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Trichobezoard, the Other Clinical Manifestation of Depression: Compared to a Case

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Abstract **Case Report**

Gastric trichobezoard is a rare condition, whose diagnosis is easy in the presence of an evocative context. We report the case of a 24-year-old patient with a history of trichophagy and followed for mood disorder, admitted for acute abdominal pain mainly epigastric with notion of chronic constipation. The clinical examination was marked by the presence of an epigastric mass, the abdominal scanner evoked a gastric bezoar. A surgical treatment was performed with excision of trichobezoard by gastrotomy, without complications and a transfer to the psychiatric service for additional management.

Keywords: Gastric trichobezoard, diagnosis, trichophagy, gastric bezoar.

INTRODUCTION

Gastric trichobezoard is a rare condition that refers to the unusual presence of hair as a solid mass in the stomach [1].

Usually asymptomatic, his diagnosis is mainly based on x-ray including abdominal CT. Treatment is often surgical [1]. The purpose of this work is to discuss through an observation of gastric trichobezoard the diagnostic difficulties and the different therapeutic methods.

OBSERVATION

24-year-old ATCD trichophagy patient and followed for a depressive syndrome for 10 years on Paroxetine 1cp/J; Congenital blindness. She has been presenting for 5 years chronic constipation not improved by symptomatic treatment in an anorexia asthma context with an unencrypted weight loss.

Admitted in an acute abdomen panel evolving for 24 hours associated with a sub-occlusive syndrome with clinical examination stable conscious patient, apyretic integument and conjunctive pales with a sensitive abdomen in the epigastric region, presence of a hard and fixed mass measuring about 10 cm long axis.

On the biological balance, there was a microcytic anemia hypochrome with a hypo proteidaemia at 60 g/L and a hypo albuminemia at 30 g/L.

The X-ray of the abdomen without preparation shows a low aeration of the digestive tract, without water-aerated level (Figure 1). The CT complement concluded with a gastric trichobezoar of 14*6*5.5 cm not occlusive (Figure 2).

She was admitted to the operating room for umbilical midlaparotomy, the exploration revealed a distended stomach containing a large bezoad. Realization of a gastrotomy allowing the extraction of a huge trichobezoard embracing the whole form of the stomach (Figure 3), then closure of the gastrotomy by a surjet with vicryl 3/0.

The surgical follow-up was simple, the patient left after the surgery, sent to psychiatry to continue her follow-up. At the last check, the patient was clinically and psychically stable.

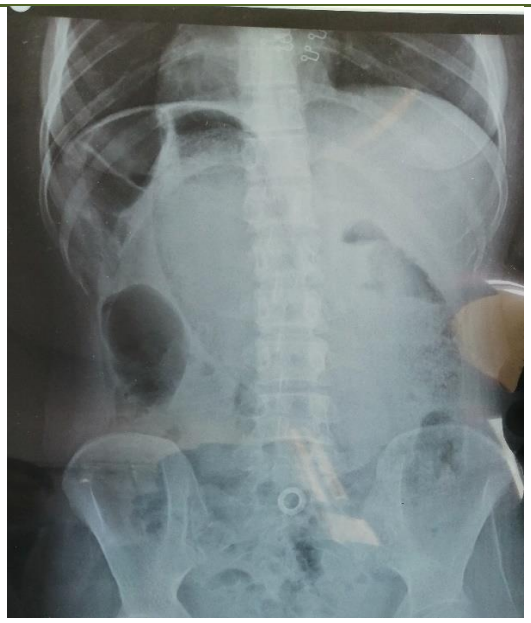

Figure 1: X-ray of the abdomen without preparation showing a low aeration of the digestive tract, without hydro-aeric level (Figure 1)

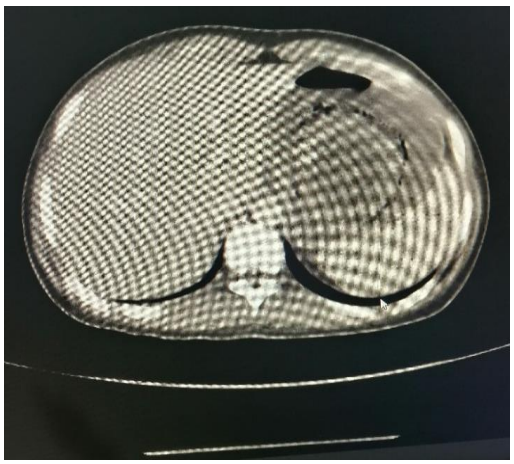

Figure 2: CT cross-section showing gastric trichobezoar 14*6*5.5 cm not occlusive (Figure 2)

Figure 3: Per operative image, the gastrostomy allows the extraction of a huge trichobezoard embracing the whole form of the stomach

DISCUSSION

Trichobezoar is a rare condition that must be evoked in front of a chronic constipation little specific; especially in young girls with mental disorders like depression, eating disorders [1] like our patient.

It represents 0.15% of the gastrointestinal foreign bodies. Our case corroborates the data of the literature on the predominance of the female sex 90% of cases and the age of occurrence is in 80% of cases less than 30 years, with a peak of incidence between ten and 30 years [2]. It is important to note that some environmental and psychological factors are a predisposing ground for the occurrence of trichobezoards (depression, tricholithomania…) [2].

This condition can remain asymptomatic for a long time or have a frustrating and varied symptomatology, which explains the delay in diagnosis that can go up to several years. Clinical symptomatology is very varied, non-specific [5].

Symptoms range from anorexia to abdominal pain, nausea, vomiting. It is possible to palpate the bezoar as a painless abdominal mass. Sometimes bezoar is revealed by a complication such as digestive bleeding or acute intestinal obstruction [3].

It can be revealed immediately by an acute complication; such as digestive hemorrhage, acute pancreatitis and even acute intestinal obstruction, as was the case with our patient [3].

Gastric localization is the most common, the curls of hair thus ingested are caught by the gastric mucosa to which they attach and form a more or less complex entanglement, a kind of mesh at the level of which the food are agglomerated, achieving a compact mass closely attached to the gastric wall [4].

The trichobezoard thus formed can extend to the small intestine sometimes arriving at the last ileal loop, or even to the transverse colon, thus achieving the Raponce syndrome [2].

In our patient, it was a trichobezoard affecting the stomach. The positive diagnosis was mentioned at the time of the examination (history of trichophagy) and confirmed by radiography.

Ultrasound can only be diagnosed in 25% of cases, by visualizing a superficial band, hyperechogenic, curvilinear with a clear cone of posterior shadow [5].

Computed tomography with opacification of the digestive tract, as well as magnetic resonance imaging, have a lesser interest in the diagnosis of trichobezoard. CT helps with the positive diagnosis and also helps to eliminate other possible etiologies in an occlusive syndrome with intra-gastric mass.

Oestroduodenal fibroscopy remains the examination of choice, allows the visualization of pathognomonic tangled hair of trichobezoard. It can sometimes be of therapeutic interest by allowing endoscopic extraction of small trichobezoar [5]. Surgical treatment allows extraction of gastric trichobezoard through gastrotomy [6].

Developments are often favourable. However, it remains conditioned by psychiatric management, based on behavioural therapy, parental education and medical treatment. It is mandatory to prevent recurrence.

CONCLUSION

Trichobezoard is a rare but not exceptional cause of occlusive syndrome. It should be mentioned especially in front of a psychic terrain where the history of trichophagy is present.

The poverty or even the variety of clinical symptomatology means that diagnosis is often delayed. Treatment is often surgical and psychiatric management is essential to prevent recurrence.

Ethical Aspects: The patient's consent was obtained for the use of his data for possible publication. We strictly respect anonymity and no image allows identification of the patient.

Authors' Contribution: All authors contributed to the elaboration of the work and approved the document.

REFERENCE

1. Maryame, E., Fouad, H., Mohamed, T., Wafaa, H., Ahmed, B., & Wafaa, B. (2017). Gastric trichobezoard: about a year case, *African Medical Journal*, 26, 74.
2. Khalid, M., Barsotti, P., Hicham, E., Ouadii, M., Elbachir, B., Taleb, K. A., & Abdelmalek, O. (2018). Trichobézoard gastroduodénal: à propos d'un cas. *The Pan African Medical Journal*, *30*, 25.
3. Atmani, H. E., Ibnsalah, O., Kabbaj, N., Guedira, M., Alaoui, M., Mohammadi, M., ... & Zizi, A. (2003). Gastric trichobezoar—About one case. *Acta Endoscopica*, *33*, 569-572.
4. A. Bounaim A. Sabir K. Mouhadi N. Aziz Giant gastric trichobezoard, J. Afr. Hepatol. Gastroenterol. (2009) 3:91-93
5. Moujahid, M., Ziadi, T., Ennafae, I., Kechna, H., Ouzzad, O., & Kandry, S. E. (2011). Un cas de trichobézoard gastrique. *Pan African Medical Journal*, *9*(1), 19.
6. Farouk, A., Diffaa, A., & Krati, K. (2013). Le bézoard gastrique: à propos de deux observations et revue de la littérature. *Hegel*, *3*(2), 124-127.