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Letter to the Editor

An unusual case of large gastro-duodenal bezoars

Dear Editor,

Pica has been considered as the ingestion of inedible substances. Here we present an unusual case of pica presenting as a large gastro-duodenal bezoars. A 23-year old female patient presented with complaints of recurrent vomiting, abdominal lump, and weight loss for the last 6 months. Per abdominal examination revealed a large, irregular, firm and slightly mobile lump in the epigastric region. Her laboratory test revealed anaemia with haemoglobin level of 9.0 g/dl. An ultrasound of the abdomen showed a bizarre echogenic area in the stomach region. Subsequently a computed tomography (CT) scan of abdomen was done which revealed a concentric inhomogeneous mass with entrapped air, surrounded by contrast material in the stomach and

proximal duodenum suggestive of bezoars (Fig. 1a–c). Her upper gastro-intestinal endoscopy revealed stomach filled with a mass of hair like fibre and mucus (Fig. 1d). Psychiatric evaluation revealed that she had been eating blanket string since late childhood. She had a strong and persistent desire to eat blanket's fibres. Her past history did not reveal any evidence of depressive disorders, obsessive compulsive disorder, eating disorders, emotional disturbances and other impulse control disorders. Also, there was no family history of any mental illness. The bezoar was surgically removed. The patient was counselled against eating blanket strings and was informed about the consequences of the same.

Bezoars are accumulations of undigested materials in the gastro-intestinal (GI) tract.¹ The majority of bezoars occur in the stomach, but can occur elsewhere in the GI tract. They

Fig. 1 – (a–c) Computed Tomography scan showing a concentric inhomogeneous mass with entrapped air surrounded by contrast material in the stomach and proximal duodenum. (d) Upper gastro-intestinal endoscopy showing stomach filled with a mass of hair like fibre and mucus.

are uncommon, being found in <1% of patients undergoing upper GI endoscopy.² According to their composition, bezoars have been classified into 3 major types: phytobezoars, trichobezoars and pharmacobezoars. Bezoars composed of hair or hair-like fibres are called trichobezoars. To the best of our knowledge, trichobezoars formed by blanket's strings are extremely rare with only a few case reports in literature.³ Trichobezoars are formed when hair or hair like fibres are retained in the stomach, escaping its peristaltic activity and get enmeshed into a ball which usually assumes the shape of the stomach. A trichobezoar extending from the stomach into the small intestine has been described as Rapunzel syndrome.⁴ Trichobezoars are most commonly present in adolescents and during the second decade of life. In the early stages, when the bezoar is small, the patient may be asymptomatic. Affected patients may be asymptomatic for several years and develop symptoms insidiously. Larger bezoars may cause abdominal pain, nausea, vomiting, anaemia, weight loss and GI obstruction. Pressure necrosis may lead to mucosal erosions and ulceration.⁵ Most patients with trichobezoars suffer from psychiatric disorders including trichotillomania, trichophagia, pica, depression, obsessive-compulsive disorder or anorexia nervosa. Bezoars have also been described in various clinical settings such as gastroparesis due to underlying organic disease, post surgical gastroparesis and motility disorders. Surgical removal remains the main stay of treatment of large trichobezoars with gastric obstruction. These bezoars are resistant to enzymatic dissolution. Moreover, endoscopic retrieval is often difficult to achieve. Removal of the bezoars does not alleviate the underlying problem. Preventive therapy should be implemented to avoid recurrence. Psychiatric evaluation is essential to prevent recurrence as underlying psychological and emotional disturbance may be a factor.⁶

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Letter to the Editor

Balanoposthitis caused by *Streptococcus mitis/oralis*

Dear Editor,

We herein report a rare case of genital infection caused by *Streptococcus mitis/oralis* that was isolated in our laboratory. A 22-year-old male patient with a history of high-risk behavior reported with complaints of dysuria and pus discharge around the glans penis for the past 7 days. On examination, there was profuse milky white pus discharge around the glans penis. There was no local induration, lymphadenopathy, or any active urethral discharge. He was diagnosed as a case of balanoposthitis.

Pus samples were collected before administration of antibiotics and processed immediately. Gram staining revealed dense PMN infiltration and numerous gram-positive

cocci in pairs; short chains of the cocci were seen both outside and inside the neutrophils (Fig. 1). A clear capsular halo was seen around many diplococci. On sheep blood agar, viridans group streptococci (VGS) were isolated and identified as *S. mitis/oralis* by an automated system (VITEK-2, bioMérieux). The identity of the organism was confirmed by MALDI-TOF (VITEK MS, bioMérieux) with a confidence level of 99.5%. The organism was sensitive to ampicillin, clavulanic acid, erythromycin, clindamycin, cefotaxime, and vancomycin but resistant to penicillin, ampicillin, and ciprofloxacin both by automated and by conventional methods. Urine culture was sterile. The patient was seroreactive for HBsAg but nonreactive to RPR, HCV, and HIV-1/2. He was counseled adequately and placed on parenteral third-generation cephalosporins, and he made a swift recovery.