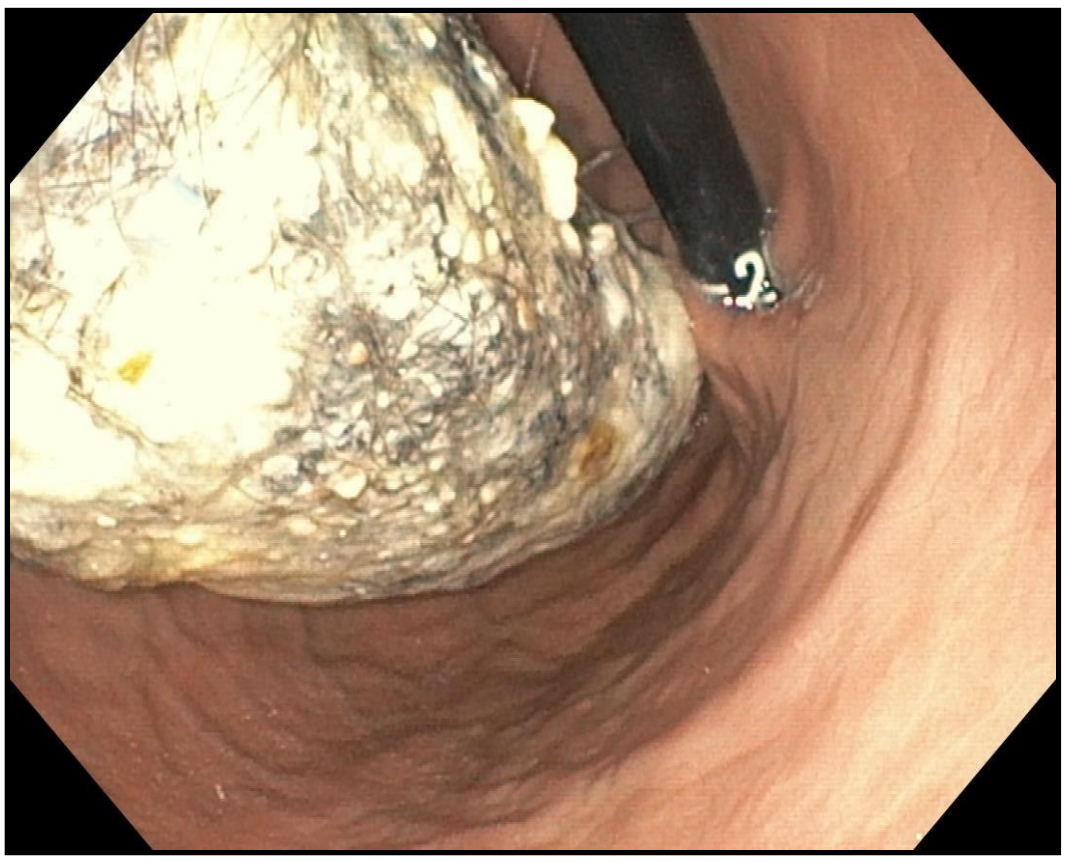

Figure 1: Endoscopic image of the Trichobezoar

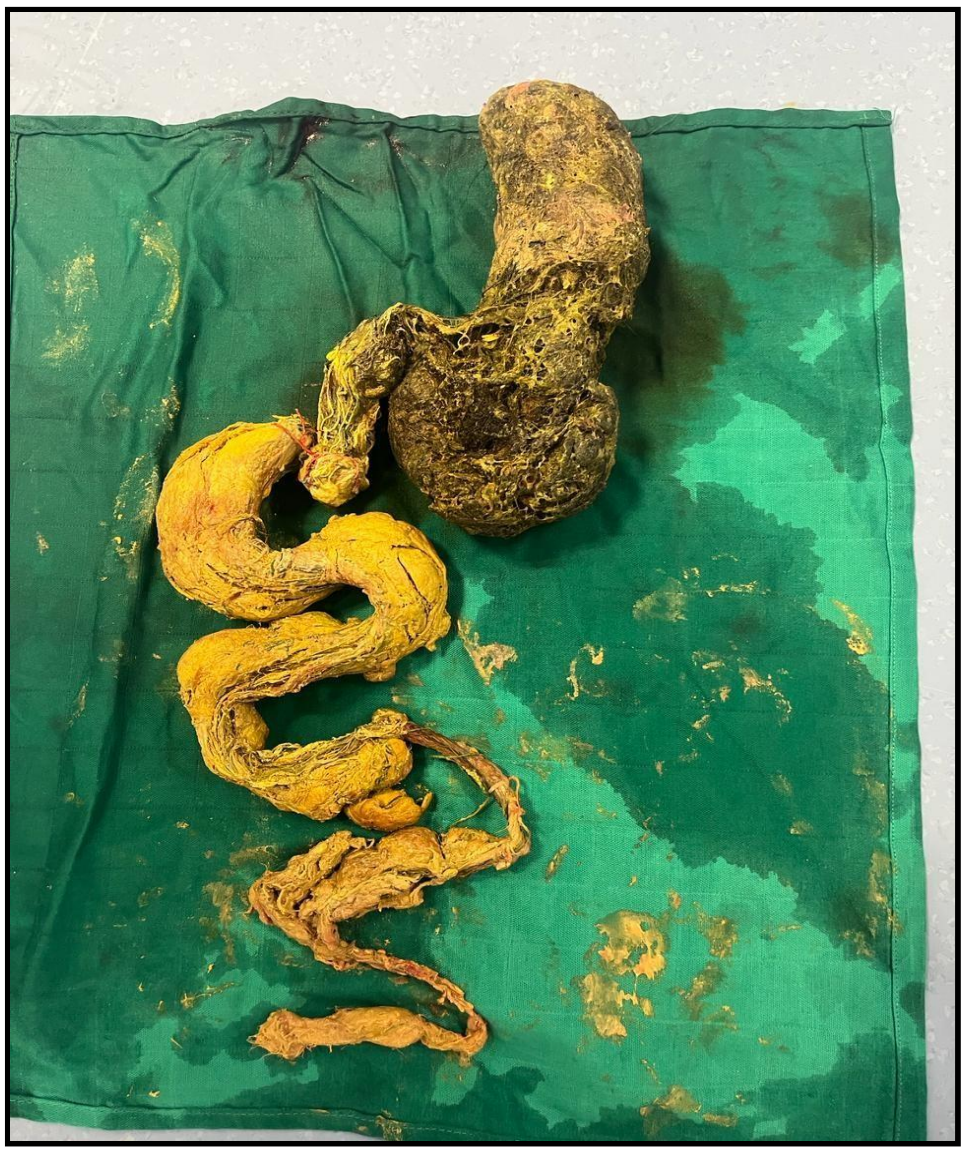

Figure 2: image of the trichobezoar after extraction

Discussion

The term "Bezoar" comes from the Arabic Badzehr, which means antidote or poison **[2,3]**. It refers to a rare condition, secondary to the unusual accumulation, in the form of solid masses, of substances of various kinds inside the digestive tract and more particularly in the stomach. The nature of these substances determines the type of bezoar. Thus, the trichobezoar, which represents 55% of all bezoars, is made of hair, hair or fibers of carpets or rugs of varying sizes, intertwined with each other, most often in the gastric lumen that can mold it **[2]**.

Trichobezoar is most often seen in emotionally disturbed or depressed patients, psychiatric patients, mentally retarded people, and prisoners, who swallow their hair (trichophagia) after pulling it out (trichotillomania) **[4]**. It can occur spontaneously in hairdressers, wool workers, and carpet weavers **[2]**

The female sex is affected in more than 90% of cases and the age of onset is in 80% of cases under 30 years of age, with a peak incidence between 10 and 19 years of age **[2]**.

Clinical examination found in 85% of cases a well-limited, smooth, firm, mobile abdominal mass with epigastric localization. Alopecia may also be noted **[2,5]**.

In our patient, it is of gastric localization that extends to the transverse colon. Trichobezoar can remain asymptomatic for a long time or manifest itself as epigastric discomfort (80%), abdominal pain (70%), nausea or vomiting (65%), asthenia with weight loss (38%) or transit disorders (33%) such as diarrhea or constipation **[2-5]**.

A complication may be the way in which this pathology is revealed **[5]**. These may include upper gastrointestinal bleeding due to parietal ulcerations, gastric or small bowel mechanical obstruction **[6,7]**, gastric or small bowel perforation with peritonitis or subphrenic abscess **[7-8]**, gastrointestinal fistula **[8,9]**, cholestasis or acute pancreatitis due to obstruction of the ampulla of Vater by an extension of the trichobezoar **[10,11]**. The diagnosis is based on the FOGD, which remains the examination of choice, allowing the visualization of the pathognomonic tangled hair of the trichobezoar. It can sometimes have a therapeutic interest by allowing the endoscopic extraction of small trichobezoars **[5]**. However, because of the volume of the trichobezoar, this extraction is in the majority of cases impossible, as in the case of our patient, and any attempt carries a risk of serious oesophageal damage. The oesogastroduodenal transit shows a mobile gastric intraluminal lacuna with convex margins, which may extend into the duodenum **[4]** The abdomen image without preparation may show a dense or heterogeneous rounded mass with or without calcification projecting onto the gastric area **[12]**. The transit of the small intestine completes the exploration of the intestine in search of a continuous distal extension or detached fragments **[1]**. The abdominal CT scan can show a mass of variable volume, heterogeneous, occupying almost the entire gastric lumen and consisting of multiple concentric circles of different densities distributed in onion bulbs. Two constant pathognomonic signs are the

presence of tiny air bubbles dispersed within the mass and the absence of any mass attachment to the gastric wall **[12]**.

Treatment for gastric trichobezoar can be endoscopic or surgically. A small trichobezoar can be recovered endoscopically using a basket or snare. **[13]** Wang et al. reported that a 14-year-old girl with a huge gastric clichobeze was successfully treated by endoscopic extraction using a polypectomy collar and an electro-surgical knife. **[14]** However, gastric trichobezoar often requires surgical removal because the tightly woven hairs do not appear to lend themselves to chemical softening or endoscopic removal.

With the advent of laparoscopic surgery, the gastric trichobezoar was removed by laparoscopic approach. **[15-16]** Nirasawa et al. first reported a 7-year-old girl who underwent laparoscopic gastrotomy and suprapubic mini-laparotomy recovery. **[17]** Tudor et al. also reported 2 cases of gastric trichobezoars that were removed by the laparoscopic wound retractor technique. **[18]** Although laparoscopic surgery is advantageous due to the aesthetic results and shorter length of hospitalization, an open approach is always performed in cases of large gastric trichobezoar due to the shorter operative time and lower complication rate. **[13,19]**

Conclusion

Trichobezoar is a rare pathology, its diagnosis and treatment is simple while a psychiatric consultation and regular follow-up after treatment must therefore be considered in children and their parents in order to prevent the recurrence of gastric trichobezoar.

References

1. Ousadden A, Mazaz K, Mellouki I, Taleb KA (2004) Gastric trichobezoar: one case report. Ann Chir. 129(4): 237-40.
2. DeBakey M, Ochsner A, DeBakey M (1939) Bezoars and concretions: comprehensive review of the literature with analysis of 303 cases and presentation of eight additional cases. Surgery. 4:934–63. 5: 132–210.
3. Faria AP, Silva IZ, Santos A, Avilla SG, Silveira AE (2000) The Rapunzel syndrome a case report: trichobezoar as a cause of intestinal perforation. J Pediatr (Rio J). 76(1): 83–6.
4. Dalshaug GB, Wainer S, Hollaar GL (1999) The Rapunzel syndrom (Trichobezoar) causing atypical intussusception in a child: A case report. J Pediatr Surg. 34(3): 479–80.
5. Qureshi NH, Morris K, McDevitt B (1992) Trichobezoar: a condition to think of in case of mobile abdominal mass. Ir Med J. 85(2): 74.
6. Deslypere JP, Praet M, Verdonk G (1982) An unusual case of trichobezoar: the Rapunzel Syndrome. Am J Gastroenterol. 77(7): 467-70.
7. Sinzig M, Umschaden HW, Haselbach H, Illing P (1998) Gastric trichobezoar with gastric ulcer: MR findings. Pediatr Radiol. 28(5): 296.
8. Mehta M, Patel RV (1992) Intussusception and intestinal perforations caused by multiple trichobezoars. J Pediatr Surg. 27(9): 1234-5.
9. Weiss M, Danoff DM, Wood B (1998) Radiological case of the month. Jejunojejunal intussusception caused by a trichobezoar with a tail. Arch Pediatr Adolesc Med. 152(4): 403-4.
10. Shawis RN, Doig CM (1984) Gastric trichobezoar associated with transient pancreatitis. Arch Dis Child. 59(10): 994-5.
11. Katapadi M, Kostandy G, Wang A, Gutierrez R, Malik A, et al. (1997) Can a bezoar cause acute pancreatitis? J Clin Gastroenterol. 24(2): 120-1.
12. Hafsa C, Golli M, Mekki M, Kriaa S, Belguith M, Nouri A et al. (2005) Giant Trichobezoar in Children - Place of Ultrasound and Esogastroduodenal Transit. J Pediatr puer. 18: 28-32.
13. Ahmad Z, Sharma A, Ahmed M, Vatti V (2016) Trichobezoar causing gastric perforation: A Case Report. Iran J Med Sci. 41(1): 67-70.
14. Wang YT, Gou YW, Ye F, Liu YL, Hou GF, et al. (2022) Endoscopic recovery of a huge trichobezoardgastric using a polypectomy collar and an electrosurgical knife: about a case. J Dig Dis. 23(1): 54-6.
15. Shami SB, Jararaa AA, Hamade A, Ammori BJ (2007) Laparoscopic ablation of a huge gastric trichobezoar in a patient with trichotillomania. SurgLaparosc Endosc Percutan Tech. 17(3): 197-200.
16. Cintolo J, Telem DA, Divino CM, Chin EH, Midulla P (2009) Laparoscopic removal of a large gastric trichobezoar in a 4-year-old girl. JSLS. 13(4): 608-611.
17. Nirasawa Y, Mori T, Ito Y, Tanaka H, Seki N, et al. (1998) Laparoscopic removal of a large gastric trichobezoar. J Paediatric surgeon. 33(4): 663-5.
18. Tudor EC, Clark MC (2013) Laparoscopically assisted ablation of gastric trichobezoar; a novel technique to reduce operative complications and time. J Paediatric surgeon. 48(3): e13-5.
19. Haggui B, Hidouri S, Ksia A, Oumaya M, Mosbahi S, et al. (2022) Management of trichobezoar: about 6 cases. Afr J Paediatr Surg. 19(2): 102-104.