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Case Report

A Double Trichobezoar with a Gastric and Jejunal Locations: A Case Report

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Introduction

The trichobezoar is defined as a solid bulk of hair ingested in the digestive tract. It is mainly gastric but other locations have been reported as extending to the duodenum or the intestine. A double localization gastric and intestinal or fragmentation of the bezoar is exceptional in the literature. We report a case of double trichobezoar localized in the stomach and the jejunum in a 43-year-old woman revealed by an upper gastrointestinal stenosis and secondarily by an occlusive syndrome. We insist on the emergency of the treatment in such a situation and stress on the importance of ante and per-operative investigation of all the digestive tract in case of trichobezoar.

A single, 43 years-old women, suffering from untreated mental retardation with the notion of trichotillomania, was referred by a gastroenterologist with an upper gastrointestinal stenosis syndrome and a relatively severe general state alteration. The clinical examination classified the patient's general status as WHO 2. She was neither anemic nor icteric. Abdominal palpation found a soft motile 150 mm bulk extending from the left hypochondrium to the under-umbilical area. The patient had an abdominal ultrasonography completed with a tomodensitometry (Figure 1).

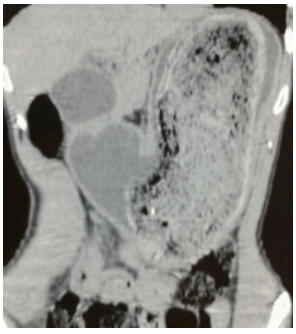

Figure 1: Patient after tomodensitometry with enlarged stomach and no parietal anomalies.

That concluded to an enlarged stomach with a strange body and no parietal anomalies. The patient had an incomplete upper gastrointestinal tract endoscopy because of the foreign body. After reanimation, the patient underwent laparotomy to extract the gastric bezoar by a short medial sus-umbilical incision that allowed exploring a large stomach with a slightly thickened but soft wall. We proceeded to a longitudinal gastrotomy on the anterior wall of the gastric antrum and corpus that showed a 250 mm trichobezoar molding the digestive lumen that was extracted easily by the gastrotomy (Figure 2,3).

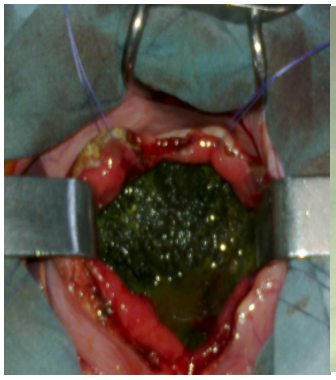

Figure 2 **Figure 3**

Figure 2,3: A longitudinal gastronomy on the anterior wall of the gastric antrum and corpus showing 250 mm trichobezoar molding the digestive lumen.

At day one after the surgery, the patient experienced a brutal hypovolemic choc needing intensive reanimation care with vascular refilling that corrected the patient's blood volume. A loss of 5 points of hemoglobin was in favor of a post-surgical hemorrhage and led to a second abdominal scan showing an intra-peritoneal effusion of average abundance associated with an inflated stomach and a jejunal occlusion over a bezoar (Figure 4).

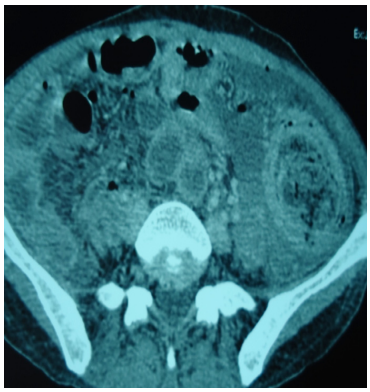

Figure 4: Second abdominal scan showing an intra-peritoneal effusion associated with an inflated stomach and a jejunal occlusion over a bezoar.

Frequent vomiting was responsible of inhalation of digestive fluid followed by two heart arrests leading to an oro-tracheal intubation and the use of vasoactive drugs then to external electric chocks. The patient was still unstable.

Tracheal aspiration showed digestive fluid. The patient underwent a second explorative laparotomyin emergency. We found a stinky intraperitoneal effusion with false membranes and a perforation in the first jejunal loop due to a 70mm trichobezoar (Figure 5).

Figure 5: After second explorative laparotomyin emergency showing a false membrane and a perforation in the first jejunal loop due to a 70mm trichobezoar.

The gastrotomy was solid. We extracted the bezoar then resected the hole in the jejunal loop to realize a jejuno-jejunal anastomosis. The patient had a multi-organ failure, quickly, and died immediately after surgery.

Discussion

A trichobezoar is a solid bulk made of hair, occurring in 90 % of the cases in single women under 30 years, suffering from trichotillomania [1]. Its location is mainly gastric with a possible duodenal and/or jejunal extension, called the Rapunzel syndrome [2]. A double gastric and intestinal location, such as in our case, is rare. This illness is generally asymptomatic. If the bezoar has not reached a certain size, patients have no functional impairment. Generally, for large ones, the symptoms of an upper gastrointestinal stenosis have been described.

Otherwise, clinical features are polymorphic, dominated by an epigastric bulk in 85 % of all cases [3], an occlusive syndrome due to a jejunal location [1,4], is rare (10 % of the cases) [5]. Our patient presented, secondarily, with an occlusive syndrome associated with a jejunal perforation and peritonitis due to the trichobezor that has been omitted. The upper gastrointestinal tract endoscopy is the key of the diagnosis and it may extract the small bulks. The abdominal scan is also an effective tool for the diagnosis of intestinal locations [4,6]. It shows an intraluminal motile and heterogeneous mass not taking the contrast. In our case, the scan only focused on the stomach and there were no enough intestinal views to detect the second location of the bezoar. A careful per-operative exploration of the gastrointestinal tract is an important step to detect the locations that may be omitted by the imaging techniques. Usually, the trichobezoar is exteriorized, intraoperatively, as a solid mass that has the shape of the stomach extending to the duodenum or the first jejunal loop (such as in the Rapunzel syndrome). During the surgery, we emphasize the importance of a gentle mobilization of the bowel to remove the entire mass and check the shape of the bezoar, especially, its distal side in order to explore the duodenal extension and leave no trichobezoar that may cause more serious complications. In our patient, the distal extension of the bulk was not in the duodenum (Figure 3); that can be explained by a disconnection of a fragment that migrated into the small intestine and causes signs of upper gastrointestinal stenosis that prompted hospitalization. This possibility is the most probable in our patient especially that her clinical features, after the first surgery, are not improved, in addition to initial CT scan images showing an aspect of “cutting “at the distal portion of the bezoar without any upstream extension. Is it then a spontaneous detachment which preceded by the surgical procedure or was it secondary to surgical mobilization? This last hypothesis is the most plausible considering the arguments we just move on.

We, finally, insist on the usefulness of intraoperative examination of all the digestive tract to seek any other unknown locations of the bezoar. Concerning our patient, all the small intestine was flat and seemed healthy. The trichobezoar may have been initially in the duodenum and then migrated after the release of the gastric obstruction. A second look to the initial scan views suggests that the duodenum is abnormally inflated (Figure 6).

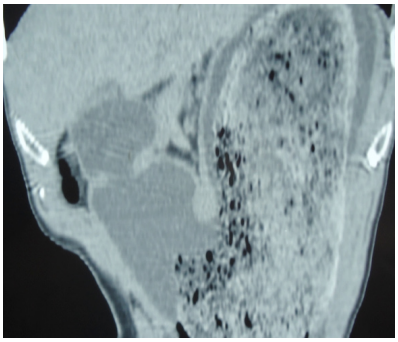

Figure 6: Initial scan views suggests that the duodenum is abnormally inflated.

Surgery is the gold standard for the treatment [1]. The endoscopic removal of the bezoar is rarely possible because of the usually important size of the bulk. Some cases of chemical or manual fragmentation with extraction of the bezoar through the ileocecal valve have been reported [6]. Recently, some authors have suggested that laparoscopy may supply laparotomy [7]. But the treatment has to be completed by psychiatric therapy in order to prevent relapses.

Conclusion

The trichobezoar are a rare entity. Their diagnosis is easily done when relying on upper gastrointestinal tract endoscopy, but a careful scannographic investigation and an exhaustive peroperative gastrointestinal exploration are also needed to look for intestinal locations.

Surgery is the main treatment option; it allows, in the one hand, a final assessment of the illness and, in the other hand, to treat all the locations, especially the intestinal ones that are the most serious ones. It is an emergency to treat surgically those patients. Once the vital threat is apprehended, a psychiatric therapy is strongly recommended to prevent recurrence.

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