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Letter to The Editor

Giant gastric trichobezoar – A rare condition

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Dear Editor

With great interest we read the illustrative case study published in this Journal of a 13-year-old female diagnosed with a giant gastric trichobezoar related to a psychological disorder.[1] Her antecedents included trichotillomania, trichophagia, and nocturnal colic episodes. She had acute abdominal symptoms, and the diagnostic suspicion was raised based on the abdominal images and established by an endoscopic study. The laparotomy showed the giant trichobezoar weighing 1033.8 g and measuring 31.5 x 18 cm in its larger diameter. The authors emphasized this giant gastric trichobezoar as the largest one ever described. The imperative post-surgical psychological treatment was prescribed to prevent recurrences; she underwent nine cognitive-behavioral sessions, considered the most effective option.[1] The rarity of this unsuspected giant trichobezoar that had a very long period with mild symptoms raises the possibility of some other underdiagnosed and underreported cases. Therefore, the aim of the next short comments on additional more recent references is to enhance the awareness and suspicion index about a rare entity evolving unnoticed.[2-5]

Anees A, *et al*. reported a 25-year-old woman with repetitive abdominal pain after meals, and a hard epigastric mass that the imaging studies revealed to be a gastric bezoar which was removed by gastrostomy (measuring 24 cm × 16 cm and weighing 1865 g).[2] As the patient had a history of trichotillomania and trichophagia since childhood, her psychiatric care included follow-up consultations and satisfactory occupational therapy. The authors highlighted this rare and challenging etiology of digestive obstruction which must be considered in patients presenting with the association of psychiatric symptoms.[2] Di Buono G, *et al*. described a 68-year-old male with schizophrenia, who presented with an episode of upper digestive hemorrhage due to four gastric ulcers and a perforation associated with a large (10 cm × 5 cm) phytobezoar that was removed by gastrotomy; the patient was discharged on postoperative day 12 with psychiatric support.[3] The authors commented on laparoscopy and endoscopy surgery for giant phytobezoars. Korekawa K, *et al*. reported an 87-year-old female who had an unsuccessful endoscopic mechanical crushing to treat a giant gastric bezoar and evolved with duodenal obstruction by the remaining fragments. A new endoscopic crushing procedure was mandatory.[4] In spite of the laboratory analysis performed, the etiology of the bezoar persisted unknown; the authors called attention to the need to carefully monitor the post-crushing process.[4] Lieto E, *et-al*. described a 16-year-old female with psychiatric disorder, hematemesis, and a giant gastric trichobezoar due to trichotillomania and trichophagia during five years.[5] The bleeding had origin in the lesions of a Mallory-Weiss syndrome, and the bezoar (measuring 52 cm × 7 cm and weighing 2500 g) was completely removed by gastrotomy. The postoperative course was unremarkable, and she was followed up by a psychiatrist. The authors highlighted the early endoscopic procedure to remove small bezoars, while those diagnosed with very large volume requires an open gastric surgical intervention.[5]

The published case studies involving this scarcely reported condition contribute to reducing misdiagnosis and late diagnosis, favoring less invasive curative procedures.

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