Case Report

Trichobezoar presenting as intestinal obstruction in a child: A case report

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ABSTRACT

Trichobezoar is a rare cause of gastrointestinal (GI) obstruction resulting from the accumulation of ingested hair. Most affected cases are of young females with underlying psychiatric disorders. It is a slowly progressive condition that later presents with symptoms of GI obstruction. We present the case of a 5-year-old previously healthy girl who presented with progressive abdominal distension, abdominal pain, and vomiting. Ultrasound imaging revealed signs suggestive of intussusception, a common cause of pediatric bowel obstruction. Emergency exploratory laparotomy was done to prevent the risk of delayed intervention and, surprisingly, revealed two boluses of trichobezoar, which were successfully removed. The post-operative period remained uneventful, and psychiatric counseling was initiated. Trichobezoar, though rare, should be considered as a differential diagnosis of terminal ileal obstruction in the pediatric population presenting with acute abdomen, unusual eating habits, and family discord. Various treatment modalities include upper GI endoscopy, laparoscopy, and/or laparotomy depending on the location of obstruction. Most importantly, a comprehensive psychiatric workup has proven beneficial for long-term prognosis.

Key words: Children, Intestinal obstruction, Laparotomy, Rapunzel syndrome, Trichobezoar

Bezoars are intraluminal accumulations of indigestible material within the gastrointestinal tract, most commonly located in the stomach due to the restrictive effect of the pylorus. Rarely, it may cross the gastric body through the pylorus and can present in the small intestine. Trichobezoars in the stomach extending to the small intestine are commonly referred to as Rapunzel Syndrome [1]. Trichobezoars are often associated with a history of trichophagia and trichotillomania, which is a condition involving recurrent pulling of one's hair for gratification [2]. Although Baudamant reported the first case of trichobezoar in 1779 [3], the term "Rapunzel syndrome" was first described by Vaughan *et al*. in 1968 to denote gastric trichobezoar with extension into the small intestine [4]. Trichobezoar is uncommon in younger children and is more frequently reported in adolescent females with underlying psychiatric disorders [5]. The presentation is often insidious, with symptoms ranging from abdominal discomfort, early satiety, and vomiting to complications such as intestinal perforation and peritonitis.

The following report describes a case of terminal ileal trichobezoar in a 5-year-old girl presenting with acute intestinal obstruction, initially suspected to be intussusception on ultrasonography. Though an uncommon differential diagnosis, timely management with laparotomy and psychiatric intervention resulted in a favorable outcome. This case highlights the diagnostic challenges and emphasizes the importance of maintaining clinical suspicion in atypical presentations.

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CASE REPORT

A previously healthy 5-year-old girl presented to the Emergency Department with the sudden onset of generalized abdominal pain for 2 days. It was associated with 4–5 intractable episodes of bilious vomiting per day for the past 2 days. There were no significant aggravating or relieving factors. The child had a history of on-and-off abdominal pain for almost 3 months prior to the acute presentation. On retrospective questioning, the parents confirmed the history of trichotillomania and trichophagia. There was no history of constipation, diarrhea, hematemesis, melena, fever, trauma, or loss of weight. The patient had no relevant past medical or surgical history. Immunization status was up to date. The child was born at term with an uneventful postnatal period. All developmental milestones for the age were

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attained. Family history was insignificant for any medical or psychiatric illness. The parents were divorced, and the child is staying with the mother.

On general physical examination, the patient appeared inactive and irritable. All vital signs were normal for age (blood pressure: 100/60, pulse rate: 106/min, respiratory rate: 18/min, temperature: 98.7°F). Clinical examination revealed pallor and no lymphadenopathy. Peripheral pulses were present with good volume. Systemic examination revealed a soft, distended abdomen, a vague mass was palpable in the right lumbar region, non-tender, no guarding, or rigidity. Bowel sounds were hyperperistaltic. Per rectal examination showed no fecal staining or ballooning. Other systemic examinations were unremarkable.

Laboratory parameters were unremarkable except for an elevated total white blood cell count (13930 cells/mm^3) with neutrophilic predominance (85.1%) and serum alkaline phosphatase (300 IU/L). All other clotting parameters and renal function tests, including serum electrolytes, remained normal (Table 1).

Table 1: Laboratory investigations of the patient

Category	Parameter	Value
Complete blood picture	International normalized ratio	1.23
	Hemoglobin	12.0
	Red blood cells	4.63
	Packed cell volume	36.9
	Mean corpuscular volume	79.7
	Mean corpuscular hemoglobin	26.0
	Mean corpuscular hemoglobin concentration	32.6
	Red cell distribution width	14.3
	Total count	13930
	Polymorphs	85.1
	Lymphocytes	13.4
	Eosinophils	0.2
	Monocytes	0.9
	Basophils	0.1
Liver function tests	Total bilirubin	1.2
	Direct bilirubin	0.2
	Indirect bilirubin	1.0
	Serum glutamic-oxaloacetic transaminase	41
	Serum glutamate pyruvate transaminase	22
	Alkaline phosphatase	300
	Total protein	6.6
	Serum albumin	4.3
	Globulin	2.3
	A/G ratio	1.9:1
	Gamma-glutamyl transferase	13
Prothrombin time	PT-test	16.30
	PT-control	13.5
Renal function tests	Blood urea	14
	Serum creatinine	0.3
	Serum sodium	136
	Serum potassium	3.9

Ultrasound of the abdomen and pelvis showed a bowel-appearing lesion of size 30 × 20 mm in the right iliac fossa with mild prominence of proximal bowel loops (2.6 cm). Sluggish peristalsis was noted in the proximal bowel loops. A few subcentimetric lymph nodes were noted along with mild ascites. The above radiological assessment showed features suggestive of ileocecal intussusception. X-ray of the abdomen in the erect position showed dilated small bowel loops, possibly an ileum with multiple air fluid levels (Fig. 1). Contrast-enhanced computed tomography (CT) was not performed due to signs of acute obstruction and ultrasound findings suggestive of intussusception requiring urgent intervention.

Given the clinical signs of obstruction, radiologic evidence, and ultrasound findings suggestive of ileocecal intussusception, the risk of delayed intervention was avoided, and the patient was admitted and taken up for emergency exploratory laparotomy to prevent bowel ischemia and further deterioration.

Operative findings included approximately 100 mL of serous peritoneal fluid. The proximal small intestinal loop was distended, and the terminal ileum and transverse colon were found to be collapsed. Intraoperatively, what was expected to be an ileocecal intussusception turned out to be 2 boluses of hair of sizes measuring approximately 7 cm and 9 cm in the terminal ileum about 30–50 cm proximal to the ileocecal junction. Ileotomy was performed, and the trichobezoar was removed (Fig. 2).

The post-operative period was uneventful. The child and parents were counseled for behavioral therapy and long-term psychiatric follow-up. The patient was started on an oral diet on postoperative day 2 and was discharged on postoperative day 5.

DISCUSSION

Acute onset of abdominal pain is one of the most common complaints in the pediatric population. Bezoars in children are uncommon and may be classified based on

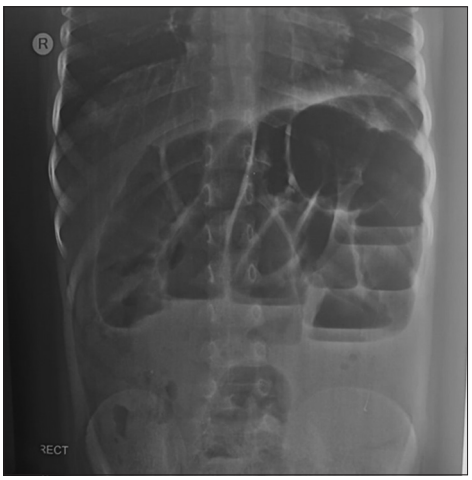

Figure 1: X-ray abdomen showing multiple dilated bowel loops suggestive of intestinal obstruction

Figure 2: Trichobezoar: Boluses of hair measuring approximately 7 cm and 9 cm removed from the terminal ileum

their composition into trichobezoars (hair), phytobezoars (vegetable fibers), pharmacobezoars (medications), and lactobezoars (milk solids). Among these, trichobezoar is closely related to an underlying psychological stressor associated with trichotillomania and trichophagia.

Pediatric trichobezoar typically presents with abdominal pain, early satiety, vomiting, weight loss, or a palpable abdominal mass. The absence of constipation in this case may be explained by the evolving and incomplete nature of the obstruction prior to complete luminal occlusion.

A previous study reported a case of gastric trichobezoar associated with idiopathic thrombocytopenic purpura and iron deficiency anemia in a 15-year-old girl with complaints of loss of weight, and she was treated with laparotomy [6]. Another case report described a case of trichobezoar with features suggestive of small bowel obstruction found in a 14-year-old girl. She presented with complaints of upper abdominal pain, bilious vomiting, and constipation for 5 days, and underwent exploratory laparotomy [7]. The present case is unusual due to the young age (5 years) of presentation, distal small bowel location, and a radiological mimicry of intussusception.

The differential diagnosis of acute intestinal obstruction in children includes intussusception, volvulus, Meckel's diverticulum, congenital bands, and foreign bodies. Diagnosing trichobezoar before surgery can be difficult because the symptoms are often non-specific and overlap with other common causes of intestinal obstruction in children. On ultrasonography, an intraluminal mass such as a bezoar may produce a target-like appearance resembling intussusception and lead to diagnostic confusion. While contrast-enhanced CT provides better delineation of size, location, and extension, emergency surgical exploration was prioritized in this case due to acute obstruction and patient bystander preference.

Endoscopic removal may be attempted for small gastric bezoars [8]. However, large bezoars or those extending beyond the pylorus typically require surgical removal via laparoscopy or laparotomy. In cases presenting with distal small bowel obstruction, as seen here, enterotomy with removal remains the definitive treatment [9]. Psychiatric evaluation and behavioral therapy are crucial components of management to prevent recurrence.

CONCLUSION

Trichobezoar can present as a terminal ileal obstruction in children. It may clinically and radiologically mimic more common conditions such as intussusception, leading to diagnostic challenges. Early surgical intervention combined with psychiatric evaluation is essential for optimal outcomes. A high index of suspicion is necessary, particularly in children with atypical presentations or behavioral risk factors.

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