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CASE REPORT

A 4-year-old girl presented with 1-year history of fatigue, early satiety, intermittent vomiting, alopecia, pallor, and weight loss without changes in bowel habits or overt gastrointestinal bleeding. Examination revealed thin hair, pale conjunctivae, and mucous membranes. Tachycardia and a systolic flow murmur (grade II/VI) were present. Abdomen was nontender, distended, and tympanitic, with hyperactive bowel sounds and a palpable mass in her left upper quadrant. Initial labs revealed iron deficiency anemia (hemoglobin 3.3 g/dL, mean corpuscular volume 48 FL, platelets 515 000, ferritin 1.6 ng/mL) and hypoalbuminemia 2.9 g/dL. She was transfused with packed red blood cells and parenteral iron. Abdomen computed tomography (Figure 1) revealed a large gastric bezoar extending into the duodenum and a localized air-filled out pouching of stomach wall abutting the surface of liver concerning for sealed perforation. There was no small bowel obstruction or free air. Upper endoscopy confirmed a large trichobezoar in the stomach. She underwent a laparotomy with longitudinal gastrostomy and removal of the large trichobezoar (Figure 2). Intraoperative inspection showed ulceration over the fundus/body with contained perforation into the liver (segments 2/3). The patient did well postoperatively and tolerated a regular diet prior to discharge. A

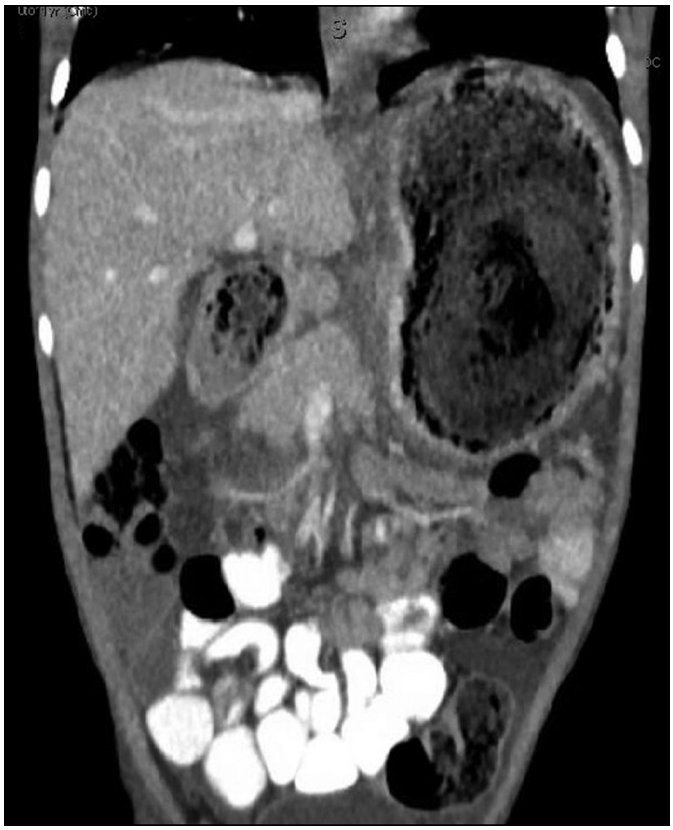

Figure 1. Abdominal computed tomography showing gastric bezoar.

Figure 2. Trichobezoar measuring 14 x 13 x 7.5 cm casted in the shape of the stomach, pylorus, duodenal bulb, and C-sweep.

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psychiatric evaluation is pending in light of a complicated social circumstance.

Rapunzel syndrome is a rare diagnosis with approximately 40 pediatric cases in the literature.[1] It is defined as a gastric trichobezoar extending into the small bowel with or without obstructive symptoms. Presentation typically follows a protracted course that progresses to intermittent obstruction and anemia. Obstructive jaundice and pancreatitis have been described.[2] Depending on the size of the trichobezoar and its degree of extension into the small bowel, endoscopic removal may be successful. Surgical management is indicated with larger trichobezoars and complications such as perforation or hemorrhage. Underlying psychiatric or psychosocial stressors should be addressed to prevent recurrence.[3] Our case is one of the youngest patients with severe anemia and a contained perforation. The above findings are consistent with an indolent course. A prompt diagnosis is dependent on a high index of suspicion.

DISCLOSURES

Author contributions: M. Soubra wrote the manuscript and obtained the images. V. Pottahil edited the manuscript. R. El-Abiad wrote and edited the manuscript, and is the article guarantor.

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Informed consent was obtained for this case report.

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