General Surgery

INDEX COPERNICUS INTERNATIONAL

ICV value for 2023 = 74.57

Case Report

International Journal of Medical Case Report

A rare case of Esophageal fibroma: A case report

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INTERNATIONAL JOURNAL OF MEDICAL CASE REPORTS ISSN 2455-0574

Abstract

Benign tumors of the esophagus are rare, with fibrovascular polyps being an uncommon intraluminal type that can lead to symptoms such as dysphagia, odynophagia, and airway obstruction. We report a case of esophageal fibroma in a 51-year-old male with a three-year history of neck swelling and painful swallowing. Imaging revealed a 5.7 × 4.5 cm intraluminal mass in the upper esophagus with tracheal deviation. Rigid esophagoscopy was attempted but led to significant bleeding, prompting surgical intervention. A left cervicotomy and esophagotomy allowed for complete excision of the lobulated tumor. Histopathology confirmed a solitary fibrous tumor. The patient recovered without complications. This case underscores the importance of recognizing fibrous tumors as a potential diagnosis in esophageal masses and supports surgical excision for large, vascular lesions to prevent severe complications.

Keywords:- Esophageal Neoplasms, Fibroma, Fibrovascular Polyp, Dysphagia, Cervicotomy.

INTRODUCTION

Benign tumors of the esophagus are rare. In 1933, Patterson, in an article titled "Benign Tumors of the Esophagus," reported that after carefully reviewing the literature, she was able to compile records of sixty-two cases published between 1717 and 1932. [1] Since then, several isolated cases have been described, and the condition is no longer considered a pathological curiosity.

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While no individual surgeon has had the opportunity to manage a large series of cases, it is important for those interested in thoracic surgery to be familiar with the facts.

Therefore, summarizing the recorded features of these tumors may prove useful. Benign esophageal tumors can be classified as intramural-extra mucosal or intraluminal. Intramural-extra mucosal tumors, as described by Schatzki and Hawes, are most commonly represented by leiomyoma, followed by neurofibromas, both of which are classified as intramural-extra mucosal.[2]

The most common intraluminal tumor is the fibro vascular polyp, which has also been referred to as a fibroma, fibrolipoma, myxofibroma, polyp, or pedunculated lipoma. It consists of a mixture of fibro vascular tissue, adipose cells, and stroma, originating from the mucosa or sub mucosa. The fibrous component can range from loose and myxoid to dense with thick collagenous fibers. Most fibro vascular polyps are solitary, although multiple cases have also been documented. Symptoms, including progressive dysphagia, odynophagia, and respiratory issues, generally appear when the polyp reaches a large size.[3]

CASE REPORT

We present the case of a 51-year-old man who complained of neck swelling and painful deglutition, which had been present for 3 years. His previous and concomitant comorbidities included well-controlled ulcerative colitis managed with medication.

Computed tomography revealed a large soft tissue mass at the left posterior aspect of the lower neck, involving the upper esophagus. The mass measured 5.7 × 4.5 cm and showed intense development of gas locules. It protruded almost entirely into the lumen of the esophagus and caused deviation of the trachea. The bronchi, mediastinum, and lungs appeared normal. There was no other focal lesion seen on computed tomography (Figure 1). In view of this lesion further evaluation was planned.

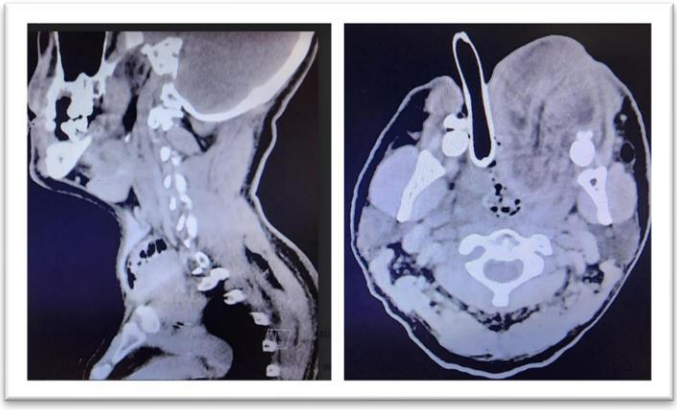

Figure 1:- Sagittal and Axial CT images showing a large soft tissue mass at the left posterior aspect of the lower neck.

Rigid esophagoscopy was done. The procedure was challenging due to heavy bleeding encountered. The patient underwent surgery, which involved a left longitudinal cervicotomy along the sternocleidomastoid muscle. After reaching the pharyngo-esophageal junction, a longitudinal incision was made in the esophagus just beneath the cricopharyngeus. A lobulated tumor mass was visualized and completely removed. The mucosa at the excision site was sutured, and a two-layer suture was applied to the esophageal wall. A subsequent histopathological examination of excised tumor was done which showed Solitary fibrous tumor.

DISCUSSION

Fibrous tumors are rare submucosal tumors that predominantly originate from the cervical part of the esophagus, at the level of the pharyngo-esophageal junction. They are histologically benign but often cause asphyxia. The risk of aspiration and asphyxia may be caused by the fact that the vocal cords are unable to perform complete adduction. This may lead to life- threatening asphyxia, as the entrance to the larynx may be blocked. Fibrous tumors are often pedunculated on thick stalks that are well vascularized. Their surface is often indistinguishable from the nearby intact mucosa and may thus be missed during esophagoscopy.[3]

It is rare for the mucosa of the tumor to become malignant, or for the tumor to grow to gigantic sizes, reaching the level of the stomach. Dysphagia, vomiting, weight loss, and respiratory symptoms are among common complaints.[4]

Multiple synchronous fibrovascular polyps of the hypopharynx have also been described.[5]

In the clinical case we presented, rigid esophagoscopy was performed; however, significant bleeding was encountered. This may be due to the large, well-vascularized stalk of the tumor, which caused hemorrhage. As a result, a cervicotomy and esophagotomy were performed for its extirpation. The removal of fibrous tumors is obligatory because of the risk of fatal asphyxia due to laryngeal obstruction. Small tumors (under 2 cm to 3 cm) with thin stalks may be removed endoscopically. Though rarely, large fibrous tumors may also be endoscopically managed with ultrasound scissors.[6] Large tumors, especially those above 5 cm and those with a thick, vascularized stalk, are strongly recommended for a surgical procedure— esophagotomy and excision.

Tumors located in the cervical part of the esophagus and in the pharyngo-esophageal junction are removed by a vertical cervicotomy, either on the left or right side. In the case of a gigantic fibrovascular polyp, a simultaneous transcervical and transabdominal approach for extirpation is possible.[7]

CONCLUSION

Clinical imaging and esophagoscopy are the primary steps in diagnosing intraluminal lesions of the esophagus. Intraluminal fibrous tumors of the esophagus that are unsuitable for endoscopic removal should be managed with surgical treatment

Conflict of interest

None

Source Of Funding

None

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Author Contribution:- SJ,MM: Conceptualized, supervised, revised, and edited the manuscript. EB,EA: Acquisition of data. Wrote the original draft, revised, and edited the manuscript.

Received : 20-01-2025 Revised: 27-02-25 Accepted : 05-03-25