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Case Study

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CASE REPORT: A 16 YEAR FEMALE WITH INTELLECTUAL DISABLITY PRESENTING AS TRICHOBEZOAR

***Dr. Shiwani Chowalta and Dr. Ankaj Sharma**

Department of Radio-Diagnosis, DRPGMC Tanda.

***Corresponding Author: Dr. Shiwani Chowalta**

Department of Radio-Diagnosis, DRPGMC Tanda.

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INTRODUCTION

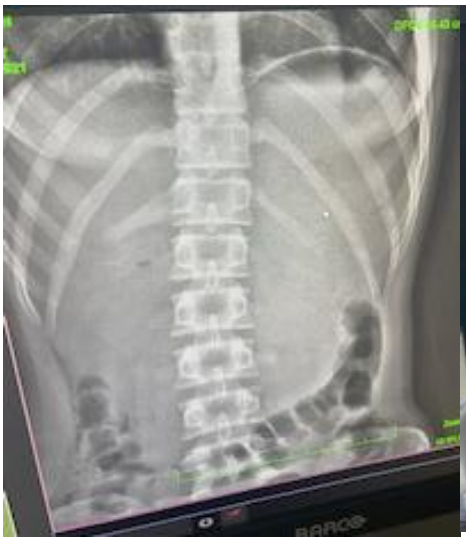
Trichobezoars were first described by Baudomant in 1779 consisting of a compact mass of hair, occupying the gastric cavity to a various extent. The term "bezoar" is thought to be derived from the Arabic word for antidote – "bazahr" or "badzehr", because stones obtained from the stomach or intestines of animals were thought to have medicinal properties.[1,2] Bezoars can be classified in four types: phytobezoar (vegetable); trichobezoar (hair); lactobezoar (milk/curd) and miscellaneous (fungus, sand, paper, etc).[3] They are usually found in the stomach, but they may also be found in the duodenum and other parts of the intestine. The most frequent type of bezoar in adults is phytobezoar, while trichobezoars are more often found in children and teenage girls.[4] The pathogenesis of bezoars is not consensual. It is believed that the smooth surface of hair does not allow for its propagation through peristalsis, getting trapped in the mucosa. When the trichobezoar is seen extending from the stomach to various lengths of the intestine is called "Rapunzel Syndrome", for its resemblance to a tail. The diagnosis of trichobezoars is based on imagiologic evidence. Ultrasonography is effective in detecting an epigastric mass, although CT-scan is more accurate in revealing a characteristic bezoar image and allowing the identification of the presence of additional gastrointestinal bezoars. The definite diagnosis is established by endoscopy.

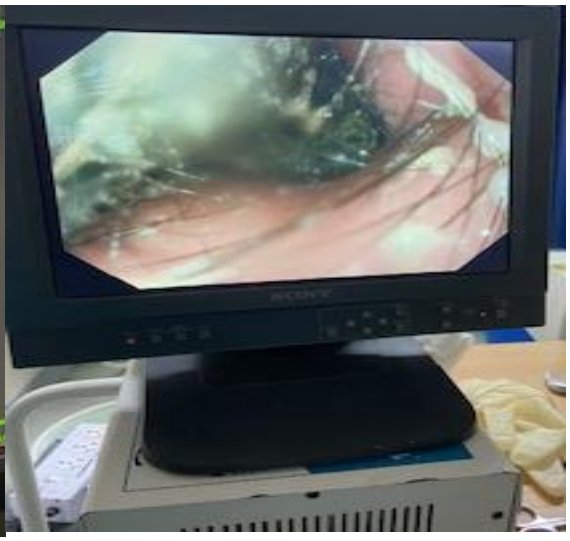
RELEVANT HISTORY

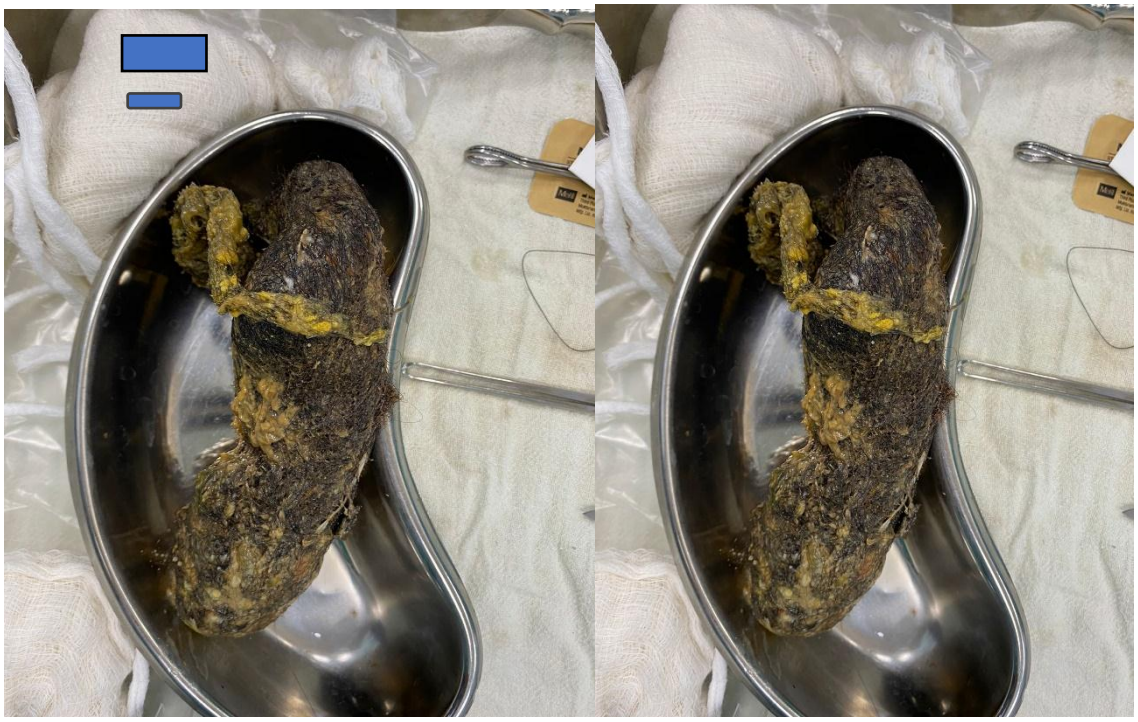
We here present a case of 16 years old female adolescent known case of intellectual disability presented in paediatric OPD with a history of pain and lump in abdomen for 8-10 days. On examination vitals were stable with palpable lump in epigastric region. History was reviewed and mother gave history of trichophagia.

FINDINGS

X ray abdomen was suggestive of trapped air within the stomach and ultrasound abdomen was not conclusive. For confirmation upper GI endoscopy was done which was suggestive of trichophagia extending up to duodenum. Then patient undergone laparotomy and trichobezoar was removed and was discharged successfully.







DISCUSSION

Trichobezoars are usually associated to underlying psychiatric disorders, such as depression, obsessive-compulsive disorder, body dysmorphic disorder and, particularly, trichotillomania. However, their prevalence and co-morbidity is unclear. The early detection of trichophagia and trichobezoar depends on an effective screening for trichotillomania and related behaviours, in order to prevent a possibly life threatening condition with important medical and surgical morbidity. Trichobezoar should be considered as a differential diagnosis in young females who present with nonspecific symptoms such as epigastric pain, fatigue, weight loss and epigastric mass. This increases the risk of severe complications, such as gastric mucosal erosion, ulceration and even perforation of the stomach or the small intestine. In addition, intussusception, obstructive jaundice, protein-losing enteropathy, pancreatitis and even death have been reported as complications of (unrecognized) trichobezoar in the literature. Various modalities are used for diagnosis of this rare condition. A contrast upper gastrointestinal series often diagnostic of trichobezoars. They are also easily diagnosed on abdominal ultrasonography and or computed tomography scan. However, upper GI endoscopy is an effective diagnostic tool to confirm the presence of a trichobezoar. Endoscopy also helps the clinician to differentiate between a trichobezoar and another foreign body. Surgical removal at laparotomy or laparoscopically is the treatment of choice. Mechanical fragmentation, chemical substances to dissolve small trichobezoars are options apart from surgery or endoscopic removal. Surgery and removal of the long trichochobezoar through gastrostomy is the procedure described as standard of care.

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