

TRICHOBEZOAR DISCOVERED BY FOGD IN A YOUNG BREASTFEEDING WOMAN**ABSTRACT**

The trichobezoar is a foreign body present in the digestive tract, composed of hair, hairs and fibers. Rare in frequency, and usually occurring in adolescents with a proven psychiatric history, it is often of strictly gastric location, as in this case reported by the authors, and upper digestive endoscopy was sufficient to establish a positive diagnosis. Thus they make it a strong recommendation in the support of identical forms. However, support psychotherapy after surgical treatment should be the rule.

KEYWORDS: Trichobezoar-endoscopy-surgery-psychotherapy-woman

INTRODUCTION

The trichobezoar is a foreign body present in the digestive tract, composed of hair, hairs and fibers. In the vast majority of cases, it develops in the stomach, but can progress into the intestinal lumen often causing an obstruction.

Its diagnosis is mainly based on upper digestive endoscopy and its treatment is essentially surgical. However, to clarify the extension, eliminate the existence of other synchronous localizations and look for complications, CT may be suggested.

CASE REPORT

21-year-old nursing woman with no particular history, admitted to the visceral surgical emergency department of the Ibn Sina hospital in Rabat for epigastralgia, feeling of epigastric heaviness, early postprandial vomiting, deterioration of general condition, bald patches.

Her story goes back two years when, after conception of a pregnancy, the patient began to consume her own hair unconsciously, she says, and this, up to 2 years after childbirth.

In whom, an esogastroduodenal fibroscopy was performed externally and revealed a trichobezoar consisting of human hair marrying all the gastric lumen up to two-thirds of the pylorus, leaving a small passage to the duodenum. Given the impossibility of endoscopic extraction, the patient was referred to our department for better care. A preoperative assessment was carried out and revealed a hemoglobin level of 10.5g/dl, slight hyponatremia and hypokalaemia, hypoalbuminemia at 2.5g/dl.

After conditioning and correction of the hydroelectrolytic disorders, the patient was presented to the UCV (visceral surgical emergencies) staff where the decision to perform a gastrotomy for bezoar extraction without any other imaging was taken. The patient was scheduled and a gastrotomy with removal of the trichobezoar was performed.



Fig I: Image of intraoperative gastrotomy



Fig II: Image of the surgical piece made of human hair (those of the patient)

The postoperative course was simple, a gradual resumption of food was instituted with the administration of a proton pump inhibitor, an antibiotic and an antispasmodic. Gradual weight regain was observed after three months.

A psychiatric consultation was scheduled after the wound had healed.

DISCUSSION

According to the data in the literature, the trichobezoar is often discovered in young children or even in adolescents and especially in young girls [1; 2; 3; 4; 5; 6; 7]. Trichophagia and trichotillomania since childhood are frequently mentioned [8; 9; 10; 11]. The trichobezoar whose first case was published in 1779 [12,13] and which represents 55% of all bezoars is made of hair, hairs or fibers of carpet or of variable size, intertwined most often in the gastric lumen, which can mold it with sometimes extensions in the duodenum, the jejunum and even beyond. It is known as "Rapunzel Syndrome" [14].

while the factors favoring the appearance of other bezoars are diverse – gastric emptying disorders, loss of normal motor functions of the pylorus, post-partial gastrectomy, high fiber diet, gastric antisecretory, absence of teeth, tachyphagia [18], those of the trichobezoar are psychological, as in our case: trichotillomania, trichophagia, depression, mental retardation or behavioral disorders [15-16; 17, 18,19].

At an early stage, nonspecific digestive signs (pain, nausea, vomiting, foul breath and early satiety) may be associated with weight loss, bald patches, eating disorders or anemia [17, 20, 5]; the same findings in our study.

Biologically, there may be anemia, hydroelectrolytic disorders, hypoalbuminemia as observed in our patient, hyperleukocytosis [5].

The esogastro-duodenal fibroscopy remains the reference paraclinical examination, which can have a diagnostic interest from the outset as in our case, and therapeutic by allowing the endoscopic extraction of small gastric trichobezoars [4; 5].

Abdominal ultrasound only allows the diagnosis to be made in 25% of cases, by visualizing a superficial, hyperechoic, curvilinear band with a clear posterior cone of shadow [4]. The esogastroduodenal transit demonstrates a gastric intraluminal lacuna, mobile, with convex edges, which may have an extension into the duodenum [4]. The transit of the small intestine completes the exploration of the intestine in search of a continuous distal extension or detached fragments [4]. The abdominal CT scan may show a mass of variable volume, heterogeneous, occupying almost all of the gastric lumen and made up of multiple concentric circles of different densities distributed in onion bulbs. Two pathognomonic and constant signs are the presence of tiny air bubbles scattered within the mass and the absence of any attachment to the gastric wall [20].

The treatment is usually surgical, and the evolution remains good [2].

Early diagnosis coupled with rapid surgical management after well-conducted exploration always lead to a simple postoperative follow-up [2].

CONCLUSION

The trichobezoar appears as a pathological curiosity, because of its particular nature.

Endoscopy may, for localized forms, be sufficient to make a positive diagnosis.

Supportive psychotherapy is an important step for better follow-up and should in no way be underestimated.

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