RARE CAUSE OF DYSPHAGIA: A CASE REPORT OF OESOPHAGEAL FIBROVASCULAR POLYP

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ABSTRACT

Fibrovascular polyp is a benign, pedunculated and intraluminal tumour of the oesophagus. The symptoms develop when the size is enormous. We describe a case of oesophageal polyp in a 33-year old lady with worsening dysphagia, foreign body sensation and significant weight lost. The upper gastrointestinal endoscopy revealed an elongated intramural oesophageal mass covered by normal mucosa. The images from barium swallow study, Computed Tomography scan and Magnetic Resonance Imaging are suggestive of oesophageal fibrovascular polyp.

Keywords: fibrovascular polyp, oesophageal tumours, dysphagia, barium swallow.

Introduction

Fibrovascular polyp of the oesophagus is a rare benign tumour. It is slow growing and can occupy the entire oesophageal lumen. It can cause dysphagia, foreign body sensation and acute asphyxia which lead to sudden death.

Case Report

A 33-year old woman was referred to our department for a barium swallow study. She presented with foreign body sensation in the throat for about one year. She also has history of regurgitation of a mass into the mouth. She developed progressive dysphagia, odynophagia and occasional vomiting after meals. There was no significant past medical history.

The barium swallow revealed an intraluminal mass which cause filling defect in dilated oesophagus from the lower cervical region to the gastro-oesophageal junction. The barium was able to flow distally into the stomach. She has a Computed Tomography (CT) scan of the thorax after the barium swallow examination. There was a smooth elongated soft tissue mass within the oesophageal lumen which was surrounded by the barium. The mass was pedunculated with the stalk at the level of seventh cervical spine (Fig. 1). There was no infiltration of the oesopha-

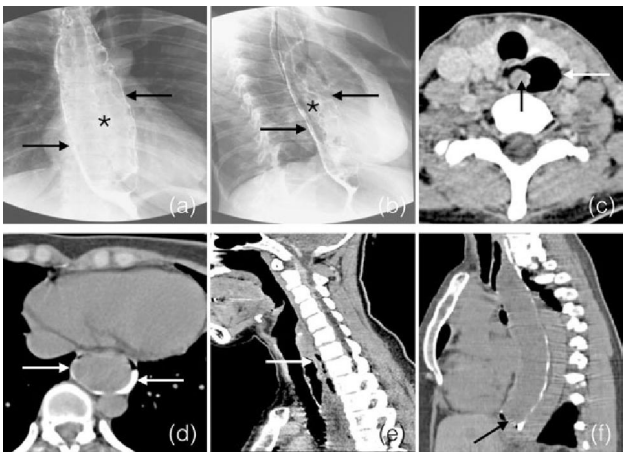

Figure 1: Barium swallow images (a) and (b) showed dilated oesophagus (arrow) with intraluminal mass (*) with filling defect. Transverse CT scan images (c) and (d) showed the stalk of the mass (black arrow) in dilated oesophagus (white arrow). Reformatted sagittal CT images clearly showed the stalk (white arrow) in (e) and inferior margin of the mass (black arrow) in (f).

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geal wall and the mediastinal structures. The oesophageal wall was smooth. The mass has no calcification or fluid level.

Magnetic Resonance Imaging (MRI) has been performed for further evaluation of the mass. The mass was isointense to hyperintense on T1 weighted image (T1WI) and minimally hyperintense on T2 weighted image (T2WI). There were necrotic areas within the mass (Fig. 2). She later has upper gastrointestinal endoscopy which revealed an intraluminal pedunculated oesophageal mass from the upper oesophagus to the gastro-oesophageal junction. The mass has smooth margin and was covered by normal oesophageal mucosa. Considering the clinical informations and the investigations, a diagnosis of benign intra luminal oesophageal mass such as polyp was made.

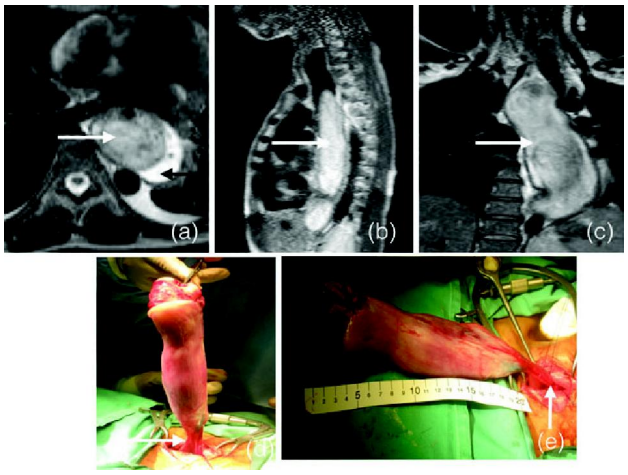

Figure 2: The mass has heterogenous signal intensity as seen in axial (a), sagittal (b) and coronal (c) of MRI images. Intra operative images (d) and (e) showed the stalk (arrow) and necrotic area at the inferior aspect of the mass. The length of the mass was approximately 25 cm

She had left transcervical oesophagotomy to remove the entire mass. There was no complication during and after the surgery. The mass histopathologically was consistent with fibrovascular polyp of the oesophagus (Fig. 2). Currently the patient is well and on follow-up at the surgical clinic.

Discussion

Benign oesophageal tumours account for 20% of the oesophageal mass.[1] Fibrovascular polyp which was previously classified as “fibromas”, “lipomas”, and “fibrolipomatous”polyps account for 1% - 2% of oesophageal tumours.[1,2] Malignant transformation of the polyp is extremely rare.[2,3]

The fibrovascular polyp originates from two lower resistance areas in the pharyngeal musculature. It can arises from the Killian’s dehiscence between the superior and inferior cricopharyngeal muscles or from the Laimer’s triangle between the inferior cricopharyngeal muscle and the proximal end of the oesophagus.[1,4,5]

The polyp is characterised by the development of a pedunculated intraluminal mass and has the tendency to prolapse into the mouth causing the characteristic “regurgitation of a fleshy mass”.[4,5] Though benign, fibrovascular polyp can cause asphyxia and sudden death when it prolapses and obstructs the pharynx.[5] In this reported case, this patient is lucky not to develop asphyxia though she has frequent regurgitation of the polyp into the mouth.

Fibrovascular polyp usually has smooth margin and it causes widening of the oesophageal lumen.[3,6] Due to oesophageal peristalsis, it has tendency to grow inferiorly toward and into the stomach.[4,6] Giant fibrovascular polyp is considered when the size is larger than 5 cm in maximum diameter or the length reaches 25 cm.[1,3,5]

Barium swallow study will reveal the dilated oesophagus and smooth sausage-like intraluminal filling defect cause by the fibrovascular polyp.[1,3,6,7] Endoscopy has been reported to miss up to 25% of the diagnosis. This was attributed by the normal squamous epithelium covering the polyp and the polyp might occupy the entire oesophageal lumen.[3,8]

CT scan will provide further details of the mass and its relation with other mediastinal structures prior to surgery. CT scan has the ability to perform image reconstruction, hence, the stalk of the fibrovascular polyp is easily identified.[2] As in our case, the stalk and the extension of the polyp is well depicted on CT scan. MRI helps to demonstrate the composition of the polyp.[1,5] It will help the surgeon to decide the type of surgery to perform base on the vascularity of the fibrovascular polyp.

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