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Simultaneous locations of trichobezoar in a girl: Case report

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Abstract

Fingertip Trichobezoar is a rare condition in paediatrics, characterised by the presence of hair and/or fibres within the digestive tract. The stomach is the most common site of involvement, with possible extension into the small intestine, forming the well-known Rapunzel syndrome. In addition to small bowel extension, detached fragments may localise beyond the stomach. We report a case of gastro-duodenal and colonic trichobezoar in a 12-year-old girl, where the synchronous colonic location was discovered intraoperatively. Our aim is to highlight the diagnostic and therapeutic modalities of this condition, emphasising the importance exploration of the entire gastrointestinal tract to avoid missing synchronous lesions associated with gastric trichobezoar.

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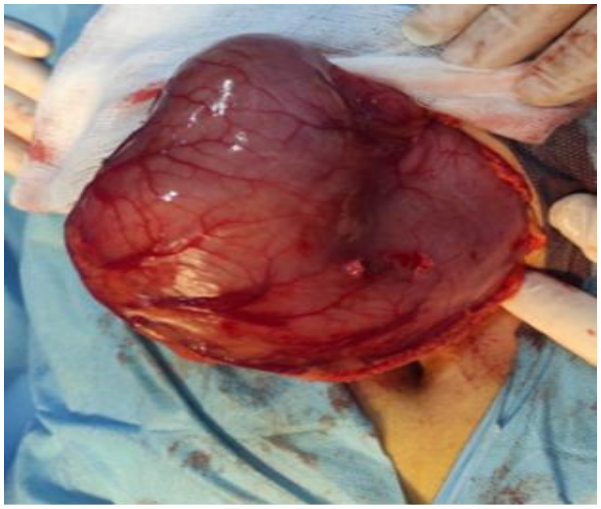
Introduction

Trichobezoar refers to the accumulation of indigestible material within the gastrointestinal tract, most commonly hair, but also animal fur or textile fibres. These materials become compacted with food debris and gastric secretions to form a solid mass, usually located in the stomach. This rare condition occurs predominantly in girls, accounting for approximately 90% of cases[1,2]. Clinical presentation is typically digestive but non-specific, often including a palpable epigastric mass. Treatment is mainly surgical, as endoscopic extraction is generally unsuccessful. Through this case, we revisit the diagnostic and therapeutic aspects of trichobezoar in children.

Case Description

We report the case of a 12-year-old schoolgirl with a 9-month history of mild epigastric pain and occasional vomiting. She presented to the paediatric surgery emergency department with diffuse abdominal pain, predominantly epigastric, associated with postprandial vomiting, without cessation of stool or gas passage.

Figure 1: Stomach containing the trichobizoar.



On clinical examination, she was conscious, afebrile, and well perfused. Abdominal examination revealed a firm, mobile, oblong epigastric mass measuring

approximately 12 cm. Abdominal ultrasound showed a distended stomach filled with heterogeneous impacted material extending toward a jejunal loop, suggestive of a trichobezoar. Routine blood tests were within normal limits, with no evidence of anaemia.

Figure 2: Trichobezoar visualisation after gastrotomy.

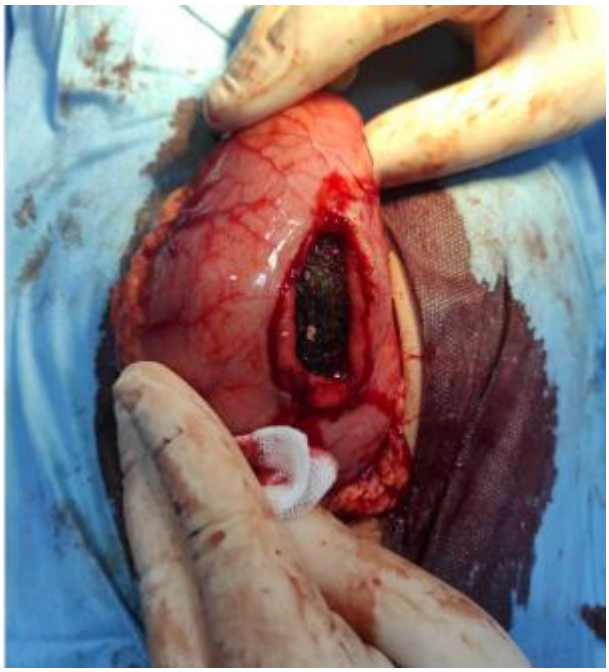
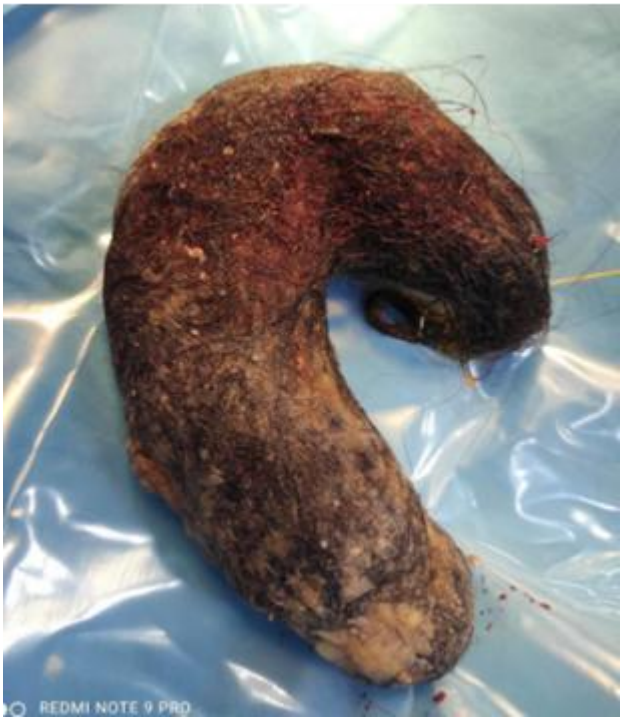


Figure 3: Trichobizoar after extraction.



A diagnosis of trichobezoar was made, and surgery was performed through a supraumbilical incision. Intraoperative findings revealed a mobile intragastric mass moulding to the shape of the stomach and extending into the duodenum (Figure 1). A 7-cm anterior gastrotomy allowed direct visualisation of the trichobezoar (Figure 2), which was successfully removed (Figure 3). The gastrotomy was closed in two layers (Figure 4).

Further exploration of the gastrointestinal tract revealed a second trichobezoar located in the transverse colon (Figure 5), which was removed via enterotomy. Postoperative recovery was uneventful. The patient was subsequently referred for psychiatric evaluation and follow-up.

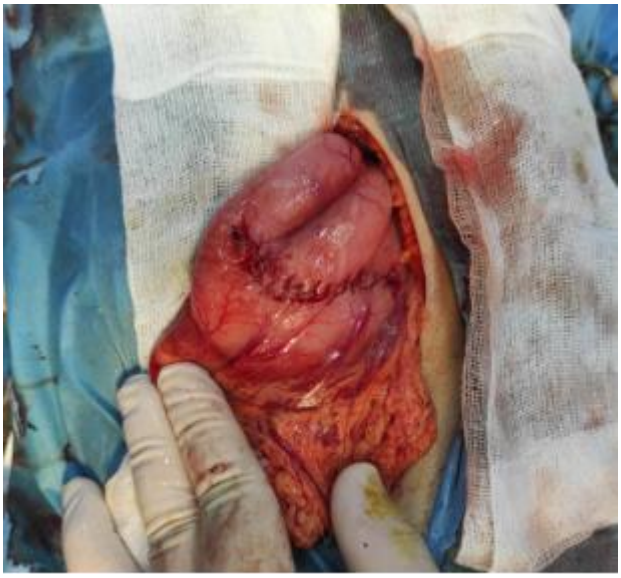
Discussion

Trichobezoar remains a rare paediatric condition, representing approximately 0.15% of all gastrointestinal foreign bodies[1]. In 75% of cases, it occurs in older children, with a marked female predominance. Our case is consistent with these epidemiological findings.

Although gastric localisation is the most common[3], a trichobezoar may extend through the pylorus into the duodenum and small intestine, a presentation known as Rapunzel syndrome. Detached fragments may migrate and cause obstruction in other segments of the gastrointestinal tract. Therefore, synchronous locations should be systematically investigated using imaging modalities or during surgical exploration. The discovery of a second synchronous colonic trichobezoar in our patient illustrates this rare presentation and highlights the importance of complete intestinal exploration.

Complications such as gastrointestinal bleeding, intestinal obstruction, perforation, secondary pancreatitis due to oedema at the ampulla of Vater, or intussusception may reveal the disease[4]. However, uncomplicated trichobezoars often present with non-specific digestive symptoms, including epigastric pain, nausea, vomiting, altered bowel habits, and abdominal mass. Extra-digestive manifestations such as iron-deficiency anaemia and weight loss have also been reported[5].

Figure 4: Stomach Appearance after the closure



Trichophagia-related alopecia, considered a key diagnostic clue, was absent in our patient, although she had long hair and reportedly chewed its ends. Psychological factors such as anxiety, emotional disturbances, or social withdrawal are frequently described. However, our patient had no diagnosed psychiatric disorder and demonstrated satisfactory academic performance.

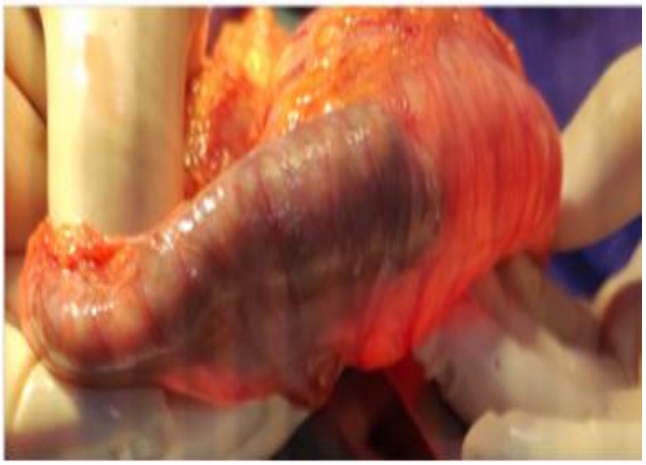
Ultrasound establishes the diagnosis in only approximately 25% of cases[6], but it was sufficient in our patient and no additional imaging was required. Typically, it reveals a hyperechoic mass with posterior acoustic shadowing. Some authors recommend combining ultrasound with contrast studies to assess extension into the duodenum and jejunum[7]. On contrast studies, a trichobezoar appears as a well-defined or heterogeneous filling defect within the gastric cavity.

Computed tomography and magnetic resonance imaging have limited additional diagnostic value[8] but may help identify synchronous locations[9]. Upper gastrointestinal endoscopy remains a valuable diagnostic tool for confirming trichobezoar and differentiating it from other intragastric foreign bodies[4].

Surgical removal through gastrotomy remains the standard treatment. Any extensions or detached fragments should be removed via additional enterotomies when necessary. Although laparoscopic extraction has been described by Palanivelu et al.[10], open surgery remains the preferred approach, particularly for large bezoars. Endoscopic removal may be attempted for small trichobezoars, but is often unsuccessful[4,8].

In our case, the patient had a massive trichobezoar occupying the entire stomach, requiring laparotomy for complete extraction. Psychiatric management is essential to prevent recurrence, and our patient was referred to a child psychiatrist upon discharge.

Figure 5: Second trichobezoar in the transverse colon.



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