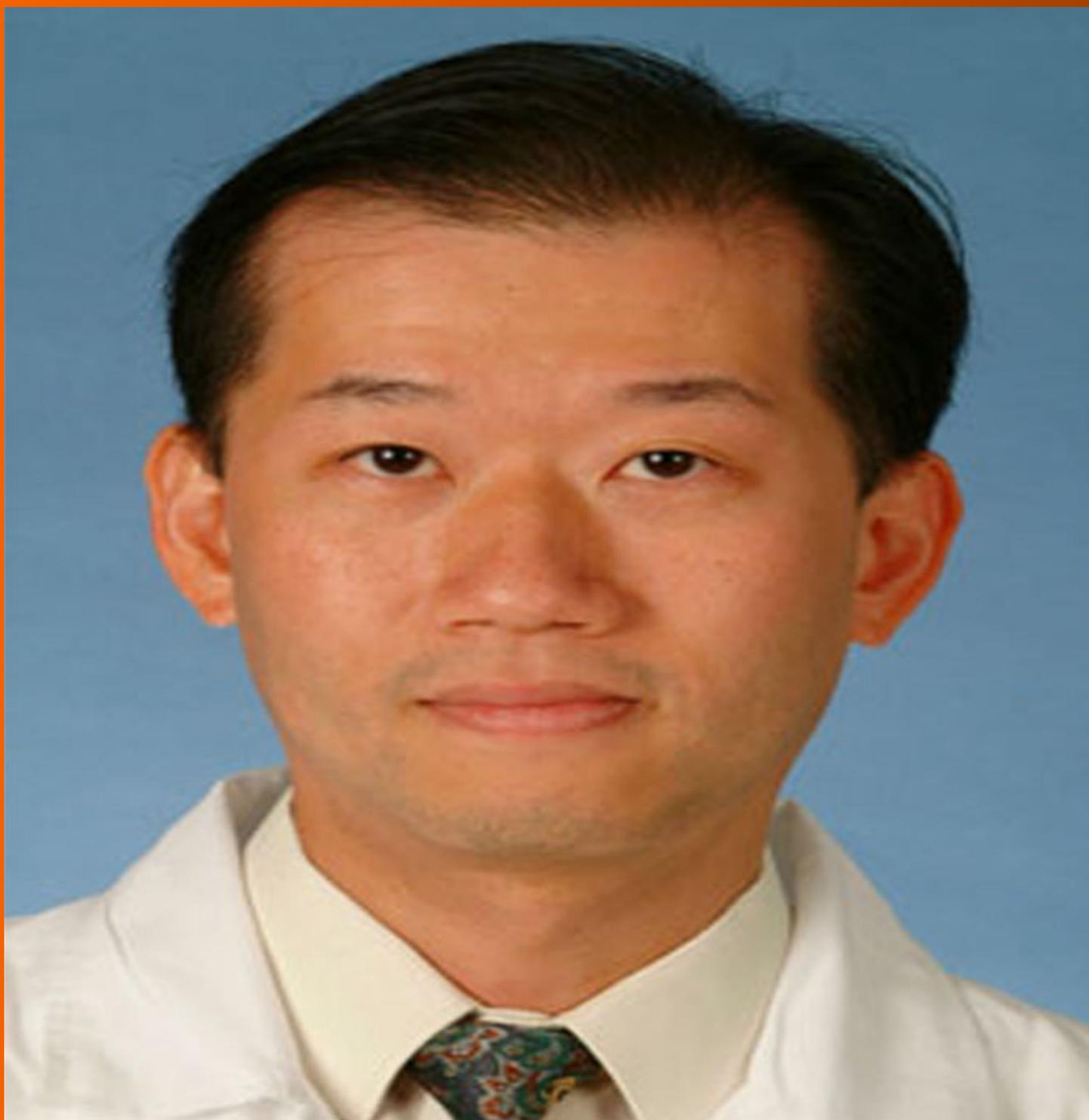


World Journal of *Clinical Cases*

World J Clin Cases 2019 November 6; 7(21): 3384-3682



EDITORIAL

- 3384 Current controversies in treating remnant gastric cancer: Are minimally invasive approaches feasible?
Ma FH, Liu H, Ma S, Li Y, Tian YT

ORIGINAL ARTICLE**Retrospective Study**

- 3394 Efficient management of secondary haemophagocytic lymphohistiocytosis with intravenous steroids and γ -immunoglobulin infusions
Georgiadou S, Gatselis NK, Stefos A, Zachou K, Makaritsis K, Rigopoulou EI, Dalekos GN
- 3407 Impress of intergenerational emotional support on the depression in non-cohabiting parents
Jia YH, Ye ZH
- 3419 Nomograms for pre- and postoperative prediction of long-term survival among proximal gastric cancer patients: A large-scale, single-center retrospective study
Chen QY, Hong ZL, Zhong Q, Liu ZY, Huang XB, Que SJ, Li P, Xie JW, Wang JB, Lin JX, Lu J, Cao LL, Lin M, Tu RH, Zheng CH, Huang CM

Observational Study

- 3436 Modified Cortex Mori Capsules improving the successful rate of functional filtering blebs after reclinical glaucoma filtering surgery
Yu J, Qiu LX, Qing GP, Zhao BW, Wang H
- 3446 Effect of cognitive behavior therapy combined with exercise intervention on the cognitive bias and coping styles of diarrhea-predominant irritable bowel syndrome patients
Zhao SR, Ni XM, Zhang XA, Tian H

Prospective Study

- 3463 Normal values of shear wave velocity in liver tissue of healthy children measured using the latest acoustic radiation force impulse technology
Sun PX, Tong YY, Shi J, Zhang H, Liu SJ, Du J

SYSTEMATIC REVIEW

- 3474 Characteristics of clear cell renal cell carcinoma metastases to the thyroid gland: A systematic review
Khaddour K, Marernych N, Ward WL, Liu J, Pappa T
- 3486 Irritable bowel syndrome and functional constipation management with integrative medicine: A systematic review
Dai L, Zhong LL, Ji G

- 3505 How about the reporting quality of case reports in nursing field?

Yang KL, Lu CC, Sun Y, Cai YT, Wang B, Shang Y, Tian JH

CASE REPORT

- 3517 Gastro-gastric intussusception in the setting of a neuroendocrine tumor: A case report

Zhornitskiy A, Le L, Tareen S, Abdullahi G, Karunasiri D, Tabibian JH

- 3524 Retroperitoneal perivascular epithelioid cell tumours: A case report and review of literature

Touloumis Z, Giannakou N, Sioros C, Trigka A, Cheilakea M, Dimitriou N, Griniatsos J

- 3535 First Italian outbreak of VIM-producing *Serratia marcescens* in an adult polyvalent intensive care unit, August-October 2018: A case report and literature review

Iovene MR, Pota V, Galdiero M, Corvino G, Di Lella FM, Stelitano D, Passavanti MB, Pace MC, Alfieri A, Di Franco S, Aurilio C, Sansone P, Niyas VKM, Fiore M

- 3549 Transfemoral aortic valve implantation in the case of pre-existing mitral prosthesis and pure aortic regurgitation: A case report

Erdem A, Esen Zencirci A, Ozden K, Terzi S

- 3553 Methotrexate-related lymphoproliferative disorders in the liver: Case presentation and mini-review

Mizusawa T, Kamimura K, Sato H, Suda T, Fukunari H, Hasegawa G, Shibata O, Morita S, Sakamaki A, Yokoyama J, Saito Y, Hori Y, Maruyama Y, Yoshimine F, Hoshi T, Morita S, Kanefuji T, Kobayashi M, Terai S

- 3562 Re-revision surgery for re-recurrent valgus deformity after revision total knee arthroplasty in a patient with a severe valgus deformity: A case report

Du YQ, Sun JY, Ni M, Zhou YG

- 3569 Liver transplantation for severe portopulmonary hypertension: A case report and literature review

Chen XJ, Zhu ZJ, Sun LY, Wei L, Zeng ZG, Liu Y, Qu W, Zhang L

- 3575 Leiomyosarcoma of the stomach: A case report

Kang WZ, Xue LY, Tian YT

- 3583 Out-of-hospital cardiac arrest in a young adult survivor with sequelae of childhood Kawasaki disease: A case report

Zhu KF, Tang LJ, Wu SZ, Tang YM

- 3590 Squamous cell carcinoma of the nail bed: A case report

Li PF, Zhu N, Lu H

- 3595 Multidisciplinary treatment of a patient with necrotizing fasciitis caused by *Staphylococcus aureus*: A case report

Xu LQ, Zhao XX, Wang PX, Yang J, Yang YM

- 3603** Myocardial ischemic changes of electrocardiogram in intracerebral hemorrhage: A case report and review of literature
Lin XQ, Zheng LR
- 3615** Adenomyoma of the distal common bile duct demonstrated by endoscopic ultrasound: A case report and review of the literature
Xu LM, Hu DM, Tang W, Wei SH, Chen W, Chen GQ
- 3622** Child with Wiskott–Aldrich syndrome underwent atypical immune reconstruction after umbilical cord blood transplantation: A case report
Li BH, Hu SY
- 3632** Epiphyseal distraction and hybrid reconstruction using polymethyl methacrylate construct combined with free non-vascularized fibular graft in pediatric patients with osteosarcoma around knee: A case report
Liang YH, He HB, Zhang C, Liu YP, Wan J
- 3639** Bilateral common carotid artery common trunk with aberrant right subclavian artery combined with right subclavian steal syndrome: A case report
Sun YY, Zhang GM, Zhang YB, Du X, Su ML
- 3649** Giant gastroduodenal trichobezoar: A case report
Dong ZH, Yin F, Du SL, Mo ZH
- 3655** Compound heterozygous mutation of *MUSK* causing fetal akinesia deformation sequence syndrome: A case report
Li N, Qiao C, Lv Y, Yang T, Liu H, Yu WQ, Liu CX
- 3662** Hypoparathyroidism with Fahr’s syndrome: A case report and review of the literature
Zhou YY, Yang Y, Qiu HM
- 3671** Primitive neuroectodermal tumors of the abdominal wall and vulva in children: Report of two cases and review of the literature
Xu QQ, Xing WW, Chen G, Dang YW, Luo YG, Chen P, Liang SW, Chen JB

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Giant gastroduodenal trichobezoar: A case report

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Abstract

BACKGROUND

We report a case of giant gastroduodenal trichobezoar, an extremely rare upper gastrointestinal bezoar due to trichotillomania and trichophagia.

CASE SUMMARY

The patient was a 10-year-old girl who presented with an abdominal mass that was discovered at palpation and noninvasive imaging examinations. Computed tomography (CT) showed a well-circumscribed heterogeneous mass extending from the stomach into the duodenum. The patient underwent a laparotomy to pull out the trichobezoar. Although these imaging findings are nonspecific, trichobezoar should be included in the differential diagnosis of gastric mass, especially with the history of an irresistible urge to pull out and swallow their hair.

CONCLUSION

Laparotomy is useful and practical for the management of giant gastroduodenal trichobezoar.

Key words: Tomography; X-ray; Trichobezoar; Trichotillomania; Trichophagia; Case report

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Core tip: A case of giant gastroduodenal trichobezoar, an extremely rare upper gastrointestinal bezoar due to trichotillomania and trichophagia, is reported. The patient was a 10-year-old girl who presented with an abdominal mass that was discovered at palpation and noninvasive imaging examinations. Computed tomography showed a well-circumscribed heterogeneous mass extending from the stomach into the duodenum. Laparotomy is useful and effective for the treatment of giant gastroduodenal

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INTRODUCTION

A trichobezoar is a rarely encountered mass of hair, wool, and similar material in the stomach and intestine of some patients with trichotillomania and trichophagia. The accumulated hair within the stomach and intestine is resistant to digestion, which occasionally presents as trichobezoar-induced bowel or gastric outlet obstruction^[1-6]. Moreover, trichobezoar frequently leads to a spectrum of nonspecific clinical findings, including early satiety, anorexia, vomiting, and vague abdominal pain^[7,8]. Clinically, most of the trichobezoars are usually found in young females between 15 and 20 years of age because of their nonspecific presentations or even lack of clinical symptoms in the early stage^[9,10]. Herein, we describe the clinical and imaging features of a 10-year-old girl determined as having a giant gastroduodenal trichobezoar with a history of an uncontrolled urge to pull out her hair (trichotillomania) and swallow it (trichophagia).

CASE PRESENTATION

Chief complaints

A ten-year-old girl presented to our emergency department with a one-day history of abdominal pain after intermittent vomiting of gastric contents and inappetence for approximately 9 d.

History of present illness

Acute gastritis was initially suspected, while it was not supported by the symptoms and therapy history.

History of past illness

It is noteworthy that her mother admitted that this girl had developed an irresistible habit of pulling and swallowing her hair from two years old, which mainly happened unconsciously during sleep or when she was lonely.

Personal and family history

Her parents had no history of swallowing hair.

Physical examination

On physical examination, a movable mass was palpable in the left upper quadrant, and no sign of a rebound, peritonitis, or apparent hair loss was noted.

Laboratory examinations

Laboratory results indicated anemia, hypoproteinemia, and hyponatremia, with a hemoglobin level of 115 g/L (normal range, 120–160 g/L), hematocrit 33.5% (normal range, 35.0%–49.0%), total protein 58 g/L (normal range, 63–82 g/L), albumin 28 g/L (normal range, 35–50 g/L), and sodium 136 mEq/L (normal range, 137–145 mEq/L). An elevated white blood cell count of 10050/μL (normal range, 4000–10000/μL) and a neutrophil ratio of 80% (normal range, 50.0%–70.0%) were demonstrated.

Imaging examinations

Noninvasive imaging examinations were performed, including plain chest radiography, ultrasound, and computed tomography (CT). Plain radiographs showed that the chest was normal. Abdominal ultrasound demonstrated an intragastric hyperechoic mass, with a prominent posterior acoustic shadow of 13 cm in the maximum diameter. The residual dual gastric cavity could be detected at the fundus of 1.3 cm in width after drinking 300 mL of water. Noncontrasted-enhanced CT clearly showed a heterogeneous, meshlike mass with air sign filling the gastric cavity,

from the fundus to the pylorus, measuring approximately 12.7 cm × 9.4 cm × 5.3 cm in size (Figure 1). On the coronal CT images, the mass extended from the stomach into the duodenum (Figure 2). Furthermore, the well-defined margin of the mass was outlined by the surrounding air in the stomach on the three-dimensional (3D) maximum intensity projection images (Figure 3).

FINAL DIAGNOSIS

Based on the clinical, imaging, and surgical outcomes, the final diagnosis was a giant gastroduodenal trichobezoar due to trichotillomania and trichophagia.

TREATMENT

Since the mass was so large, laparotomy was considered (Figure 4). Under general anesthesia, all the imaging findings mentioned above were confirmed during the surgical process.

OUTCOME AND FOLLOW-UP

The postoperative course was uneventful, and the girl was referred to behavioral and mental health providers after discharge.

DISCUSSION

In 1779, Baudamant described the first case of trichobezoar that is one of the bezoars with intraluminal accumulations of indigestible ingested hair. Trichotillomania is an uncommon disorder affecting about 1% of the population, and one-third of these patients have trichophagia^[11]. It usually occurs in patients with mental retardation, personality or psychiatric abnormalities, and sufferers have an irresistible urge to pull out and swallow their hair, termed as trichotillomania and trichophagia. Occasionally, Rapunzel syndrome is encountered as an infrequent complication of trichobezoar formation in which the gastric bezoar is extended into the duodenum and small intestine, which can increase the risk of complications such as obstruction and perforation. Trichobezoar with Rapunzel syndrome is predominantly found in emotionally disturbed or developmentally disabled youngsters because of their nonspecific presentations or even lack of clinical symptoms in the early stage^[12].

Clinically, patients with trichobezoar frequently present nonspecific symptoms and signs including loss of appetite, weight loss, vomiting, and abdominal pain^[10,13,14]. After long periods of time, the epigastric mass can be palpable when it is gradually enlarged, even associated with trichobezoar-induced gastric pylorus or bowel obstruction. In clinical practice, early diagnosis may be difficult for these nonspecific symptoms and signs. However, advanced noninvasive imaging modalities, including conventional upper gastrointestinal radiography, ultrasound, CT, and nuclear magnetic resonance imaging (MRI), are beneficial for making preoperative diagnosis and clinical management decision as previously reported^[13,15-19]. In our case, the little girl was initially suspected with acute gastritis based on the nonspecific symptoms and laboratory results such as abdominal pain, anemia, hypoproteinemia, and hyponatremia. Fortunately, ultrasound and CT provided the positive information for the diagnosis, especially combined with 3D reconstructed CT images. As a noninvasive and nonirradiated tool, MRI is also useful for detecting this entity, especially in the pediatric population^[20]. More importantly, the history of mental disorder, the uncontrolled urge to pull out one's hair and swallow it, is vital as a critical clue for making a clinical diagnosis. After the diagnosis is made, treatment modalities, including observation, dissolution, and surgery, could be considered. When a thickened mass is detected, surgical approach severing as an optimal choice could either be laparoscopic or open laparotomy^[6,8,12,21,22]. Before the operation, noninvasive imaging modalities are beneficial for the pre- and post-operative assessment of trichobezoar and its possible complications, which can help make management decisions to reduce the frequency of clinical hazards.

CONCLUSION

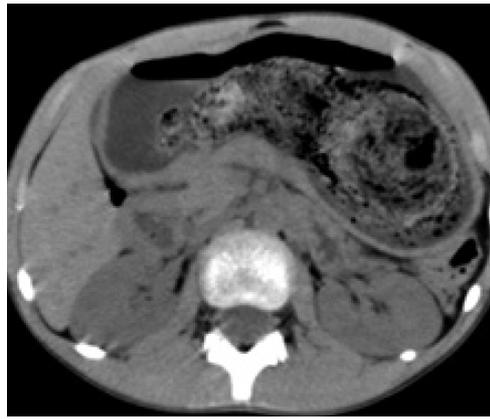


Figure 1 Axial computed tomography image showing a hairball in the stomach.

As above, laparotomy is useful and practical for the treatment of giant gastroduodenal trichobezoar.

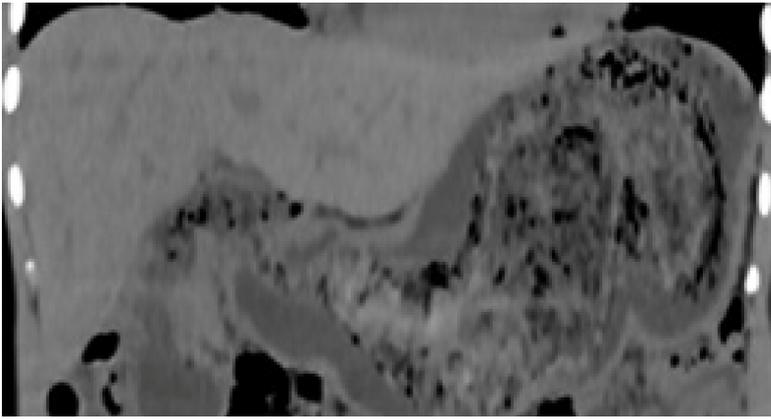


Figure 2 Coronary multiplanar reconstruction computed tomography image showing the extension of a hairball from the stomach into the second part of the duodenum.

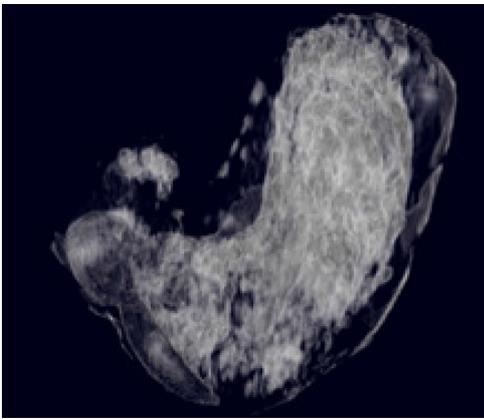


Figure 3 Three-dimension maximum intensity projection image showing the outline of a hairball defined by the air pockets in it.

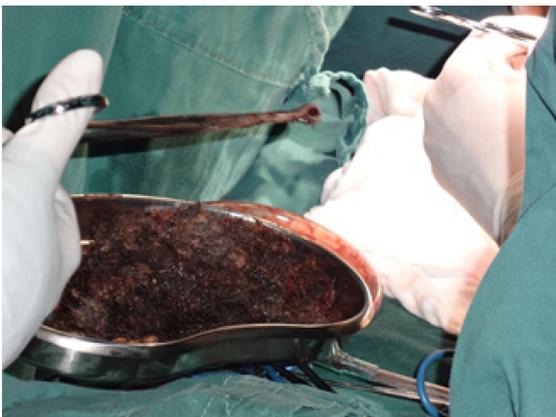


Figure 4 Postoperative photograph of the hair pulled from the stomach.

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