



# Endoscopic resection for giant oesophageal fibrovascular polyp

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## ABSTRACT

A fibrovascular polyp is a rare benign pseudotumour of the oesophagus and hypopharynx. Although patients usually present with dysphagia, aspiration related mortality may occur. If the tumour is too large and/or located in the proximal oesophagus, it may protrude from the mouth. The general approach to treatment is complete reconstruction with cervicotomy. We present our experience of a giant oesophageal fibrovascular polyp that was protruding from the mouth and treated with endoscopic resection.

A 55-year-old man was admitted to our outpatient clinic complaining of a mass protruding from his mouth when he coughed. Endoscopy and bronchoscopy both revealed a 15–18cm long polypoid mass originating from the proximal oesophagus (at the level of the hypopharynx). Complete resection was performed via endoscopy.

## KEYWORDS

Giant fibrovascular polyp – Oesophagus – Endoscopic resection

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## Introduction

Oesophageal fibrovascular polyps are rare benign tumours of the cervical oesophagus and hypopharynx.<sup>1</sup> They are asymptomatic when small but may also cause potentially fatal airway complications associated with oesophageal and respiratory obstruction (such as dysphagia, vomiting, retrosternal pain, shortness of breath and/or asthma) when the tumour grows.<sup>2</sup> Conventional surgical treatment comprises vertical oesophagotomy with a cervical approach and excision of the tumour. There are few publications reporting resection with an endoscopic approach.<sup>2,5</sup> We present our experience of a giant oesophageal fibrovascular polyp that was protruding from the mouth and treated with endoscopic resection.

## Case history

A 55-year-old man was admitted to our outpatient clinic with a mass protruding from his mouth when he coughed. His past medical and surgical history was unremarkable. Computed tomography of the neck and thorax revealed a large pedicled polypoid mass approximately 16cm long in the proximal oesophagus. Bronchoscopy was normal. Endoscopy showed a 15–18cm long polypoid mass originating from the proximal oesophagus (at the level of the hypopharynx) approximately 13cm from the incisors.

Biopsy was performed initially and the results were reported as an oesophageal fibrovascular tumour. Complete resection was performed via endoscopy under sedoanalgesia (Video 1 – available online). The patient was discharged two days later. In the pathology report, the size of the tumour was given as 15cm x 3.5cm and the surgical margins were clean. The patient did not develop any complications during the follow-up period.

## Discussion

Oesophageal polyps are rare and originate from the mucosa or submucosa of the oesophagus, usually the upper third. Giant fibrovascular polyps, which consist of fibroadipose connective tissue and blood vessels coated with stratified squamous epithelium, constitute <2% of all benign oesophageal tumours.<sup>4</sup> Although very few cases with fibrovascular polyps have been reported, most of the reported cases were male patients in their seventh and eighth decades.<sup>5</sup>

Fibrovascular polyps may remain asymptomatic for a long time. Nevertheless, they can cause mild symptoms such as coughing and dysphagia or even severe fatal symptoms such as life threatening airway obstruction requiring a tracheotomy.<sup>6</sup> Diagnosis may be difficult and often requires a combination of history, imaging and endoscopy. Barium swallow is commonly used but its

sensitivity for polyps with a regular surface is relatively low. In addition, it cannot show the neoformation of the pedicle. For better visualisation of the polyp, endoscopic ultrasonography is preferred in order to measure the size, display the pedicle and evaluate vascularity; it also offers the advantage of enabling fine needle aspiration. Computed tomography can show the feeding vessels of the polyp, and magnetic resonance imaging can provide detailed anatomical data with multiple planes of section and high differentiation resolution of soft tissues.<sup>7</sup>

The definitive treatment for fibrovascular polyps is surgical excision. Resection not only results in symptom control but also eliminates the risk of choking. Although these polyps can be resected via a transoral, transthoracic or transcervical approach, endoscopic resection can also be performed with a low risk of perforation since the base of the polyp does not contain the muscularis propria. Some authors have reported that polyps with a wide pedicle and measuring >8cm are not suitable for endoscopic interventions owing to the risk of bleeding.<sup>8</sup> However, oesophageal surgery is known to be complex, associated with high morbidity and not always technically feasible. In addition, advanced endoscopic instruments and increased endoscopic experience have made safe endoscopic resection of polyps larger than 8cm possible. While surgical excision is generally curative, several cases of recurrence have been reported in the literature.<sup>6,9</sup>

## Conclusions

Endoscopic resection can be performed safely and effectively in the treatment of giant oesophageal fibrovascular polyps. In this way, the morbidities caused by transcervical or transthoracic excision can be also avoided.

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