

Case report - Thoracic general

## Fibrovascular polyp of the esophagus: diagnostic dilemma

Cemal Ozcelik<sup>a,\*</sup>, Serdar Onat<sup>a</sup>, Mehmet Dursun<sup>b</sup>, Adem Arslan<sup>c</sup>

<sup>a</sup>Department of Thoracic Surgery, Dicle University School of Medicine, 21280 Diyarbakir, Turkey

<sup>b</sup>Department of Gastroenterology, Dicle University School of Medicine, 21280 Diyarbakir, Turkey

<sup>c</sup>Department of Pathology, Dicle University School of Medicine, 21280 Diyarbakir, Turkey

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### Abstract

A 51-year-old female patient was admitted to our department. She had symptoms of dysphagia, regurgitation of a fleshy mass into the mouth, and attacks of dyspnea. Every effort was made for diagnosis. At cervical exploration, upper esophageal polyp was discovered incidentally, and removed. We present this case because of rarity and emphasize the clinical presentation. The physician should be aware of the presence of this rare esophageal tumor.

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### 1. Introduction

Fibrovascular polyps of the esophagus are rare tumors. They usually arise close to cricopharyngeus muscle. Symptoms include dysphagia and regurgitation of the fleshy mass into the mouth, which can cause asphyxia [1,2]. We present a fibrovascular polyp of the esophagus causing diagnostic problems.

### 2. Case report

The patient, a 51 year-old female, has had three hospitalizations. The third and last was to our hospital a year and half after her initial symptoms. During this period she had admissions to two different hospitals. With the symptoms of regurgitation of a fleshy mass into the mouth, attacks of dyspnea, and dysphagia, she had been operated on for nodular goitre with no relief. Then, she had psychiatric consultation. She had visited another hospital and undergone endoscopy of laryngeal and esophageal inlet. A polypoid mass at postcricoid area had been seen. At

surgery, mass could not be seen and she had been discharged from hospital. On admission to the gastroenterology clinic in our hospital, cervical computed tomography revealed a soft tissue mass measuring 10 × 6 mm behind left vocal cord. An upper gastrointestinal series showed filling defect of upper esophagus (Fig. 1). Both fiberoptic and rigid esophageal endoscopy showed compression of upper esophagus from anterior. Cervical ultrasonography confirmed this finding.

She has been transferred to our clinic. At cervical exploration, a mass, moving with finger dissection, undistinguished from esophagus was palpated. A longitudinal esophagotomy just over the mass was performed and a large, broad pedunculated mass was identified (Fig. 2a). Its base was just below the cricopharyngeus muscle. The entire polyp was delivered through the esophagotomy and then the base was ligated and excised, and the mucosa was repaired with absorbable suture. The tumor was fleshy in consistency, measured 25 mm in length, 15 mm in width. The tumor was covered with a smooth pinkish gray mucosa similar to that of normal esophagus. The mucosa of tumor was torn during finger dissection (Fig. 2b). Microscopically, the specimen was squamous epithelial-lined polypoid structure composed of fibrovascular and adipose tissue, and reported as fibrovascular polyp. Postoperatively course was uneventful.

\* Corresponding author. Tel.: +90-412-2488001; fax: +90-412-2488-520.

E-mail address: cozcelik@dicle.edu.tr (C. Ozcelik).



Fig. 1. Barium esophagogram showing a filling defect of upper esophagus.

### 3. Comment

Although rare, fibrovascular polyps comprise most benign intraluminal tumor-like lesions of the esophagus [3]. These lesions are composed of loose or dense fibrous tissue, adipose tissue, and vascular structures and are covered by normal squamous epithelium [3]. Depending on which histologic components predominate, these lesions have been called lipomas, fibromas, fibrolipomas, fibromyxomas, and fibroepithelial polyps [3,4].

Symptoms occur when the polyp reaches a large size. Symptoms included dysphagia, a mass in the throat and regurgitation of the polyp into the mouth with its disappearance on swallowing [5]. Asphyxiation can result from impaction of the polyp in the glottis and is the most feared complication [2].

Unless regurgitated, the presence of a fibrovascular polyp can be difficult to diagnose [6], and up to 30% of patients may die without a correct diagnosis [6]. Accurate diagnosis is best established with endoscopy [7]. But, it may be totally missed at endoscopy because the polyp is covered by normal mucosa and can be easily displaced [8]. The misfortune of our patient was that the history of thyroidectomy clouded the picture and both endoscopy and radiologic examinations such as CT and ultrasonography of the neck and barium swallow were interpreted incorrectly.

Surgical excision is the definitive treatment, done through an esophagotomy where direct control of feeding vessel is easily accomplished. The stalk must be completely excised or recurrence is possible [6–8].

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(a)



(b)

Fig. 2. (a) Intraoperative photograph of a large, pedunculated mass being delivered through the cervical esophagotomy. (b) The photograph of fibrovascular polyp. The tumor was covered with a smooth pinkish gray mucosa similar to that of normal esophagus. The mucosa of tumor was torn during finger dissection.

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