Case Report

Rare Cause of Dysphagia: the Gastric Trichobezoar (about a Case)

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Abstract

The trichobezoar is a rare disorder, defined by the presence of a gastric foreign body formed by hair or textile fibers. The authors report the case of a gastric trichobezoar revealed by dysphagia. Through this observation and a literature review, we describe the epidemiological, clinical, radiological and therapeutic characters of the trichobezoars.

Key Words: Trichobezoar; Dysphagia; Surgery

Introduction

The trichobezoar is defined by the presence of a gastric foreign body formed by ingested hair or textile fibers. It is a rare condition that occurs with particular frequency in young children, even teenagers, often female, with psychic disorders (depression, behavior disorders) or mental retardation. The symptoms are misleading. Imaging allows raising the diagnosis and it is high digestive endoscopy which confirms this. The treatment can be done endoscopically, but the most effective treatment is surgery. Through observation and review of the literature, we will discuss the epidemiology, the diagnosis and therapeutic modalities of the trichobezoar.

Observation

Our case concerns a 25 year old woman, with a notion of trichophagia reported by her mother since the age of 6, and who complained of dysphagia for 6 months with anorexia and weight loss unencrypted. The patient was never diagnosed nor treated as a case of trichotillomania with trichophagia. Thinning hair was not iced but no alopecia. Abdominal palpation revealed an epigastric mass up to the left upper quadrant, of a hard consistency and a mobile character, of about 15cm of long axis, oblique left to right and from top to bottom.

Abdominal ultrasound objectified a well limited intragastric heterogeneous mass. Abdominal CT showed a hypodense gastric intraluminal heterogeneous mass, in favor of a gastric bezoar (Figure 1 and 2).

The biological assessment found a hypo albuminemia to 21 g/l and hypochromic microcytic anemia (hemoglobin =8.4 g/dl).

Trichobezoar extraction was carried out through a longitudinal Gastrostomy (figure 3, 4 and 5). The postoperative period was uneventful and the patient was discharged after 6 days. The psychological counselling of the patient was conducted by the psychiatrist of our hospital.

Figure 1: Gastric intraluminal mass heterogeneous hypodense

Figure 2: Intragastricheterodense process molding the gastric wall and separated from it by a hypodense rim

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Discussion

The bezoar word comes from the Persian 'bad-zahr' which means "hunting the poison", so against poison [1]. The bezoar means a mass of swallowed foreign material that collects in the stomach and fails to pass through the intestines [2].

The trichobezoar represents 0.15% of gastrointestinal foreign bodies [3]. It is more common in the pediatric population than adults; the age of finding has been reported to range between 1 and 56 years [4], with a peak incidence between 10 and 19 years. Young girls are 9 times more affected than boys [5].

The trichobezoars are often associated with underlying mental disorders [6], such as depression, mental retardation, behavior disorders, which are observed in approximately 10% of cases [7]. The trichobezoar can remain long asymptomatic, what explains the diagnostic delay which can go up to several years [8]. Complications can be revealing, such as perforation or bowel obstruction [9].

The examination outside the complications found a palpable abdominal mass, presenting special characters [10]: mobile with breathing, lying down and to the right, fleeing under the hand, firm and smooth, painless well-defined contours well separated from the other abdominal organs, with convex higher board and concave lower board. The upper gastrointestinal fibroscopy remains the reference examination. It has a double interest, diagnostic first for the visualizing a process composed of tangled hair, pathognomonic for the trichobezoar and sometimes therapeutic, when realizing the endoscopic retrieval of it [11].

Ultrasound allows the diagnosis in 25% of cases, by visualizing a surface strip, hyperechogenic, curvilinear with posterior net shadow cone [12,3]. Rarely used, upper gastrointestinal transit can see a gastric intraluminal gap with convex edges, mobile, with some extensions into the duodenum. The gregar transit completes exploration of the intestine looking for extension or detached fragments.

Computed tomography shows an intraluminal mobile, heterogeneous mass, that does not catch contrast product [12]. Magnetic resonance imaging (MRI), the trichobezoar has a variable appearance according to its composition in air, water, grease and food residue [8]. Biological assessment can found often anemia hypochromic microcytic, a Leukocytosis with neutrophil predominance [13,14,15], increased erythrocyte sedimentation rate [16] and a hypoprotidemia with hypoalbuminemia [17,18].

In some cases, the diagnosis is made as per operative. This ignorance is due to its extreme rarity and the fact that the history is often incomplete and quick done [10]. Spontaneous resolution has never been reported, however, the small bezoars may be rejected during the efforts of vomiting. This situation is most often caused by mixtures of plants emetogenic and it is lived in our context as a
Complications of gastric trichobezoar are common and may occur at any time of its evolution. They are often related to malabsorption syndrome (anemia, hypoproteidemia with hypoalbuminemia), traumatic (peptic ulcer [10], gastritis, acute pancreatitis [20], ischemia of the intestinal or gastric wall [21,22]...) or mechanical (acute bowel obstruction, [23,24] acute intussusception, volvulus of the large intestine [25], [26] appendicitis...)

Several treatments have been reported in the literature. Thus, in the presence of small trichobezoar, some authors propose the use of abundant drink associated with the use of accelerators of transit, if unsuccessful endoscopic extraction of it can be tempted [27]. Extracorporeal lithotripsy has been proposed in the literature as an alternative [28]. However, these techniques are often incomplete and expose the patient to a risk of intestinal obstruction by trichobezoar fragment [28].

The preferred treatment is conventional or laparoscopic surgery [29], allowing the exploration of the entire digestive tract, the extraction through a gastrostomy as well as potential extensions (tail) or fragments through one or more enterotomies [30]. Moreover, psychiatric care of patients must often be achieved with shaving the hair of those who tend to trichotillomania or have ever had a hairball in their history. To avoid recurrence, an integrated approach of surgeons, pediatricians, psychiatrists, and gastroenterologists is imperative.

Conclusion

The trichobezoar remains a pathological curiosity, because of its nature and its rarity. Its diagnosis and treatment are simple. The psychiatric care of patients is essential.

Contributions of the Authors

All authors have contributed to the editing of this manuscript and read and approved the final version.

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