Upper gastrointestinal obstruction due to trichobezoar

Un cas d’occlusion digestive secondaire à un trichobézoard

A bezoar is an intraluminal mass formed by the agglomeration of indigestible material in the GI tract. A trichobezoar is made of indigestible hair or hair-like fibres. It is seen mostly in women less than 30 years with trichotillomania and/or trichotillipha-gia and is usually associated with other psychiatric disorders. Clinical symptoms are non-specific. Complications include GI tract obstruction and perforation. Removal of the bezoar using endoscopic and/or surgical approach is often the sole treatment. We report here the case of a 16-year-old woman, suffering from acute-on-chronic upper GI obstruction due to trichobezoar that required surgical removal.

Case report

A 16-year-old woman presented herself at the emergency department with a 2-week history of abdominal pain. Associated symptoms included anorexia, postprandial emesis and bloating. She had no prior history of medical problems or ongoing medication. She denied any ingestion of NSAIDs or caustic agents. Physical examination revealed abdominal tenderness and a tender epigastric mass. She had lost 7 kg over the past 2 months (BMI 15 kg/m²). CT-scan showed a heterogeneous and non-enhancing mass extending from the fundus to the duodenum (figure 1). Laboratory investigations showed an albumin of 23 g/L (normal range, 30–50), an haemoglobin of 6.9 g/dL (12.5–15.5) with VGM of 67 µL, a ferritin of 7 µg/L (50–120). B9 and B12 vitamins were normal, as well as transglutaminase antibodies. Esophagogastroduodenoscopy revealed a large bezoar occluding the entire stomach and extending into the duodenum. The patient stated that she had a habit of trichotilliphagia when she was a child but she had stopped eating her hair since she was 8. Endoscopic removal was attempted but failed due to the large size of the bezoar. Laparoscopic removal was also attempted. Conversion to an open procedure was then required to remove 1.2 kg of agglomerate hair (figure 2). The patient was discharged at day 8 after resuming normal oral feeding. She was referred for psychiatric follow-up. One year after the surgery, she was asymptomatic, regained her normal body weight and denied any remnant trichotilliphagia. CT-scan showed no recurrence of the bezoar.

Discussion

Herein we report an unusual case of upper GI obstruction due to trichobezoar in a 16-year-old woman. The natural history of trichobezoar remains unclear. Trichobezoars are collections or concretions of indigestible hair or hair-like fibres that accumulate and coalesce in the gastrointestinal tract, usually the stomach [1]. It is believed that the smooth surface of hair does not allow for its propagation through peristalsis, getting trapped in the lumen [2]. However, the stomach of normal individuals is able to clear even large foreign bodies in 80 to 90% of cases, which may imply that bezoars require years to form and even more to become symptomatic [3,4]. In this case, the trichobezoar became symptomatic almost 10 years after the patient had stopped eating her hairs. Trichotilliphagia is often characterised by repetitive rituals that resemble the ritualistic behaviors of obsessive compulsive disorder [5]. Although behavioural therapy and cognitive behavioural therapy have demonstrated good efficacy in randomized controlled trial, a substantial percentage of patients relapse after acute treatment discontinuation [6]. Therefore, it is questionable whether this patient had really stopped trichotilliphagia and

Figure 1
CT-scan showing a heterogeneous and non-enhancing mass extending from the fundus to the duodenum
trichotillaphagia as she had not been followed up for years. It is also conceivable that a trichobezoar continues to grow with the aggregation of other undigested materials. Indeed, it has been reported that trichotillomania could be associated with other obsessive compulsive symptoms such as nail biting and eating [6]. Therefore, it should be considered to propose endoscopic screening for patients with trichotillomania and/or trichotillophagia, since endoscopic removal of a larger bezoar at a later stage may be more challenging and lead to surgery.

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References


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Cavitary pulmonary disease in a patient treated with natalizumab

Pneumopathie cavitaire sous natalizumab

Natalizumab (Tysabri®) is a humanized monoclonal antibody, a selective adhesion molecule inhibitor. It inhibits binding of cells expressing α4β1 integrin and αvβ7 integrin (e.g., lymphocytes) to vascular-cell adhesion molecule 1 and mucosal addressin-cell adhesion molecule 1 on endothelial cells. Thus, it reduces the migration of immunocompetent cells from peripheral blood into the target organs, i.e. the central nervous system of patients with multiple sclerosis (MS) and the intestinal tract of patients with inflammatory bowel disease [1]. Natalizumab is indicated in active remitting-relapsing MS and as second-line therapy for induction and maintenance of remission for moderate to severe Crohn’s disease. With the exception of progressive multifocal leukoencephalopathy (PML) due to JC polyomavirus [2], natalizumab does not appear to increase the risk of infection in clinical trials.