

Clinical cases

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Giant Fibrovascular Esophageal Polyp Misdiagnosed as Achalasia

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Rezumat

Polip esofagian gigant – confuzie diagnostică cu acalazia

Prezentăm cazul unei paciente în vârstă de 59 de ani internată în clinica noastră cu un istoric îndelungat de disfagie și regurgitații postprandiale. La internare pacienta era purtătoarea unei gastrostomii definitive de alimentație, montată în alt serviciu chirurgical. S-au efectuat examen cu substanță de contrast, endoscopie digestivă superioară și manometrie esofagiană, investigații care au stabilit diagnosticul de acalazie. În consecință, s-a practicat o esomiectomie tip Heller și suprimarea gastrostomiei, evoluția postoperatorie fiind simplă, cu externarea pacientei după o săptămână, afirmativ fără disfagie. O lună mai târziu, pacienta este internată de urgență, prezentând exteriorizarea prin cavitatea bucală a unei mase fibromusculare gigante, după un puseu puternic de tuse și vărsături. O nouă endoscopie digestivă superioară evidențiază un polip esofagian voluminos cu originea la nivelul joncțiunii faringo-esofagiene, scăpat din vedere la investigația anterioară. S-a practicat rezecția polipului printr-o cervicotomie stângă, iar evoluția postoperatorie a fost fără complicații. Dimensiunile extreme ale polipului (27 cm) au prevenit asfixia prin blocarea acestuia la nivel laringian posibilă în cazul unor dimensiuni mai mici ale tumorii. Cum esofagografia cu substanță de

contrast a fost normală la o lună postoperator diagnosticul de acalazie a fost pus serios sub semnul întrebării.

Cuvinte cheie: polip esofagian, tumoră esofagiană benignă, acalazie

Abstract

A 59 years old woman was admitted in our unit accusing longtime dysphagia and regurgitation. On admission, the patient was wearing a 3 month old definitive feeding gastrostomy tube. The contrast swallow, endoscopy and esophageal manometry established the diagnostic - achalasia. We removed the gastrostomy tube and we performed an open Heller myotomy. The postoperative period was uneventful and the patient was discharged one week later with affirmatively unimpaired deglutition. One month later, the patient was admitted via emergency with a giant fibrous tumor arising from her mouth after an episode of strong coughing and vomiting. The repeated endoscopy showed a giant esophageal polyp that was missed by the previous investigations, originating from pharyngoesophageal junction. The esophageal polyp was resected by cervical approach with good postoperative outcome. The polyp's particular extreme dimensions (27 cm) prevented the acute asphyxia by blockage at the laryngeal level, possibly provoked by smaller tumors. As postoperative one month barium swallow showed a normal esophageal aspect, a final question remains - was achalasia real or an erroneous diagnosis was established the second time too?

Key words: esophageal polyp, esophageal benign tumors, achalasia

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Introduction

Fibrovascular polyps are uncommon benign tumors of the esophagus that usually remain asymptomatic for a long period of time. Symptoms appear when the tumor reaches a large size (from here the known appellation – giant polyp) and include progressive dysphagia and odynophagia (more than 80%), respiratory symptoms as cough, wheezing and stridor (25%), occult bleeding from distal mucosal ulceration and a pathognomonic sign when appears – regurgitation of a fleshy mass after an episode of coughing or vomiting (1). The mere presence of this tumor is an indication for surgery in order to prevent fatal asphyxiation by blockage at the laryngeal level (2).

Case report

A 59 years old woman was admitted in our unit with a 2 years long history of dysphagia and food regurgitation. She was wearing for 3 months a definitive feeding gastrostomy tube, placed in another department, where the patient was clinically misdiagnosed with an esophageal cancer. The barium esophagogram showed a dilated and tortuous (sigmoid) esophagus, aperistalsis of the body, impaired esophageal emptying and “bird’s beak” appearance at the level of the gastroesophageal junction (Fig. 1). By endoscopy, the esophagus was dilated, with a normal mucosa, the lower esophageal sphincter was easily traversed. Esophageal manometry showed aperistalsis of the esophageal body and abnormal lower sphincter relaxation indicating the diagnosis of achalasia.

A small epigastric laparotomy was made in order to allow a Heller myotomy and the removal of the gastrostomy tube. Postoperative evolution was uneventful and the patient was discharged one week later with affirmatively unimpaired deglutition.

One month later, the patient was admitted in emergency with severe dyspnea due to a giant fibrous tumor arising from her mouth after an episode of strong coughing and vomiting (Fig. 2). The newly performed endoscopy showed a giant esophageal polyp that was missed by the previous investigations, originating from pharyngoesophageal junction with a large implantation root that made dangerous any attempt of endoscopic resection.

The esophageal polyp was resected by cervical approach (Fig. 3). The tumor was 27 centimeters long (the largest reported in the literature), 3.3 centimeters in the largest diameter, formed by fibrovascular and adipose tissue covered by normal esophageal mucosa and with a central vascular axis. The postoperative outcome was without complication and the patient was discharged in the fourth postoperative day, after starting per oral nutrition.

Discussion

Regarding again to the first contrast swallow (Fig. 1) we can see a filling defect that was previously missed. At first follow up, one month after polyp’s resection, the barium esophagogram showed a normal esophageal aspect that didn’t match with the



Figure 1. Preoperative barium swallow



Figure 2. Esophageal polyp - macroscopic aspect



Figure 3. Intraoperative aspect

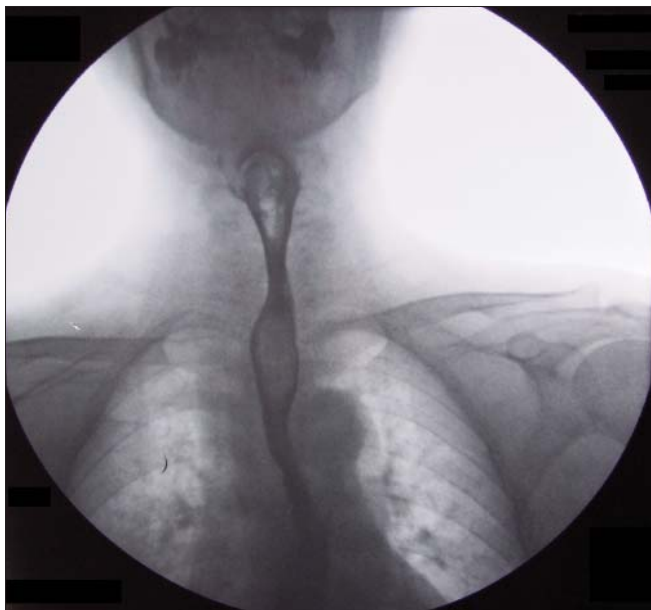


Figure 4. One month postoperative barium swallow

initial diagnosis of achalasia (Fig. 4). It is known that after myotomy for achalasia the esophagus remains dilated, so it is quite probable that first time we established an erroneous diagnosis.

The use of a liquid contrast substance instead of thick barium solution and the accumulation of food in the dilated esophagus can partially explain why we missed the lesion. The tortuous, sigmoid aspect was also very “achalasia-like” and we were caught in the “mirage” of the obvious. Esophagoscopy can usually reveal the intraluminal mass, but the overlying normal mucosa and the distensibility of the esophagus can hamper endoscopic detection. Diagnosis by endoscopy and barium swallow may be unexpectedly difficult, as previously reported, and can arrive up to 25% of the cases (3). The most frequent incorrect diagnoses are achalasia or an intramural or mediastinal tumorous mass compressing the esophagus.

Small lesions are usually removed by means of endoscopy (4), in bigger ones this procedure being demanding but possible in experienced hands (5). The presence of a large pedicle proved by eco-endoscopy or suggested by a large root, should mandate either a cervical incision (most frequently) or a transthoracic esophagotomy for more distal polyps (6). Specific cases may require more invasive surgical interventions as an esophagectomy (7). Malignant degeneration was rarely reported in the literature (6).

In summary, fibrovascular polyps are rare benign tumors of the esophagus which frequently reach giant dimensions before patients develop symptoms. Due to the potential of fatal asphyxiation the removal of these tumors is mandatory, thing that could be accomplished by endoscopy or surgery. Even though it seems obvious, the initial correct diagnosis can be difficult.

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