

CASE REPORT

GIANT TRICHOBEZOAR MIMICKING GASTRIC TUMOUR

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Abstract: We present a case of giant gastric trichobezoar retrieved through a long gastrotomy in a 40 years old married women from rural Sindh with unreported psychological disturbance. Trichobezoar almost exclusively occur in females with an underlying psychiatric disorder. It has an insidious development of symptoms which accounts for its delayed presentation and large size at the time of diagnosis. They are associated with trichophagia (habit of compulsive hair eating) and are usually diagnosed on CT Scans or upper GI Endoscopy. They can give rise to complications like gastro-duodenal ulceration, haemorrhage, perforation, peritonitis or obstruction with a high rate of mortality. The treatment is endoscopic, laparoscopic or surgical removal and usually followed by psychiatric opinion.

Keywords: Trichobezoar, Psychiatric Disorder, Management

INTRODUCTION

Trichobezoar are the hair balls of digestive tract and is a rare condition usually found on the shelves of the pathological museums of the teaching institutes. It was first notified in 16th century by Imad ul Oia.¹ The earliest reference on the subject was made by Sushruta in India in 12th century BC.² In western world it was reported by Bau damant³ in 1779 but the first surgical intervention was attempted by Schonhorn⁴ in 1883. Since then number of case reports and small case series has been reported in the literature. This is the first ever rare case report of giant trichobezoar reported from our public sector university hospital.

CASE REPORT

A 40 years old thin built, married woman is admitted in the department of surgery with epigastric pain and lump along with nausea, regurgitation and progressive weight loss (Figure-1). Her general and systemic examinations were unremarkable however her abdominal examination reveals a hard, sausage shape lump lying transversely in the epigastrium (Figure- 2). Her base line investigations and hepatic profile were within normal limit. Ultra-sonography was not helpful in diagnosis. Hence on the basis of history, physical examination and relevant investigations a provisional diagnosis of gastric tumour was suspected. Later a preliminary gastroscopy confirms the diagnosis of trichobezoar. Later on query from patient, relatives including her children have denied her habit of trichophagia.

She underwent surgical intervention and a huge gastric trichobezoar was removed via a long gastrotomy (Figure-3 and 4). Her postoperatively recovery was unremarkable except that she start swallowing her hairs which was an evidence of her habit of trichophagia in the past. Finally she was discharged and referred for psychiatrist opinion.



Figure-1: Thin built lady with short hair tail



Figure-2: Hard lump in the epigastric region



Figure-3: Giant trichobezoar retrieved from stomach



Figure-4: Specimen of giant trichobezoar

DISCUSSION

Trichobezoar is a rare condition and is more common in young women's associated with trichophagia and co-existent psychiatric disturbances; however no age group is exempted. The insidious development with no symptoms accounts for its late presentation and large size at the time of diagnosis.^{5,6}

The most common features are abdominal pain, lump and intestinal obstruction, but the patient may present with progressive weight loss, loss of appetite, Nausea and vomiting as stomach remains full all the time.^{7,8}

Trichobezoar have a low prevalence but with a high mortality due to ulcers leading to gastrointestinal bleeding, perforations, intussusceptions and obstruction.⁶ An extreme rare variety of trichobezoar known as Rapunzel syndrome with a long tail of hair strands extends from the main mass in the stomach along the small intestine have been also reported from our university hospital.⁹

The majority of cases preoperatively has been diagnosed by computerized tomography scan with a well defined avoid intra-luminal heterogeneous mass with interposed gas.¹⁰ MRI seems less helpful than CT scan.¹¹ Ultrasonography is not pathognomonic¹² as well as barium meal is also not helpful diagnostically. A preliminary Endoscopy will confirm the diagnosis and it could be occasionally therapeutic for small trichobezoar in well equipped laparoscopic centers.¹³ Earlier enzymatic (papain) dissolution was tried with little success. Surgical removal by gastrotomy was the treatment of choice in the past, however presently endoscopic and laparoscopic¹⁴ approaches are the most commonly used techniques in the developed countries. Nevertheless large giant trichobezoar where laparoscopic approach could be problematic like in our case still requires open surgical treatment.¹⁵ Minilaparotomy in young girls with good cosmetic results could also be an alternative to laparoscopy in cases of moderately large size trichobezoars in centres with moderate experience in advanced laparoscopic surgery.⁷

For this case we observed diagnostic dilemma on history, physical examination and relevant investigations giving a suspicion of gastric tumour initially as we never thought of a rare condition of trichobezoar. Later a preliminary gastroscopy confirmed the diagnosis. Forty years of age of the patient in this case was also higher than common age incidence reported in teen age girls.

The approximate weight (3,000 gm) at the time of the removal of the trichobezoar was also heavier than

the reported weight (2,500gm) in the current literature.⁷

Initially as a definitive history of trichophagia was denied by patient and her relatives including her children's but as she start swallowing her own hairs postoperatively which confirms her habit of trichophagia, it was suggested to cut short her scalp hairs before discharge and sending her for psychiatrist opinion.

Lastly, through a conversation with the patients' attendants, they were requested to keep a strict watch on her hair swallowing habit as recurrence may be anticipated, which may be difficult to manage.

We conclude and suggest that in patients with epigastric lump and co-existent psychiatric disorder a diagnosis of trichobezoar although rare should be kept in mind. Once trichobezoar is dealt, the cause of the trichophagia must be looked into for some mental disorder to prevent further episodes and must required a psychiatrist advice.

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