RECURRENT TRICHOBEZOAR IN A CASE OF TRICHOTILLOMANIA

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ABSTRACT

A rare case of 13 years old female child with recurrent trichobezoar stomach which needed reoperation for its removal is reported. Patient also had trichotillomania and mental retardation. She showed satisfactory response to therapy with fluoxetine.

Key Words: Trichobezoar, trichotillomania, fluoxetine.

A bezoar is a mass of foreign material in the stomach and intestine of man and animals. Trichobezoars are formed from the hair of the patient, other humans or animals, bristles, raffia, carpet fiber, the wool of clothes or blankets and the hair of dolls and other children's toys. They are an occupational hazard in brushmakers, blanket weavers and wool workers. Eighty percent of cases occur before the age of 30 years with a peak in the second decade. Trichobezoars are comparatively rare in children. More than 90% are reported in females, particularly those with long hair. An underlying psychological disturbance is common and recurrence and the need for reoperation is rarely encountered (Bouwer & Stein, 1996; Jiledar et al., 1996). A case of recurrent trichobezoar requiring reoperation is reported because of its rarity.

CASE REPORT

This 13 years old daughter of an exserviceman was admitted on 12-10-99 with the complaints of pain abdomen, vomiting, anorexia, weakness and loss of weight of 2 months duration. History revealed that about three years back she was admitted with pain abdomen and operated when a ball of hair was removed from her stomach. Patient admitted to pulling her hair and eating the hair quietly while lying under a quilt. There was no family history of psychiatric disorders. She was the eldest of three siblings from a non-consanguineous marriage. Eldest sister 21 years old was married, younger sister 11 years old was studying in class 5. No maternal illness during pregnancy. She was a full term normal delivery in hospital. Developmental milestones were normal. She began going to school at 4 years of age. Even after 4 years she could not pick up anything and discontinued studies. As per parents she was quiet child, had no friends but helped her mother in household chores. Menstrual history—menarche not attained.

Examination showed a thinly built child. Height 140 cms. Weight—27 kg. Pallor+. Halitosis+. Abdomen showed old midline laprotomy scar. A soft, vaguely outlined 15 cm by 10 cm mass palpable in epigastrum to the left side. Mental status examination showed an illkempt girl with loss of hair. She spoke very little in low tone and was depressed. There were no features of psychosis.

Investigations: ESR 48 mm fall in first hour(Wintrobe). Hb 7.7 gm%. LFT, blood urea, serum creatinine—WNL. Abdominal radiograph AP view showed a mass projecting into the gastric air bubble. Barium meal & follow through—2 hours after administration of Ba meal appearance suggested a large mass in the lumen of stomach with barium adsorbed on its surface (bezoar). Patchy thickening of jejunal mucosa and spasm of caecum was noted.
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USG abdomen showed a 12 cm long & 4 cm wide echogenic lump to the left of the epigastrum. Liver, gall bladder, spleen, kidneys & bladder were normal. On Seguin form board her mental age was less than 6 years.

She was initially treated with hematinics, fluoxetine 20 mg daily and supportive psychotherapy. She improved gradually. Depression lifted, appetite improved and she said that she had stopped pulling and eating her hair. On 5 Jan 2000 she was operated and trichobezoar removed. She was discharged with advice to continue hematinics and fluoxetine. On review in Mar 2000 her weight was 34 kg. She was not depressed and hair pulling had stopped. Her hair had increased in length.

DISCUSSION

Trichotillomania (TTM) patients demonstrate a range of behaviours surrounding their hair pulling, including stroking and playing with the hair before pulling or biting and swallowing the hair after it has been pulled. Oral behaviour using pulled hair is present in half the patients with 5-18% ingesting hair (trichophagia). Although the medical complications of TTM may be dermatological (scalp infection, lack of hair regrowth, colour and textural changes), orthopedic (carpal tunnel syndrome) and dental (gingivitis), trichobezoar is undoubtedly the most worrisome (Sharma et al., 2000). The incidence of trichobezoar in TTM is unclear. Three series of 186, 100 & 24 TTM patients reported that 0%, 1% & 37.5% had bezoars (Bouwer & Stein, 1998; Bhatia et al., 1991). 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 ileocaecal valve (Singla et al., 1999).

Trichobezoars may present with abdominal pain, nausea, vomiting, weakness, loss of weight (as seen in our patient) and may be complicated by obstruction, ulceration, perforation and peritonitis. Less common presentations and complications include nutritional deficiencies, change in levels of medication, pancreatitis, obstructive jaundice, superior mesenteric artery syndrome, intussusception and acute appendicitis. Investigations may show anemia as in our patient. Although iron deficiency has been suggested to be a cause of trichophagy, normal iron levels in most patients with TTM suggest that this is rather a consequence (Bouwer & Stein, 1998; Jileddar et al., 1996).

The only satisfactory treatment for trichobezoar is surgical intervention which carries a low mortality (5%). Endoscopic removal is possible. Cognitive behavior therapy is the most effective treatment for TTM. Although studies of the pharmacotherapy of TTM remain inconsistent, some patients, like the one described here, do respond to fluoxetine or other SSRIs.

REFERENCES

Bhatia, M.S., Singh, P.K. & Rastogi, V. (1991) Clinical profile of trichotillomania. Journal of the Indian Medical Association 89, 137-139.

Bouwer, C. & Stein, D.J. (1998) Trichobezoars in trichotillomania. Case report and literature overview. Psychosomatic Medicine 60, 658-660.

Jileddar, Singh, G. & Mitra SK. (1996) Gastric perforation secondary to recurrent trichobezoar. Indian Journal of Pediatrics. 63, 689-691.

Sharma, N.L., Sharma, R.C., Mahajan, V.K., Sharma, R.C., Chauhan, D. & Sharma A.K. (2000) Trichotillomania and trichophagia leading to trichobezoar. Journal of Dermatology 27, 24-26.

Singla, S.L., Rattan, K.N., Kaushik, N. & Pandit, S.K. (1999) Rapunzel syndrome - a case report. American Journal of Gastroenterology. 94, 1970-1971.

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