Trichotillomania With Gastroduodenojejunal Trichobezoar

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Abstract

A 6-yr old girl presented with pain abdomen for 3 years and vomiting for one and half month. There was history of pulling of own scalp hair (Trichotillomania) and its ingestion (trichophagia). Her body weight was 16 kg, she looked pale. There is no alopecia. Per abdomen an irregular, firm non tender lump of 5 X 4 cm overlying the part of epigastrium and part of right hypochondrium, which moved from right to left after food intake. Ultrasound report shows a crescentic echogenic area in left hypochondrium in the region of stomach and dense acoustic shadowing posterior to it suggesting bezoar. Mildly dilated small bowel loops. CECT whole abdomen shows gastroduodenojejunal bezoar with bezoar in ileal loops and mild ascites. MRI abdomen shows bezoar in distal duodenum with adjoining thick wall of duodenum and proximal loop and gastric dilation. Upper GI endoscopy shows, a large ball of hair in the body of stomach with a thick root going into antrum and pylorus, scope could not be passed to the duodenum due to obstruction by hair ball. The final diagnosis was trichotillomania with gastroduodenojejunal trichobezoar.

Case Report(s)

A 6-yr old girl presented with pain abdomen for 3 years of mild to moderate intensity and vomiting for one and half month. Pain was insidious onset and gradually progressive, colicky in nature, started after food intake, relieved by vomiting and was non-radiating. Vomiting was gradually increasing in frequency and contained food particles. She also had early satiety.

There was history of pulling of own scalp hair (Trichotillomania) and its ingestion (trichophagia). She also used to take balloon and other materials within her reach.

Earlier she had defecated out hair and other materials (as told by her mother). But since last one and half year she did not defecated out those hair and others, but had fecal material. There is also history of significant weight loss in last two month. Her development was within normal limits, but there is history bed wetting.

On examination her body weight was 16 kg, she looked pale. There is no alopecia. Per abdomen an irregular, firm non tender lump of 5 X 4 cm overlying the part of epigastrium and part of right hypochondrium, which moved from right to left after food intake. Rest of the systemic examination is unremarkable

Routine laboratory investigations were Hb-11.9 gm/dl, TLC-8600/cmm, DLC-N50/L44/E04/M02, Platelets -360000/cmm. Ultrasound of upper abdomen shows few mildly enlarged mesenteric and retroperitoneal lymph nodes and minimal ascites. A second ultrasound report shows a crescentic echogenic area in left hypochondrium in the region of stomach and dense acoustic shadowing posterior to it suggesting bezoar. Mildly dilated small bowel loops. CECT whole abdomen shows gastroduodenojejunal bezoar with bezoar in ileal loops and mild ascites. MRI abdomen shows bezoar in distal duodenum with adjoining thick wall of duodenum and proximal loop and gastric dilation. Upper GI endoscopy shows, a large ball of hair in the body of stomach with a thick root going into antrum and pylorus, scope could not be passed to the duodenum due to obstruction by hair ball. The final diagnosis was trichotillomania with gastroduodenojejunal trichobezoar.

Discussion

Patients with trichotillomania may demonstrate a range of behaviours including hair-pulling, including stroking and playing with hair before pulling, or biting and swallowing the hair after it has been pulled (trichophagia). Other behaviours using pulled hair are present in half or more of patients, with 5 to 18% of patients ingesting hair. Thus, although medical complications of trichotillomania may be dermatological (eg, scalp infection, lack of hair regrowth, color and textural changes), orthopedic (eg, carpal tunnel syndrome), and dental (eg, gingivitis), trichobezoar is undoubtedly the most worrisome. The word bezoar is thought to be derived from the Arabic word for antidote—"bazahr" or "badzehr". Stones obtained from the stomach or intestines of animals were at one time thought to have medicinal properties. Of course, human The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)
classifies trichotillomania as an impulse-control disorder. Bezoars are in fact extremely dangerous. Without surgical intervention, mortality figures were noted to be more than 70% in the past and more recent estimates continue to remain high. The incidence of trichobezoar in trichotillomania is unclear. Christenson and Mansueto reported no cases of trichobezoar in their series of 186 patients with trichotillomania. Our own experience is consistent with that of Christensen and Mansueto, as this is the first of more than 100 patients screened by our clinic who has given a history of trichobezoar. However, Bhatia et al. reported that 37.5% of 24 young patients with trichotillomania had bezoars (25% trichobezoar, 12.5% trichophytobezoar)\(^2\). Similarly, a brief MEDLINE search yields dozens of cases of trichobezoar from many parts of the world, suggesting that this condition is not uncommon. More than 90% of patients with trichobezoar are females and more than 80% are under 30 years of age, figures that are reminiscent of the epidemiology of trichotillomania. Thus, the lack of a history of trichobezoar in patients attending trichotillomania clinics, who may be more motivated than others to combat their urges, may represent a form of selection bias. Trichobezoars are usually found in the stomach, but may also be found in the duodenum, ileum, jejunum, colon, or Meckel’s diverticulum. The term “Rapunzel syndrome” has been given to trichobezoars extending to the ileocecal valve. Appendicitis secondary to trichobezoar has been described only rarely. Trichobezoars may result in a range of gastrointestinal symptoms or may be asymptomatic. On physical examination, there may be a characteristic abdominal mass. Laboratory investigation may show anemia and, although iron deficiency has been suggested to be a cause of trichophagy, normal iron levels in most patients with trichotillomania suggest that this is rather a consequence. Radiological examination with barium swallow, ultrasonography, or computerized tomography may show a characteristic appearance. Given that endoscopic removal of trichobezoars is possible at times, an early diagnosis is advantageous. It has been pointed out previously that there are animal models of hair pulling, including avian feather picking. It is less well known that captive primates are also susceptible to trichophagia and trichobezoars. This may occur in the baboon, chimpanzee, and tamarin.

**Conclusion**

The importance and severity of the medical complications of trichotillomania (and of other disorders with compulsive symptoms) should not be underestimated. Although studies of the pharmacotherapy of trichotillomania remain inconsistent, some patients, like the one described here, do seem to respond to fluoxetine or other serotonin reuptake inhibitors. Increased awareness of these disorders at a primary health care level should be encouraged.

**Authors contribution(s)**

Clinical management, preparation of manuscript

**References**

Illustrations

Illustration 1

Figure 1: Trichobezoar at the pylorus of the stomach.

Illustration 2

Figure 2: Trichobezoar in the small intestine.
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