CLINICAL CASE

NOT EVERYTHING THAT OBSTRUCTS IS A TUMOR: THE BEZOAR AS A GREAT COLONIC SIMULATOR. A CASE REPORT.

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Abstract

Bezoars are accumulations of indigestible material within the gastrointestinal tract and represent an uncommon cause of intestinal obstruction. Colonic obstruction due to bezoars is exceptionally rare and may mimic colorectal malignancy, making preoperative diagnosis challenging. We report the case of a 66-year-old man with no previous abdominal surgery who presented with abdominal distension, nausea, and a two-day history of obstipation. Contrast-enhanced abdominal computed tomography demonstrated diffuse colonic dilatation with an abrupt transition point and mural thickening at the sigmoid colon, initially suggesting an obstructing colorectal neoplasm. Retrospective review of the images identified two heterogeneous intraluminal masses consistent with bezoars. Flexible sigmoidoscopy was unsuccessful because of abundant fecaloid material obstructing endoscopic progression. Owing to persistent bowel obstruction, urgent exploratory laparoscopy was performed, revealing two intraluminal bezoars, one impacted in the sigmoid colon and the other located in the descending colon. Both bezoars were removed by colotomy, and a segmental sigmoid colectomy with primary anastomosis was performed. Histopathological examination identified both masses as trichobezoars. The postoperative course was uneventful. Trichobezoars are exceptionally uncommon in older adults, particularly when presenting as colonic obstruction without a history suggestive of trichophagia. This case highlights the importance of considering bezoars in the differential diagnosis of large bowel obstruction and emphasizes the role of contrast-enhanced computed tomography in guiding diagnosis and surgical management.

Keywords: bezoar, colonic obstruction, impaction.

Introduction

Bezoars are masses of undigested ingested material that accumulate in the gastrointestinal tract. Depending on their composition, they are classified as phytobezoars (plant material), trichobezoars (hair), pharmacobezoars, and other less common types. They are a rare cause of intestinal obstruction, and their occurrence in the colon is exceptional.

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Their clinical presentation is nonspecific, and radiological findings may mimic neoplastic or inflammatory processes, making diagnosis difficult. We present the case of a colonic obstruction secondary to the impaction of two trichobezoars.

Clinical case

A 66-year-old man, originally from Colombia, with a history of hypertension and a previous hospitalization for intestinal obstruction treated conservatively, with no history of abdominal surgery. He presented to the emergency department with abdominal distension, nausea, and a two-day history of cessation of bowel movements. He did not report ingesting any foreign bodies nor did he have a known history of gastrointestinal motility disorders or predisposing factors for bezoar formation. On physical examination, he presented with a distended, soft, and non-tender abdomen, with stable hemodynamic parameters.

Laboratory tests revealed leukocytosis and elevated C-reactive protein levels. An abdominal CT scan with intravenous contrast revealed generalized dilation of the colonic lumen with an abrupt change in diameter at the level of the sigmoid colon, associated with parietal thickening suggestive of mechanical obstruction; a neoplastic process causing stenosis was initially suspected. Retrospectively, two heterogeneous intraluminal images consistent with foreign bodies were identified.

It was decided to admit the patient for initial conservative treatment and to perform a rectosigmoidoscopy, which revealed abundant fecal-like material that prevented the endoscope from advancing, with no significant mucosal lesions. In the absence of recovery of bowel function, a hard, palpable mass persisted in the left iliac fossa. A second abdominal CT scan with intravenous contrast was performed, which showed displacement of one of the intraluminal masses, while the other remained impacted in the sigmoid colon; both were consistent with bezoars.

In light of these findings, an urgent exploratory laparoscopy was performed, revealing two intraluminal bezoars: one impacted in the sigmoid colon with significant thickening and stiffness of the colonic wall, and another located in the descending colon. Both bezoars were removed via colotomy and segmental resection of the sigmoid colon with primary anastomosis. Pathological examination identified both as trichobezoars. The final diagnosis was colonic obstruction secondary to trichobezoar impaction.

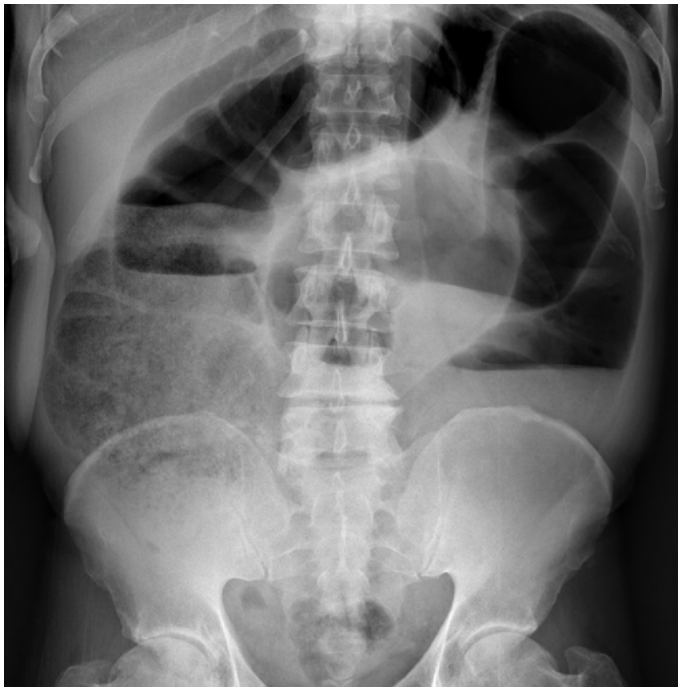


Figure 1. ***Upright plain abdominal X-ray showing generalized dilation of the colonic framework with numerous fluid-air levels, findings consistent with mechanical intestinal obstruction.***



Figure 2. ***Abdominal computed tomography (CT) scan with intravenous contrast, axial view. Dilatation of the proximal colon is observed, along with a heterogeneous intraluminal mass with a mottled pattern and air bubbles within it, located in the descending colon, consistent with a bezoar.***

Discussion

Bezoars are an uncommon cause of mechanical intestinal obstruction, accounting for approximately 0.4–4% of cases; they are usually located in the small intestine, and colonic obstruction is rare[1]. Trichobezoars represent a much less common subtype than phytobezoars and consist of ingested hair; they are classically associated with young patients with trichophagia and psychiatric disorders, making their occurrence in a 66-year-old man exceptional[2,3].

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Figure 3. ***Abdominal computed tomography with intravenous contrast, coronal reconstruction. A sudden change in caliber is identified at the level of the sigmoid colon, associated with parietal thickening and a second impacted heterogeneous intraluminal mass.***



Figure 4. ***Surgical specimen from a sigmoidectomy. The resected segment of the sigmoid colon shows significant wall thickening and stiffness secondary to bezoar impaction.***



Figure 5. ***Two trichobezoars removed during the surgical procedure following a colotomy. Pathological examination confirmed that both were trichobezoars.***



Figure 6. ***Macroscopic view of the trichobezoars removed via colotomy. Comacted hair is visible, forming irregular masses that fragmented during extraction and were responsible for the colonic obstruction.***

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Preoperative diagnosis can be complex, as the clinical presentation is nonspecific and radiological findings may mimic a neoplasm or an inflammatory stenosis. Computed tomography with intravenous contrast is the imaging test of choice, allowing for the identification of heterogeneous intraluminal masses containing air bubbles and the localization of the site of obstruction, although a definitive diagnosis may not be established until surgery or pathological examination[4,5].

Treatment depends on the location and degree of obstruction. In patients with complete obstruction or failure of conservative treatment, surgery is usually necessary to remove the bezoar and treat associated lesions. In cases of trichobezoars, it is also advisable to subsequently assess for trichophagia or underlying psychiatric disorders to prevent recurrences[6].

This case illustrates an unusual form of colonic obstruction caused by trichobezoars, which was initially interpreted as a neoplastic process, and highlights the importance of including this condition in the differential diagnosis of intestinal obstruction, even in patients without a suggestive history.

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