A 9-YEAR-OLD girl presented with a 2-week history of considerable abdominal distress. She had been experiencing intermittent, sharp abdominal pain associated with nonbilious vomiting; the initial episode of pain was accompanied by a loose bowel movement and a low-grade fever. The patient’s condition had been evaluated for similar symptoms on 2 prior occasions; on 1 occasion she required intravenous hydration. Her most recent visit occurred 3 days before this presentation. Then abdominal radiographs were reported to show considerable fecal retention and enemas were prescribed. Despite 16 enemas in the past 13 days, the abdominal distress continued, often waking her at night.

Physical examination revealed an epigastric mass to the left of the midline that, when palpated, reproduced her symptoms. An abdominal radiograph showed distention of her small and large bowel, but no obstruction or notable fecal retention. The patient was admitted to the hospital for intravenous hydration and further evaluation. The next day, radiographic studies of the abdomen (Figure 1) and an upper gastrointestinal series were obtained (Figure 2). Figure 3 indicates the cause of the abdominal distress.
Denouement and Discussion

Jejunojejunal Intussusception Caused by a Trichobezoar With a Tail

In a review of 311 cases by DeBakey and Ochsner, the characteristic clinical presentation was a freely movable, firm abdominal mass, usually located in the epigastrum, and producing pain, nausea, and vomiting. Diarrhea or constipation occurred in about one third of the cases. A history of trichophagia was common in young girls who have a trichobezoar.

In this case, a history of trichophagia was eventually elicited. The radiographic and surgical pathologic findings showed a bezoar that formed a near-perfect cast of the stomach and duodenal cap (Figure 3). From the duodenal cap, the bezoar formed a tail that extended several centimeters into the jejunum. The tail contained many regions of clumped hair, giving it a beaded texture. Two other cases have been reported in which the bezoar extended into the small bowel forming a string or tail.10,11 The operative findings indicated that the bezoar was the lead point for a small-bowel intussusception. It is likely that 1 of the terminal beaded areas created the nidus for the intussusception. The tail was reduced retrogradely to the gastrostomy site and then removed. The patient’s recovery was complicated by transient symptoms of partial small-bowel obstruction, possibly related to colonic barium impaction. She was discharged from the hospital 13 days after her surgery.

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Reprints: Mitchell Weiss, MD, Bryn Mawr Hospital, Department of Radiology, 130 S Bryn Mawr Ave, Bryn Mawr, PA 19010.

REFERENCES