

Psychiatric Co-morbidity in an 11 Year Old Child with Trichobezoar

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Abstract

Trichobezoar is generally encountered in surgical practice then during routine psychiatric practice. Trichotillomania and depression are the common comorbid psychiatric disorders associated with trichobezoar, hence it should be always looked for and treated along with its surgical management. This case report of an 11 year old girl further highlights the same. It also underlines the need for early detection of psychiatric conditions in patients with chronic abdominal pain and epigastric lump to improve long term prognosis and for the effective management of the conditions.

Introduction

A Trichobezoar is formed by concretions of hair ingested over period of years seen more often in girls of school going age and adolescents but rarely in adults. The formation of a Trichobezoar starts with Trichotillomania (Hair pulling disorder) usually in response to increased stress followed by an obsessive ingestion of the hair. The ingested hair usually accumulate in the stomach leading to reduced gastric emptying.¹ It may remain asymptomatic for a long time with the most common presentation being a non tender lump in the epigastric region. However presenting symptoms can also include nausea, anaemia, malnutrition, weight loss, signs of gastrointestinal obstruction, haematemesis and perforation.² Fatalities have also been reported in undiagnosed and untreated cases.³ Psychiatric co-morbidities associated are depression,

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anxiety disorders, obsessive-compulsive disorder, body dysmorphic disorder, eating disorders, and alcohol and substance abuse. Treatment usually involves surgical removal.⁴ Management of underlying psychiatric conditions is necessary to prevent recurrence of trichobezoar.⁵

Case Report

Miss S.A. an 11 year old girl was referred for psychiatric evaluation from surgery department. Patient was apparently alright one year back when she started getting pain in abdomen once every two to three months for which symptomatic treatment was taken from a general physician. Gradually patient restricted herself to a soft diet. The lump in the epigastric region was noticed by parents since one month for which she was referred to the surgical out patient department (OPD). Trichobezoar was detected on ultrasonography (U.S.G) of abdomen. Patient was then referred for psychiatric assessment prior to surgery.

On psychiatric evaluation patient was a full term normal delivery with developmental milestones attained at appropriate age. She had a tendency to stammer and was constantly teased by her friends which led to a regular sense of low self esteem, sadness of mood and feeling rejected with intermittent crying spells since 2 years. Patient had

then developed a tendency to pick and swallow her hair while under stress as it made her feel better. She gradually developed patchy hair loss for which symptomatic treatment was taken. Also her parents would shave her head for uniform hair growth. This would repeat every three to four months for the past two years. She was teased at school as a 'Taklu' which further reduced her interaction with the classmates. Teachers had expressed concern over tendency to remain aloof. Child further showed a steady drop in her academic performance.

There was no history suggestive of other obsessive-compulsive spectrum disorders, mania, or other disruptive behavioural disorders.

She belongs to a lower middle class nuclear family with poor socio-economic status. She is youngest of three siblings and is more attached to her eldest brother who has cerebral palsy.

Physical examination: Positive findings included pallor and a lump in her epigastric region. On examining scalp, hair of varying length were seen over the parietal region. Patient also had dental caries.

Mental status evaluation: Patient's mood was anxious and worried with ideas of guilt and worthlessness being expressed. General fund of knowledge was age appropriate and judgement was intact.

Psychometric assessment: On child apperception test (C.A.T.) she had identified with victim characters and projected themes of being bullied. There were worries about her future. Depression and anxiety features were observed.

Diagnosis: Patient was diagnosed with major depressive disorder with anxious distress, trichotillomania, trichobezoar based on DSM-5.⁵

Surgical management: An exploratory laparotomy was done. A trichobezoar of size 10 x 5 x 6 c.m. was removed from the stomach (Fig. 1).



Fig. 1

Psychiatric management: Patient was started on 25 mg Imipramine and was gradually increased to 50 mg. Regular counselling was done by a psychologist. On follow-up patient and parents had perceived marked improvement in her depressive and anxiety symptoms and increased interactions with peers at school. No further episodes of hair pulling were reported. There was proper hair growth. Academic performance had improved.

Discussion

As seen from literature both trichobezoars and trichotillomania are more known in females and only 1% of patients with trichotillomania will develop trichobezoars.

The child in this case developed anxious and depressive symptoms over a period of two years in the form of stammering and remaining aloof from the peers which went unnoticed. Gradually she started pulling her hair and eating it which again remained undetected in both home and school settings as it would happen when she was upset and alone. Patient frequently complained of pain in abdomen for which she was referred to her family physician and received only symptomatic treatment. As it is a rare condition the suspicion of trichobezoar was not aroused and hence it remained undiagnosed till patient developed a lump in epigastric region which needed further investigation. Hence, the child suffered mentally and physically before getting appropriate treatment probably due to lack of awareness of psychological problems in children and also as the physical complaints are given priority over psychological complaints or behaviour changes in children. Moreover comorbid

psychiatric illnesses are often associated with adolescent onset trichobezoar.

Patient showed good response to imipramine and counselling together. Even though fluoxetine is the preferred drug in this condition, there are case reports showing improvement with imipramine and was preferred in this patient due to affordability.^{6,7,8}

Conclusion

Trichobezoars are frequently associated with underlying psychopathology such as trichotillomania, depressive and anxiety disorders. Treatment of these conditions is essential not only for symptomatic relief of the patient but also to prevent its recurrence. Given the insidious onset, chronic course which is largely asymptomatic and potentiality for severe disability or fatal outcome, a high index of suspicion is required while screening children and adolescents with chronic abdominal pain or lump for trichobezoars and trichotillomania.

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Exercise: not a miracle cure, just good medicine

Physical activity remains the best buy for public health

Exercise is one of the top modifiable risk factors for chronic disease. Indeed, exercise produces roughly similar benefits to drugs in the secondary prevention of coronary heart disease, rehabilitation after stroke, treatment of heart failure, and prevention of diabetes. In addition, exercise has recently been shown to reduce the risk of dementia and improve mental health. The required dose is modest and achievable, with evidence suggesting that moderate intensity physical activity at even a minimum of 150 minutes a week is effective (about 30 minutes of physical activity most days comprising, for example, three 10 minute walks).

Furthermore, exercise was mentioned to only a sixth of patients with diabetes or hypertension, despite these being conditions for which exercise is recommended.

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