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Surgery with Cross-Speciality Approach to Pediatric Gastric Trichobezoar Obstruction In Indonesia: A Case Report

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Abstract

Trichobezoar, a rare condition in pediatric patients affecting less than 1%, often associated with trichotillomania, can lead to obstructive symptoms in severe cases. However, none of the published cases have documented surgical intervention alongside interdisciplinary collaboration in Indonesia that comply SCARE 2023. This case report aims to enhance pediatric trichobezoar literature, by sharing tailored approaches for limited-resource settings and the role of multidisciplinary strategies with surgical intervention. We represent a case of an 8-year-old girl from a low-resource setting with a recent episode of vomiting after consuming her own hair for the past six months. Esophagogastroduodenoscopy revealed hair bezoar completely occluding the gastric pylorus. The patient underwent laparotomy with gastrotomy to extract the bezoar. She was then treated by the psychiatrist for trichotillomania, by the pediatrics for catch-up growth, and by the dermato-venereologist for alopecia. No complications or adverse events were observed. Diagnosing and managing pediatric gastric trichobezoar necessitates a multidisciplinary approach beyond surgery for effective treatment and prevention of recurrence.

Keywords: trichobezoar, gastric obstruction, pediatrics, Indonesia, pediatric surgery

Introduction

Trichobezoar, a rare condition in pediatric patients affecting less than 1% and commonly linked to trichotillomania, can lead to life-threatening obstructive symptoms in severe cases (Habib et al., 2022; Paschos et al., 2019). Despite its rarity, trichobezoar presents significant diagnostic and therapeutic challenges, particularly in resource-limited settings like Indonesia. The decision to document our case arises from three compelling factors. Firstly, the rarity of pediatric trichobezoar with limited healthcare infrastructure necessitates sharing clinical experiences. Secondly, none of the published cases have documented surgical intervention alongside interdisciplinary collaboration (Mirza et al., 2020). Finally, there is no established standard of care for pediatric trichobezoar. This case report enhances pediatric trichobezoar literature in Indonesia, sharing tailored approaches for limited resources and multidisciplinary strategies with surgical intervention. To our knowledge, this is the first case report documenting pediatric trichobezoar in adherence with the 2023 Surgical Case Report (SCARE) guidelines (Sohrabi et al., 2023).

Case Summary

An 8-year-old elementary school girl from a low-income family was referred to the surgical outpatient clinic by her primary care physician. She presented with partial obstructive symptoms of a recent episode of vomiting, in addition to moderate upper abdominal pain persisting for three months markedly after meals. Significant weight loss and decreased stool frequency over the past three months were also noted. Her parents explained that she had been consuming her hair for six months (Figure 1). The patient had no significant past medical or surgical history, no drug history, no known allergies, and no inheritable conditions from first-degree relatives. Her parents described her as emotionally unstable and noted difficulties in socializing with peers. Additionally, her school performance was reported to be poor.

Physical examination revealed a distended abdomen with a hard, tender, immobile mass in the epigastric region. Hemodynamic parameters were normal. The patient was referred to pediatrics, dermatology, and psychiatry for further evaluation. The pediatric assessment indicated underweight nutritional status, with a Body Mass Index (BMI) below the 25th

percentile per Center for Disease Control (CDC) guidelines. A dermatological examination showed alopecia areata. The psychiatric evaluation, including a Wechsler Intelligence Scale for Children (WISC-V) test, scored 79, indicating a very low learning capacity. The mental status examination confirmed trichophagia and avoidant personality traits.

The patient's laboratory tests were remarkable. Initial abdominal X-rays in anteroposterior and left lateral decubitus views revealed a homogenous opacity in the epigastrium, extending to the left hypochondrium with a mild intestinal loop deviation and gastric dilation, suggesting partial bowel obstruction. A subsequent abdominal CT scan, both with and without contrast, showed a mixed-density mass with well-defined borders at the gastric level (Figure 2). An esophagogastroduodenoscopy confirmed the diagnosis of a hair bezoar, completely occluding the gastric pylorus (Figure 3). The diagnosis was delayed due to difficulties accessing healthcare and cultural factors that made the patient's parents hesitant to seek medical care. The initial differential diagnosis was leiomyosarcoma based on the CT scan, but esophagogastroduodenoscopy ultimately confirmed the presence of a gastric trichobezoar.

The patient underwent comprehensive preoperative preparation, including a 6-hour fasting period, intravenous hydration with normal saline, a single dose of cefazolin 1 g, and paracetamol 250 mg alongside ondansetron 3 mg, each administered three times daily. A nasogastric tube was inserted for gastric decompression to minimize the risk of aspiration from gastric reflux. The procedure was performed under general anesthesia. The timing of surgery was promptly determined upon obtaining informed consent from the patient's parents, in response to the urgency of addressing the obstructive symptoms.

To extract the bezoar, the patient underwent supraumbilical midline laparotomy (Figure 4). The incision was made through successive layers, beginning with the cutaneous layer until the gaster was exposed. Intraoperatively, a smoothly contoured intraluminal mass was discovered occupying most of the stomach pylorus. A longitudinal gastrotomy measuring 5 cm was performed parallel to the area midway between lesser and greater curvature, through which a cohesive trichobezoar encompassing the stomach was extracted. The proximal part of the bezoar mimicked the shape of the gastric pylorus, measuring 17 cm in total length (Figure 5). The bezoar mass was not sent for pathological examination because the diagnosis was confirmed through esophagogastroduodenoscopy and consistent clinical and imaging findings. Additionally, direct observation during extraction confirmed the bezoar's composition as hair, ruling out the possibility of a neoplasm. The gastrotomy was carefully closed in two layers, followed by irrigation of the peritoneal cavity with warm sterile normal saline. Closure of the gastrotomy and abdominal incision was achieved through primary repair using absorbable sutures. In this case, a patch (such as a Graham or Cellan-Jones patch) was not required. The gastrotomy was a "clean-cut" incision, allowing for primary closure through direct suturing.

The surgery was performed at the National District Hospital in Bondowoso, East Java. A surgeon with 10 years of experience conducted the procedure, strictly following the initial management plan.

Post-operative care was administered in the surgical ward following the surgery. Medications administered in the surgical ward included infusion of normal saline solution, cefuroxime injection 350 mg three times daily, and paracetamol 250 mg alongside ondansetron 3 mg, each administered three times daily. Nutrition therapy was tailored to meet the patient's daily caloric needs, calculated based on the Recommended Daily Allowance (RDA) and ideal body weight per CDC guidelines. During postoperative days 1 and 2, the patient remained on full parenteral nutrition via intravenous infusion to provide adequate caloric and protein intake while ensuring gastric rest. Clear liquids, such as water or Dextrose 5%, were introduced on day 2 to "prime" the stomach and stimulate gastric peristalsis. By day 3, oral feeding was initiated after confirming gastric passage, indicated by minimal nasogastric tube output (<1.5–2 ml/kgBW/hour), typically measured over a 4–6-hour period to align with the gastric emptying time. A liquid diet consisting of milk or other nutrient-dense liquids was administered via the nasogastric tube. On days 4 and 5, with demonstrated tolerance to liquid nutrition (absence of abdominal discomfort or distension), a gradual transition to semisolid foods such as porridge was made. A full solid diet was introduced orally on postoperative day 7.

The patient was hospitalized for five days in the surgical ward for recovery, experiencing initial wound pain. Daily follow-ups showed improvement, and by the fifth day, she was discharged with no complaints, a well-healed surgical wound, and no pus discharge. Upon discharge, she was prescribed paracetamol 250 mg and lactulose 6 grams, each three times daily. She was scheduled for follow-ups in surgery, psychiatry, pediatrics, and dermatology. In outpatient care, the psychiatrist provided supportive psychotherapy and aripiprazole 0.5 mg once daily. The pediatrician prescribed supplementation for catch-up growth, including formula F-100, folic acid, vitamin B6, and zinc 20 mg once daily. The dermatologist prescribed olive oil ointment and desoximetasone cream. The patient was advised to refrain from ingesting her hair. At the one-year follow-up, her parents confirmed adherence to this advice, although she still experienced bloating. A multislice computerized tomography (MSCT) scan revealed no foreign bodies or obstructions. She was prescribed antacid and metoclopramide 3 mg three times daily for symptomatic relief. At the two-year and three-year follow-ups, the patient remained asymptomatic, and abdominal ultrasounds within the first two years postoperatively showed normal results. Although the patient experienced episodes of vomiting during this period, and the parents expressed concern about the possibility of the child ingesting hair again, no gastric masses were detected on ultrasound. The patient's BMI improved significantly, from 14 to 18 kg/m². These outcomes align with expected clinical results, and no complications or adverse events were observed, underscoring the efficacy of the multidisciplinary approach in her recovery.

Discussion

To our knowledge, four similar published cases exist in Indonesia (Table 1). Our case is the first documented case in Indonesia of a multidisciplinary approach to trichobezoar-induced gastric obstruction in a pediatric patient, following the SCARE 2023 guidelines.

Trichobezoar is a rare condition in pediatric patients, affecting fewer than 1%, and is linked to trichotillomania (Paschos et al., 2019; Habib et al., 2022). It is more common in females, consistent with our case and previous reports (Woods et al., 2014). The typical age of onset for diagnosis is around 13 years, although similar cases have varied (Sinha et al., 2017; Kwon et al., 2023). Our case is the youngest documented case in Indonesia (Woods et al., 2014; Liang et al., 2024). Gastric trichobezoars are collections of indigestible hair that accumulate in the stomach, potentially leading to obstruction symptoms. Our patient presented partial obstruction symptoms, as gas and stool could still pass through the gastrointestinal tract. This aligns with the symptoms reported in a previous case (Poerwosusanta et al., 2020). Some obstruction cases present with progressive symptoms (Habib et al., 2022; Sinha et al., 2017), while others have an acute onset (Halimun et al., 1992; Bilommi et al., 2017; Poerwosusanta et al., 2020; Berawi et al., 2022; Kwon et al., 2023). Differentiating between gastric and intestinal obstruction based on symptoms can be challenging. However, like in our case, gastric obstruction typically presents with a sensation of fullness or pain after eating, whereas intestinal obstruction is indicated by vomiting accompanied by bile (Habib et al., 2022). Trichobezoar is usually associated with trichotillomania (Woods et al., 2014). Our case underscores the functional impairments associated with trichotillomania, such as challenges in peer socialization and low academic performance.

The most common signs of intestinal obstruction reported in previous case studies are a distended abdomen, palpable abdominal mass, and tenderness, which are consistent with our case (Mirza et al., 2020). In severe cases, abdominal perforation can occur; however, no perforation was observed in our patient, unlike in the case described before where perforation was indicated by shock and peritoneal signs (Halimun et al., 1992). Additionally, our patient exhibited signs of feeding disturbance as a result of chronic hair ingestion, specifically being underweight with a BMI below the 25th percentile. Due to trichotillomania, our patient also developed alopecia areata, which is also consistent with the clinical presentations described by two studies (Habib et al., 2022; Kwon et al., 2023). Furthermore, our case highlights the functional deficit from the mental health assessment and WISC-V. These findings are supported by studies indicating that trichotillomania diagnosis must be associated with functional deficits (Woods et al., 2014).

In our case, an abdominal X-ray and CT scan were initially utilized to exclude differential diagnoses of the abdominal mass. Following this, esophagogastroduodenoscopy was performed to confirm the diagnosis, which was consistent with the approaches reported by the two studies (Kwon et al., 2023; Poerwosusanta et al., 2020). This contrasts with some studies that relied solely on abdominal CT, plain radiographs, or ultrasound for diagnosis (Halimun et al., 1992; Bilommi, 2017; Sinha et al., 2017; Berawi et al., 2022; Habib et al., 2022). The variation in diagnostic approaches may be influenced by factors such as the urgency for diagnosis, parental willingness, the child's cooperativeness, and complications consideration (Bilommi et al., 2017; Habib et al., 2022; Kwon et al., 2023).

In our case, the extraction of the bezoar was performed through laparotomy with a supraumbilical incision followed by a gastrotomy, unlike the endoscopic-laparoscopic approach described by Kwon et al. and Poerwosusanta et al. Our center's location influenced this decision in a rural part of Indonesia, where advanced endoscopic technology is not available. Additionally, the patient's family was unwilling to travel to a well-equipped center due to financial constraints and the travel distance, which posed a burden.

Compared with other studies, our approach was similar to the majority of previously published cases (Halimun et al., 1992; Bilommi et al., 2017; Sinha et al., 2017; Berawi et al., 2022; Habib et al., 2022). The laparotomy was performed with an upper umbilical incision to access and visualize the stomach, facilitating the gastrotomy. However, we performed a 5 cm longitudinal gastrotomy midway between the lesser and greater curvatures, differing from the technique by Bilommi et al., who performed a 15 cm gastrotomy on the major curvature (Bilommi et al., 2017). This difference was due to the smaller size of the bezoar in our case, which allowed for easier access and reduced bleeding risk, given the lower vascularity between the lesser and greater curvatures. The decision was to ensure effective removal while minimizing complications.

In the future treatment of trichobezoar, it is suggested that surgery alone is insufficient to prevent recurrences; a multidisciplinary approach is essential. During follow-up, the patient was consulted cross-specialty. The psychiatrist prescribed aripiprazole 0.5 mg once daily and provided psychotherapy. By the second-year follow-up, the patient had achieved total abstinence from hair-pulling (Farhat et al., 2020). The pediatrician addressed the patient's nutritional needs, prescribing F-100 formula-based complementary feeding, folic acid, vitamin B6, and zinc 20 mg once daily for catch-up growth, following the World Health Organization guidelines. By the second-year follow-up, the patient's nutritional status had improved significantly (Brander et al., 2019). For the alopecia, the dermato-venereologist prescribed olive oil ointment to support hair regrowth (Fernandes et al., 2021). This interdisciplinary collaboration resulted in excellent outcomes, including faster recovery, no recurrences, and high parental satisfaction over a two-year follow-up period.

In reassessing recurrence, most studies do not mention specific follow-up imaging; however, our case utilized a CT scan at the first follow-up and abdominal ultrasound at the second follow-up to detect any newly developed bezoar. The rationale for this approach is that both CT scan and ultrasound can effectively identify new bezoars, with CT scan being superior. Due to the cost constraints faced by the patient's family, we performed the CT scan only once, with subsequent examinations using ultrasound (Wijaya et al., 2018).

Unlike other published reports, the unique strength of our case lies in the comprehensive, multidisciplinary approach alongside surgery intervention on pediatric trichobezoar that conforms to the most recent SCARE 2023 guidelines (Sohrabi et al., 2023). However, there are several limitations to our case. First, as a single-center report, it may not reflect the diversity in patient demographics, clinical practices, and outcomes. Multicenter

studies are needed to enhance the generalizability of our findings. Second, socioeconomic factors, including financial constraints, and limited access to advanced healthcare. Additionally, the patient's parents, from a low-education background, had difficulty recognizing the severity of the symptoms, which contributed to a delayed diagnosis.

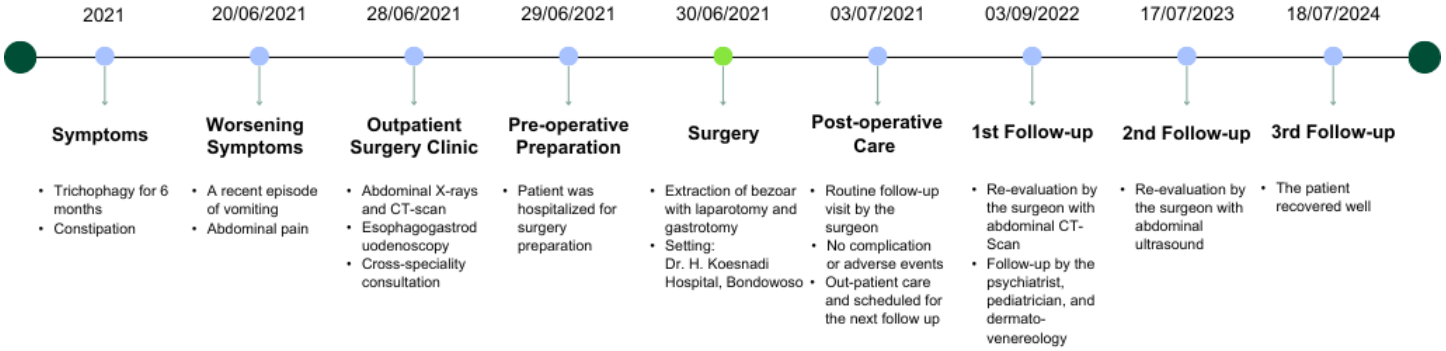

Figure 1. Timeline of events following The SCARE Guideline 2023.

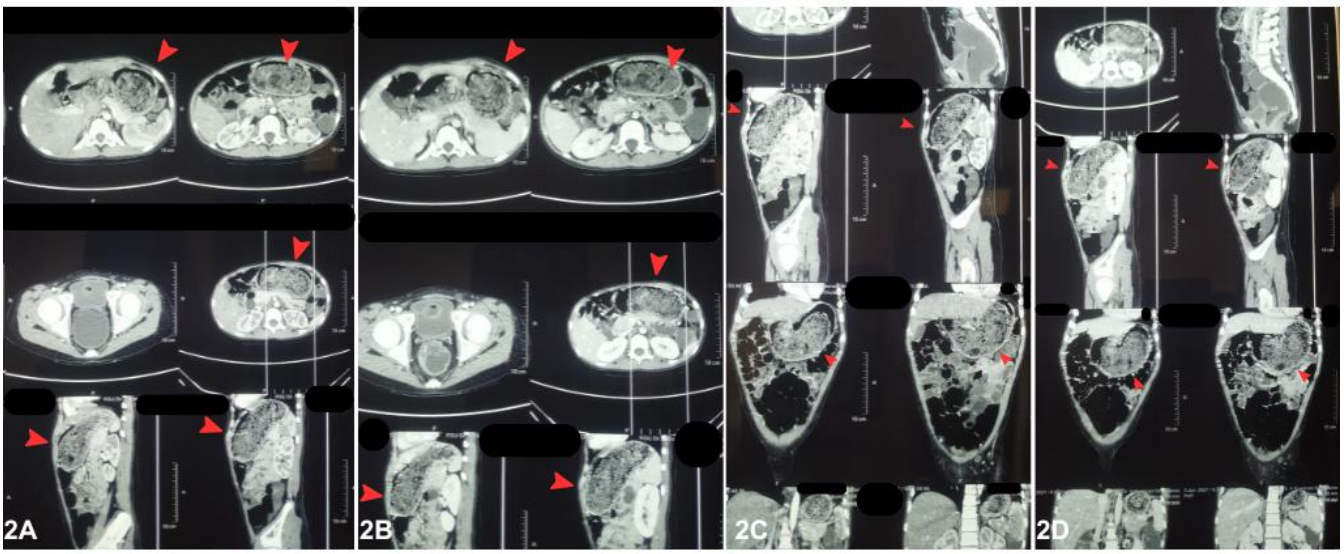

Figure 2. Axial view of abdominal CT-Scan (2A)(2B), sagittal view of abdominal CT-Scan (2C)(2D), a mixed-density mass with well-defined borders, regular edges, and encapsulation at the gastric level (red arrows).

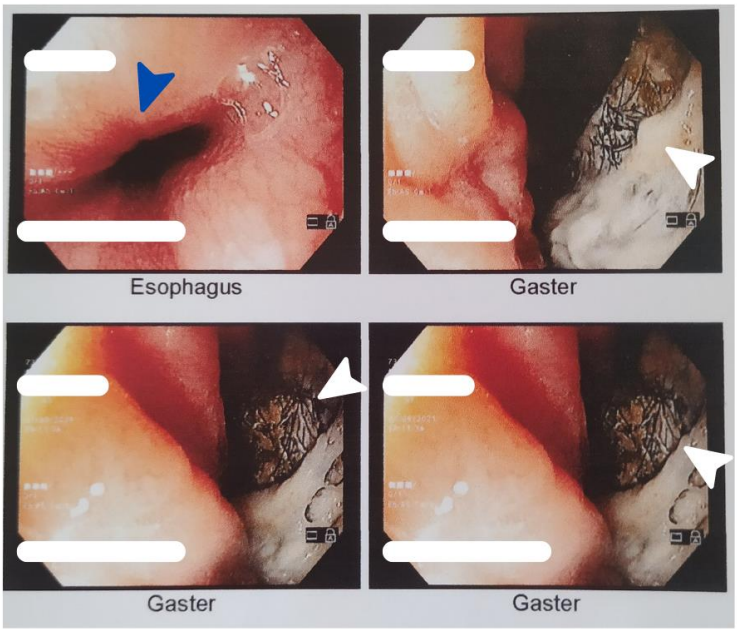

Figure 3. Esophagogastroduodenoscopy showed a hair bezoar completely occluding the gastric pylorus (white arrows) and erosive gastritis (blue arrow).

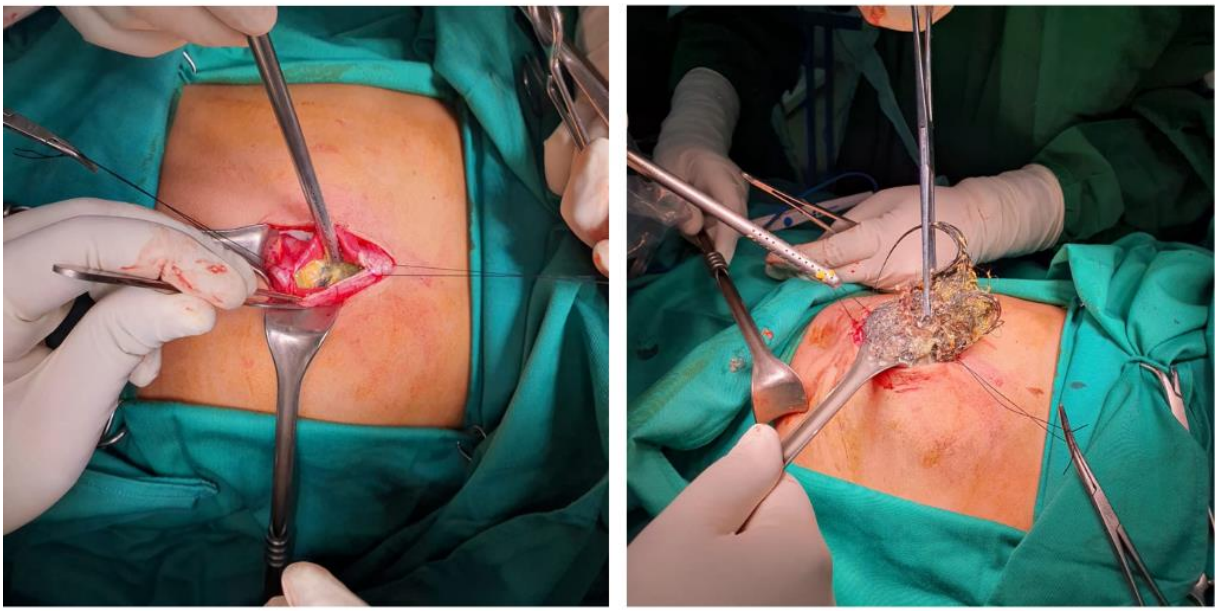

Figure 4. Supraumbilical midline laparotomy with gastrotomy.

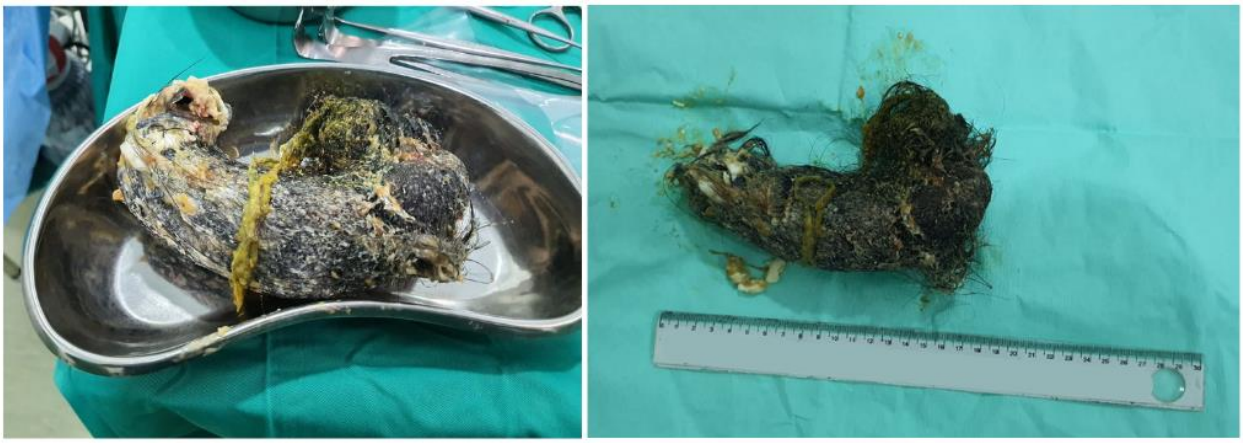

Figure 5. A trichobezoar, 17 cm long and shaped like the gastric pylorus, was extracted from the stomach.

Table 1. Summary of published cases of gastric trichobezoar in children

Author, year of publication, country	Patient's age (years)	Symptoms	Clinical presentation	Diagnosis modalities	Surgery	In collaboration with another speciality mentioned
Kwon et al., 2023, South Korea	**1st case:** 13 **2nd case:** 12	**1st case:** nausea, vomiting, and epigastric pain for 2 days. **2nd case:** epigastric pain, dizziness, and melena for 2 days	**1st case:** A large, hard mobile nontender mass was palpated in the epigastric area. Bald area on scalp. **2nd case:** Not described	**1st** case: Adbominal CT-Scan with contrast, upper gastrointestinal endoscopy **2nd** case: Abdominal CT-Scan	Endoscopic removal was initially attempted but failed, necessitating a subsequent laparoscopy. When laparoscopy also failed, the incision was extended, and a gastrotomy over the gastric antrum was performed	Pediatric psychiatrist
Habib et al., 2022, Pakistan	**1st case:** 9 **2nd case:** 12	**1st case:** abdominal pain and weight loss since 2 months, upper abdominal pain **2nd case:** anorexia and weight loss since 6 months, progressive nausea and vomiting since	**1st case:** thin hair on the scalp and a palpable non-tender, mobile mass in the epigastric region (7x8 cm) **2nd case:** palpable non-tender mobile mass in the epigastric egion (8x8 cm)	X-ray abdomen and pelvis, CT-Scan abdomen and pelvis with contrast	Exploratory laparotomy with gastrotomy	Psychiatrist

		1 month				
Berawi et al., 2022, Indonesia	11	Abdominal pain, nausea, and vomiting since 1 week	Distended abdomen, epigastric and left hypochondrium tenderness, palpable mass	Abdominal ultrasound and CT-Scan with contrast	Upper midline laparotomy with gastrotomy	Not mentioned
Poerwosusanta et al., 2020, Indonesia	9	Episodic abdominal pain around epigastrium one week before admission, vomiting after meals, anorexia, constipation, enlarged abdominal mass	Solid, mobile, irregular border mass on the epigastric region, extended to the periumbilical and right hypochondriac, and increased bowel sound	Upper-gastrointestinal x-ray, endoscopic examination	Combined-endoscopy-laparoscopy-gastrostomy	Psychiatrist, pediatrician, and anesthesiologist
Bilommi, 2017, Indonesia	12	Severe acute abdominal pain, nausea, vomiting, and fatigue	Epigastric tenderness and a hard mass with smooth margins	Abdominal CT-Scan	Laparotomy with anterior gastrotomy incision at the anterior major curvature	Psychiatrist
Sinha et al., 2016, India	**1st case:** 8 **2nd case:** 6	**1st case:** intermitten abdominal pain for one year **2nd case:** severe abdominal pain, absolute constipation, fever, and vomitting from last seven days	**1st case:** a mobile hard lump (6x5 cm) was palpable in the epigastric region **2nd case:** shock, gross distention, severe guarding, rigidity, tympanic note on percussion	**1st case:** ultrasonography and gastrointestinal constrast study **2nd case:** abdominal x-ray	**1st case:** exploratory laparotomy and gastrotomy **2nd case:** emergency laparotomy and gastrotomy	Not mentioned
Halimun et al., 1992, Indonesia	**1st case:** 11 **2nd case:** 12	**1st case:** acute severe abdominal pain and fecal vomiting **2nd case:** acute abdominal pain and vomiting	**1st and 2nd case:** signs of intestinal obstruction	Plain abdominal radiography	exploratory laparotomy	Psychologist

***CT-Scan: computed tomography scan**

Conclusion

Diagnosing and managing pediatric gastric trichobezoar in Indonesia necessitates a multidisciplinary approach beyond surgery for effective treatment and prevention of recurrence.

Patient consent

Patient consent forms have been obtained. The parent consented to use images and clinical details, understanding that the patient's identity would remain protected, with no names or initials published, and all measures taken to ensure anonymity.

Conflict of interest

The authors declare no conflict of interest.

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Contribution

H. and M. S. F. led the case report conception and design. H. and A. E. collected the data and wrote the first draft of the manuscript. All authors commented on previous versions of the manuscript. A. E. reviewed and edited the manuscript format. All authors read and approved the final manuscript.

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