Angiolipoma of Hypopharynx : A Diagnostic Dilemma

Manzoor Latoo • Mohammed Lateef • Masood Khan • Sajad Majid • Mehrajudin
Shafkat Islam • Jhsan Ali • Imtiyaz nawaz • Sajad Ahmed

Abstract

Fibro vascular polyps of esophagus are rare tumours. They usually arise close to cricopharyngeus muscle. The commonest symptom is dysphagia but regurgitation of fleshy mass into mouth, regurgitation of recently digested food and sensation of lump in throat are also reported. Several reports of polyp regurgitation and subsequent airway obstruction are mentioned¹. We present a 48-year-old male with fibrovascular polyp of hypopharynx. Diagnosis was established by barium swallow and oesophagoscopy. Transoral route was used to remove the polyp and histopathology reported as angiolipoma.

Keywords Fibrovascular polyp • Barium swallow • Regurgitation • Videoesendoscopy

Introduction

Benign oesophageal neoplasms are rare. Oesophageal tumours may be classified as intraluminal, intramural or extramural. Benign tumours are common in men than in women and typically present after age of 40. Fibrovascular polyp is the term used broadly for intraluminal oesophageal polyps like fibroma, fibrolipoma, fibroepithelial polyp, pedunculated Upoma, angiolipoma etc. It is the 2nd most common reported benign tumour of oesophagus. 80% of these occur in upper oesophagus and are often closely associated with cricopharyngeus muscle. The two most common methods of diagnosis are barium swallow and oesophagoscopy and both are usually necessary. Biopsy is not recommended because these polyps are quite vascular².

Case Report

A 48-year-old farmer presented to our department with history of swelling in the oral cavity. Examination of the patient revealed no swelling in the oral cavity. Indirect laryngoscopy revealed normal anatomical features of hypopharynx & laryngopharynx. Patient had earlier been empirically treated for these symptoms. An extra movement spent with the patient revealed that the patient was actually regurgitating a polyp in the oral cavity which was demonstrated on clinical examination, and once the patient swallowed it back anatomical landmarks were normal. There were no symptoms like dysphagia or regurgitation of food. A clinical diagnosis of esophageal polyp was made. Patient was advised barium esophagiogram which revealed a smooth bulge in hypopharynx & barium stained stalk traced up to the apex of pyriform fossa (Fig. 1). Videoesendoscopy was done, polyp was seen just below cricopharynx narrowing the lumen of upper esophagus however its stalk was seen only after the patient regurgitated the polyp and repeat esophagoscopy was done (Fig. 2). With these diagnostic modalities the diagnosis of fibrovascular polyp was made. Patient was operated under general anesthesia, before intubation patient regurgitated the polyp which was gently lifted to identify the stalk at the apex of pyriform fossa. The stalk was ligated at the apex of pyriform fossa & the polyp was removed along with the stalk. Histopathology of the

Manzoor Latoo (✉)
Registrar

Department of ENT HNS
Room No. 26, Doctors Hostel
SMHS Hospital, Srinagar - 190010, J&K
Mobile 9419040323.
manzoor_latoo@yahoo.co.in

email.

Mohammed Lateef
Prof & HOD

Masood Khan
Assoc. Prof

Sajad Majid
Asstt. Prof

Mehrajudin
Gastroenterologist

Shafkat Islam
Jhsan Ali
Imtiyaz nawaz
Sajad Ahmed
Postgraduates

Department of ENT HNS
Govt. Medical College, Srinagar

Fig. 1 (a&b) Barium swallow

Fig. 2 Endoscopic photograph showing fibrovascular polyp

polyp revealed angiolipoma. Patient was kept fasting over night and was put on orals from the next day onwards. Postoperative period and subsequent follow up was uneventful and asymptomatic.

Discussion

Fibro vascular polyps are thought to arise from areas of diminished resistance in the pharyngeal musculature & to be initiated secondary to change in pressure during the different phases of swallowing. Two areas of potential weakness in the posterior wall of hypopharynx are: First, between the superior & inferior cricopharyngeal muscle known as Killian's dehiscence; and Second, between the inferior cricopharyngeus & upper end of esophagus also known as area of Laimer haeckermann or Laimer triangle. Polyps are thought to originate from nodular sub mucosal thickening or redundant sub mucosal folds³.

Fibro vascular polyps are composed of loose and dense fibrous tissue, adipose tissue and vascular structure and are covered by normal squamous epithelium. Depending on which histologic component predominates these lesions have been called, lipoma, fibroma, fibrolipoma, fibromyxoma, angiolipoma, fibroepithelial polyp¹. The common symptoms include dysphagia, mass in throat and regurgitation of polyp into mouth with its disappearance on swallowing, asphyxiation can result from impaction of polyp in glottis.

Unless regurgitated the presence of fibro vascular polyp can be difficult to diagnose. & up to 30% of patient may die without a correct diagnosis^{1,2,3,4}. Our patient had also been treated empirically because no swelling was seen in the oral cavity which he complained of. It was only when he regurgitated the polyp that diagnosis was made and patient could be saved from being labeled as psychiatric patient as no other symptom was there. Accurate diagnosis is established by endoscopy & barium swallow². Barium swallow in our patient revealed smooth bulge in upper esophagus with barium stained stalk tracing from apex of pyriform fossa classical of fibro vascular polyp. Endoscopy is the gold standard of diagnosis. & so was in our case. Where a smooth mucosa covered polyp was seen just

below cricopharynx narrowing the upper end of esophagus with its stalk. Though classical approach is cervical esophagotomy with ligation of base and excision of polyp^{1,2}, we used transoral route to have minimal morbidity postoperatively in our patient, as our patient had no symptoms other than regurgitation preoperatively. However we identified the base, ligated it, & excised the polyp in toto.

Conclusion:

We conclude that fibrovascular polyps of hypopharynx are a diagnostic dilemma, an extra moment spent during clinical history and examination reveals diagnosis without patient being labeled as psychiatric patient as has been reported in literature

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