

Gastric Trichobezoar: Presentation of a Case

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Abstract

The bezoar is a cluster that occupies the lumen of the gastrointestinal tract, starting from the agglomeration of foreign bodies that have not been digested. There is a classification that depends on the material of which they are made, being able to be Trichobezoar and Fitobezoar, composed of hair and vegetable fibers, bezoars are usually located in the stomach, having the ability to move to the small intestine, considered a rare intestinal obstruction. This article describes the case of a Gastric Trichobezoar, accompanied by interventional images and surgical extraction, comparing it with the available international literature.

Keywords: Trichobezoar; Fitobezoar; Gastrointestinal Tract

Introduction

Bezoars are known to accumulate foreign material in the stomach. The incidence of bezoars in human patients has increased as a result of surgical manipulation of the gastrointestinal tract [1].

The most frequent location of a bezoar is gastric, followed by the bezoars of the intestine. The incidence is much lower than 0.5% among those subjects who undergo an upper digestive endoscopy [2].

Trichobezoars occur in 90% of cases in females, mostly in children under 30 years of age. It is usually presented by patients with emotional, psychiatric or mental retardation disorders [3].

One in 2,000 children suffers from trichotillomania, or morbid habit of pulling out their hair; of these, only 30% develop trichophagia and only 1% will form a Trichobezoar that requires surgical extraction [4].

Case Presentation

Patient with 11 years of age who reports having the habit of eating the hair, arriving at the care center with abdominal pain of one week of evolution, presenting hyporexia and early satiety of at least three months of evolution and within that period of time, in the last week the patient reported feeling a mass, of epigastric localization.

Being confirmed to the physical examination, where the non-mobile stony mass of approximately 10 to 15 centimeters in the epigastrium was palpated, an ultrasound is performed where the mass is visible. The patient is admitted and intervened by means of an exploratory laparotomy, where a mass composed of hair and food remains that occupied the entire stomach and the first portion of the duodenum is extracted.

A complete extraction was performed accompanied by a gastrorrhaphy and closed in two planes with vicryl 3.0. a Graham patch was placed, patient referred to the ward. Two days later the diet is started and on the fourth postoperative day there is hospital discharge with a complete diet and without complications, follow-up is given a month later, having a satisfactory evolution.



Discussion

In many cases in patients with Trichobezoar may be asymptomatic or have nonspecific symptoms, including epigastric pain, abdominal distension, nausea, vomiting, weight loss or gastrointestinal bleeding [5].

When the Trichobezoar lodges in the stomach and its distal end extends distally to the small intestine or descending colon, it is called Rapunzel syndrome [6].

This is a reason to be attentive to follow distally the image of the mass towards the gastrointestinal tract, either to observe this finding, to identify other bezoars or an obstruction of the small intestine that is the most frequent complication of bezoar [6].

Other complications that have been reported include perforation, peritonitis or abscess formation. The differential diagnosis is the remains of food in the stomach or fecal matter in the intestine, which make up the sign of “feces”, being observed proximal to an intestinal obstruction [7].

If the bezoar is small it can float at the air-water interface and is noticeable with lower density than food particles. However, large bezoars tend to occupy light, making it difficult to differentiate it from a large food impaction [7].

Unlike the sign of “feces” in the small intestine, where it is poorly defined and affects longer segments, a bezoar in the small intestine is better defined, of ovoid morphology, with gas bubbles inside and located at the transition site of the intestinal obstruction [8].

The treatment of Trichobezoar is surgical. Laparotomy is the method of choice by which gastrostomy and mass extraction is performed; however, the use of laparoscopy and endoscopy has been reported, which is sometimes limited by the size of the mass [8].

Conclusion

The prompt and adequate performance of local hospital care, accompanied by diagnostic images, anamnesis and physical evaluation are tools of great importance at the time of diagnosis of a bezoar, due to its symptomatic variability. Early identification and intervention can prevent complications and the satisfactory recovery of the patient who requires medical attention.

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