University Journal of Surgery and Surgical Specialities

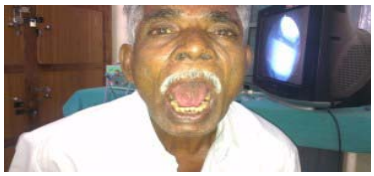
ISSN 2455-2860 2019, Vol. 5(3)

A CASE REPORT OF GIANT FIBROVASCULAR POLYP ESOPHAGUS - A RARE ENTITY

MOHAMED ABDOUL KHADER M MOHAMEDHANIFA
Department of ENT,MADURAI MEDICAL COLLEGE AND HOSPITAL

Abstract : A fibrovascular polyp is a rare, benign, intraluminal, submucosal tumour of esophagus, characterised by the development of pedunculated, intraluminal mass that can exhibit enormous intraluminal growth. It has been reported only sporadically in the literature. Symptoms are present when the polyp reaches a large size which include progressive dysphagia (more than 50 of the patients), odynophagia, respiratory symptoms and the most distinctive regurgitation of a fleshy mass into the mouth. Here we report a case of 57 year old male who presented with dysphagia and regurgitation of mass into the mouth and on further investigation through imaging studies and endoscopy a fleshly pedunculated mass arising just below cricopharynx extending upto lower esophageal sphincter was identified. He was treated by rigid esophagoscopy removal of mass with diathermy cauterization of base.

Keyword :FIBROVASCULAR POLYP, ESOPHAGOSCOPY, REGURGITATING MASS, DYSPHAGIA.

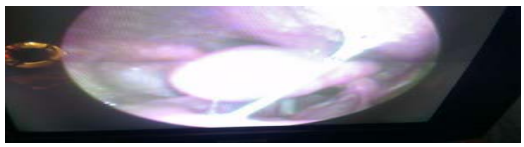


patient at rest

after retching

CASE REPORT:

A 57 year old male presented with dysphagia for 2 months and mass regurgitating through the mouth for 20 days. Dysphagia was insidious, progressive. Mass regurgitating from the mouth was sudden follows retching which can be reswallowed. Examination of oral cavity and oropharynx at rest were normal but when patient retches a fleshy pinkish mass regurgitates through the oral cavity which can be seen outside the mouth. Video laryngoendoscopy was done when the mass was outside the mouth which showed a fleshy pinkish mass whose pedicle goes through left pyriform fossa and mass slowly disappears in pyriform fossa. Patient was investigated further, On computed tomography scan of neck a soft tissue mass was seen intraluminally in the esophagus extending from cervical esophagus to above the lower esophageal sphincter. On upper GI endoscopy a fleshy mass with normal intact mucosa was seen intraluminally in esophagus originating below the level of cricopharynx and extending to above the lower esophageal sphincter, pedicle of the mass was not vascular. Laboratory investigations like hemoglobin, complete blood count, bleeding and coagulation profile, renal function test, random blood sugar were normal. Patient was planned rigid esophagoscopy removal of mass with diathermy cauterization of base.



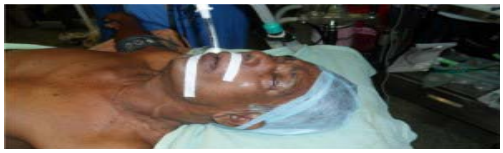
VLE showing mass which slowly disappears in pyriform fossa

upper GI endoscopy showing pedicle below cricopharynx

uppper GI endoscopy showing extend above lower esophagal sphincter

Patient was taken under general anaesthesia, rigid esophagoscope was slowly introduced into esophagus. Mass was grasped with forceps and carefully pulled up. Mass was negotiated through cricopharynx and brought to oral cavity. A stay suture was made on the mass and held outside the mouth. Once again rigid esophagoscope was introduced and the base of the mass was visualized below the cricopharynx. Base of the mass was cauterized using bipolar cautery, and the mass was removed in total. Patient recovered well from general anaesthesia. operative procedure time was around 72 minuets.

Esophagoscopy being introduced

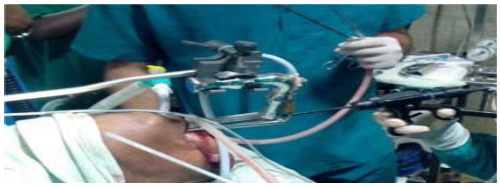


patient under GA

Immediate post operative period was uneventful. Patient was started on liquid diet from 2nd post operative day and semi solid, solid food on consecutive days. Patient was able to swallow food normally. Patient recovered completely and was discharged on 7th post operative day.

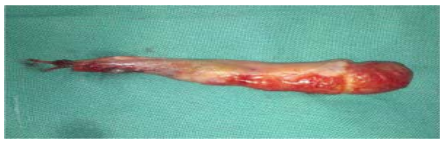
mass slowly pulled to oral cavity

mass held outside mouth by a stay suture

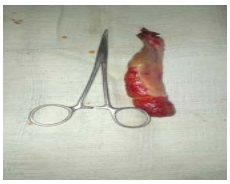


pedicle of the mass being cauterzied and removed

Biopsy report : section studied shows polyp covered by stratified squamous epithelium with surface ulceration, granulation tissue formation with underlying stroma showing admixture of fibrous tissue, adipose tissue and scattered thin walled blood vessels with areas of myxoid degeneration suggestive of fibro vascular polyp.



mass removed in total



mass beside medium sized artery forcep

Discussion:

Fibrovascular polyp of esophagus is a rare begnin tumour of esophagus. Giant fibroascular polyp are sporadically mentioned in literature. This include wide range of intraluminal polyp like fibromas, fibrolipomas, myomas, myxofibromas. Its most commonly seen in men over the age of 60-70 years of age. Place of origin is cervical esophagus below the cricopharyngeus muscle. Fibrovascular polyp begins as small mucosal tumour over time elongates with large pedicle. MOST DRAMATIC SYMPTOM IS THEIR POTENTIAL TO REGURGITATE THROUGH OROPHARYNX WHICH CAN BE RESWALLOWED. This may cause asphyxia once lodges over the laryngeal inlet which is a life threatening complication. Most common symptoms are progressive dysphagia, foreign body sensation throat, dyspnoea and rarely pain. Hemoptysis may occur by erosion of mucosa of lesion following repeated regurgitation. Malignant potential is very rare. Only one case of coextisting sqamous cell carcinoma was reported. Diagnosis is made by detailed history taking, thorough clinical examination, indirect laryngoscope and video laryngoscope examination, computed tomography scan of neck which shows intraluminal esophageal mass, upper GI endoscopy which shows - extent of mass, pedicle, mucosa over the mass. It is important to consider that if fibrovascular polyp has become giant, it means that patient approaches doctor late and this may be either because the patient shows no complaints, or because its symptoms have not been studied enough due to their nonspecificity. Fibrovascular polyp is an unusual tumor and different approaches have been proposed, including transverse cervical incision, transoral resection under direct visualization, endoscopic ligation and electrocoagulation of the pedicle (small size FVP), biapproach surgical technique (eoesophagostomy plus gastrostomy) and CO2 laser under laryngoscope . The novel technical approach that we propose using rigid esophagoscopic removal with diathermy cauterization is safe, accurate, simple scarless, with early recovery and discharge.

Conclusion:

Though surgery is the treatment of choice for giant fibrovascular, due to rarity of its presentation there is no established management protocol for giant fibrovascular polyp. Although various surgical modalities are available

rigid esophagoscopy removal with diathermy cauterization gives better result with significantly reducing intra operative time, post operative pain, facilitating speedy recovery and early discharge.

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University Journal of Surgery and Surgical Specialities