A 45-year-old woman, operated on 10 years ago for removal of a hairball in the stomach, presented with abdominal pain, postprandial fullness, vomiting after meals and lump in the abdomen since one month. She did not admit to history of hair pulling or hair ingestion although the hair over her scalp was sparse.

On examination, the patient had a midline supraumbilical scar of the previous surgery. She also had a non-tender, mobile and indurated J-shaped lump, 10 cm x 15 cm, in the epigastrium, extending into the right and left hypochondriac regions. Barium study revealed a streaked appearance, suggestive of a trichobezoar in the stomach. Gastroscopy was not performed. At laparotomy, other than a few filmy adhesions, no other evidence of the previous surgery was found. An anterior oblique gastroscopy incision was made. The stomach was filled with a slimy, dark, foul smelling hairball, 20 cm x 15 cm, extending into the first part of the duodenum. The trichobezoar was removed without difficulty. Postoperative recovery was uneventful.

On psychiatric counseling, the patient agreed to her observation and compliance with hair pulling and ingestion. She was then put on sertraline, a selective serotonin reuptake inhibitor, in a daily dose of 50 mg. The patient is on regular follow up for 3 months and does not pull or swallow her hair.

Trichobezoars are more common in young women, with more than 80% occurring in those younger than 30 years. Recurrent gastric bezoars usually result from gastric hypomotility due to vagotony or diabetic autoneuropathy. Recurrent trichobezoars are otherwise rare and are noted in children. Our patient was 45 years old and had recurrence after a long interval of 10 years. Recurrence is best prevented by prevention of ingestion of hair. Psychotherapy and drug therapy are thus important components in the management of trichobezoar, which is a psycho-surgical disorder rather than a purely surgical condition.

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Clinical significance of fading Infraumbilical abdominal veins

The superficial abdominal veins over the front, flanks and back provide a valuable clue to the type of portal hypertension. The direction of blood flow in the anterior abdominal veins predicts the site of obstruction. Normally, the flow of blood is away from the umbilicus; this gets exaggerated in cirrhosis. Reversal of blood flow in infraumbilical veins suggests suprahapatic inferior vena caval obstruction. However, when these veins are dilated, tortuous and thick walled, it is not possible to determine the direction of blood flow even in the erect posture by the ‘finger stretch and release of vein’ method. We believe that a simple inspection of the anterior abdominal veins in the erect and supine postures can give a clue to the type of portal hypertension.

Our observation is that the infraumbilical veins become less prominent and ‘fade’ in the supine position, indicating blood flow from below upwards, thereby suggesting inferior vena caval obstruction. In the presence of tender hepatomegaly and/or ascites, the level of obstruction can be predicted to be suprahapatic.

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