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A rare cause of upper gastrointestinal bleeding; giant lesion in esophagus!

Nadir bir üst gastrointestinal kanama nedeni; özofagusta dev lezyon!

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Abstract

Fibrovascular polyps are one of the benign esophageal tumors and rare gastrointestinal bleeding reasons. They are mostly located in the proximal esophagus. Swallowing and breathing problems, mass feelings, discomfort when swallowing, nausea, weight loss, and a persistent cough are the most common symptoms. Endoscopic resection or esophagectomy are the two main options for treatment. A 60-year-old male patient was admitted for epigastric pain and melena. Endoscopy showed a 15-centimeter-long pedunculated polyp originating from the proximal esophagus and extending to the cardia, narrowing the lumen. The lesion was excised with multiple incisions using surgical ligature and an endoscopic knife after endoscopic ultrasonography and computed tomography examinations. The lesion was too big to be endoscopically removed from the esophageal lumen. Therefore, nearly a 3-4 cm incision was made on the abdomen skin. Under the guidance of the endoscope, the polyp was removed from the incision region using a clamp. Following hemostasis, the stomach was reconstructed and the procedure ended. No problems occurred. The patient is protected from major surgical and operational risks with endoscopic removal of large polyps. Patients who are candidates for endoscopic resection should consider it.

Key words: Gastrointestinal bleeding, fibrovascular polyp, endoscopic treatment.

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Öz

Gastrointestinal kanamanın nadir nedenleri arasında yer alan ve benign özofagus tümörleri arasında bulunan fibrovasküler polipler çoğunlukla proksimal özofagustan köken alır. Yutma ve nefes almada zorluk, yutma sırasında hissedilen kitle hissi ve ağrı, bulantı hissi, kilo kaybı, inatçı öksürük ve kanama gibi şikâyetlere neden olan kitlelerdir. Tedavi endoskopik rezeksiyon veya özofajektomidir. 60 yaşında erkek hasta melena şikâyeti ile başvurdu. Endoskopide ön kesici dişlerden itibaren 17. cm'den başlayarak kardiaya uzanan ve lümeni daraltan 15 cm uzunluğunda pedinküle polip görüldü. Endoskopik ultrasonografi ve bilgisayarlı tomografi incelemelerinin ardından lezyon, cerrahi ligasyon ve endoskopik knife ile çoklu kesi yapılarak rezeke edildi. Lezyon büyük olduğu için özofagus lümeninden çıkarılamadı, kardiadan 3-4 cm'lik bir kesi yapıldı. Polip endoskop eşliğinde klemp ile kesi alanından çıkarıldı. Daha sonra mide onarıldı ve hemostazın ardından operasyon sonlandırıldı. Herhangi bir komplikasyon olmadı. Dev poliplerde endoskopik rezeksiyon, hastayı majör cerrahi ve operatif risklerden korur. Uygun hastalarda endoskopik rezeksiyon düşünülmelidir.

Anahtar kelimeler: Gastrointestinal kanama, fibrovasküler polip, endoskopik tedavi.

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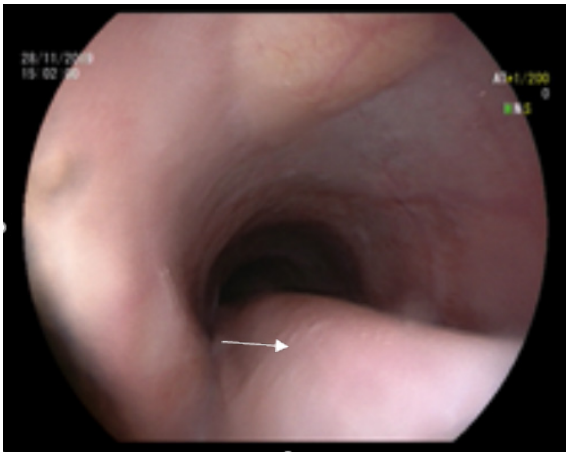
Introduction

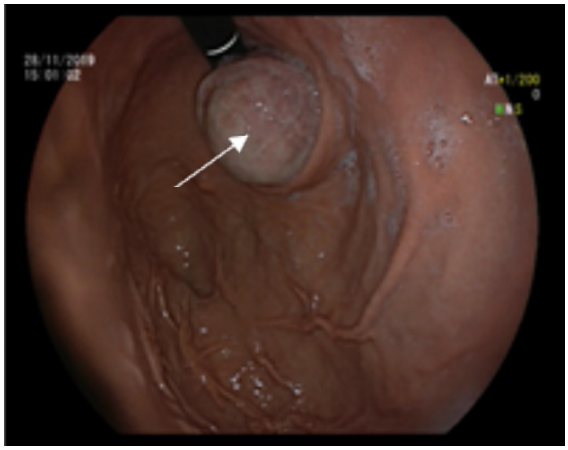
Crest syndrome, Dieulafoy's lesion, aneurysm rupture, aortoenteric fistula, Crohn's disease, Behçet's disease, and other etiologies are all rare causes of upper gastrointestinal (GI) bleeding [1]. Fibrovascular polyps, one of the benign esophageal tumors, can cause upper GI bleeding in rare cases [2]. These masses are mostly located in the proximal esophagus and can cause symptoms such as difficulty swallowing and breathing, mass feelings and discomfort when swallowing, nausea, weight loss, and recurrent cough and bleeding [3]. Endoscopic polyp excision, cervical esophagotomy, transthoracic esophagotomy, and esophagectomy are all alternatives for treating fibrovasvular polyps [4]. We report a case of a large fibrovascular polyp presenting with severe bleeding that was successfully removed using endoscopyc resection.

Case

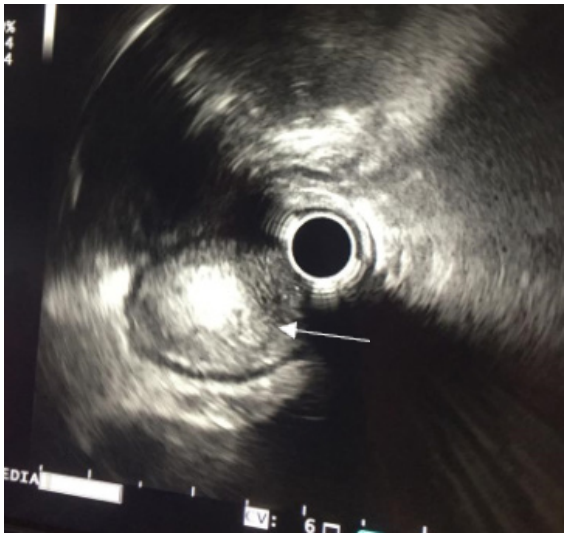
A 60-year-old male patient was admitted to our clinic for epigastric pain and melena for three days. In the upper GI endoscopic examination, a nearly 15 cm pedunculated polypoid lesion was detected in the esophagus, originating at the posterior wall, 17. cm from the anterior incisors and extending to the gastric cardia (Pictures 1, 2). The esophageal lumen was narrowing because of this lesion. Mucosal appearance showed no aberrant epitelium. With Magnifying-Narrow Band Imagine (M-NBI), the endoscopic appearance was covered with regular squamous epithelium, and the surface epithelium of the lesion did not comprise an adenomatous or aberrant structure. In an endoscopic ultrasonography (EUS) examination, we evaluated the mass parenchyma with a well-circumscribed hyperechogenic echo pattern and visible vascular structures (Pictures 3, 4). A hypodense mass in the esophagus was seen on thorax computed tomography (CT), which extended from proximal to distal, filling the lumen to a large extent and producing an increase in esophageal calibration. Endoscopic treatment was planned for the excision of the lesion, and the patient was intubated in the operating room. We began incision from proximal with an endoscopic knife, keeping the lesion's safety margin. Because of the difficulty taking a vertical cutting position on the lesion after a small incision, going forward to the interior of the lesion was not possible. Therefore, the endoscope-guided surgical ligature was carefully advanced into the lesion's incision site. The lesion was vertically positioned with the endoscope from the bottom to capture the lesion with surgical ligature. The incision was then continued in this way. Using the ligature and knife, the lesion was completely resected (Pictures 5, 6). Endoscopic long clips were used to control the hemorrhages that occurred during the procedure. The lesion was too big to remove orally using endoscopy, so it had to be pushed down into the stomach lumen with difficulty. The lesion in the stomach was planned to cut into small pieces and to remove orally. However, it was filling the corpus and fundus and was impossible to remove. Because of the possibility of obstruction and possible tumor spillage, surgical removal was chosen. Nearly a 3-4 cm incision was made on the abdomen skin. The surgery was guided by intraoperative endoscopy, and the polyp was removed out from the incision (Picture 7). Following hemostasis, the stomach was reconstructed and the procedure was finished. There was no problem after the procedure. The diagnosis of giant fibrovascular polyp was confirmed on pathological examination ((CD34 was infrequently positive in immunohistochemistry testing). Negative for S-100, Desmin, SMA, EMA, MYO-D1, Myogenin, and CD117).



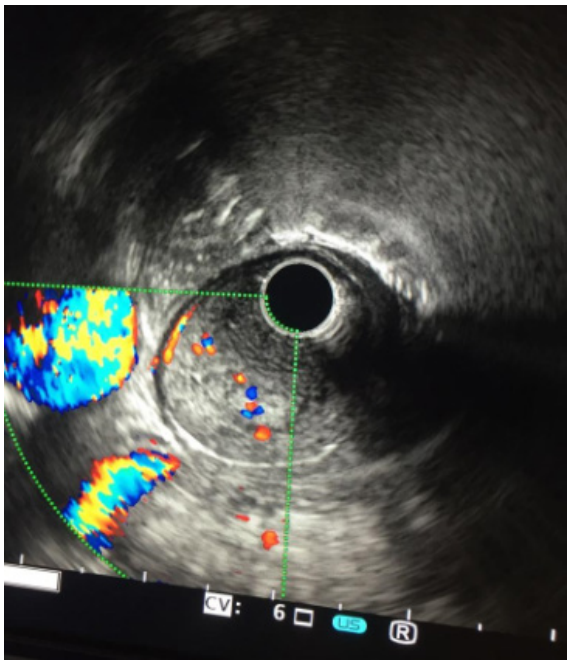
Picture 1. Endoscopic view of the lesion (thin arrow)



Picture 2. The head of the polyp is observed in the stomach (thin arrow)



Picture 3. EUS image of the lesion (thin arrow)



Picture 4. Doppler examination of the lesion with EUS

Picture 5. Floor view after polyp excision in the esophagus

Picture 6. The appearance of the mass in the stomach after excision (thin arrow)

Picture 7. The mass was removed after excision

Discussion

Benign esophageal tumors account for 20% of all esophageal tumors, and fibrovascular tumors account for 1% to 2% [5]. 85-90% of fibrovascular polyps originate from the proximal esophagus and 10-15% from the hypopharynx [3]. Swallowing and breathing problems, mass feelings, discomfort when swallowing, nausea, weight loss, and a persistent cough are the most common symptoms [6]. Fibrovascular polyps of the esophagus are presented as large, pedunculated lesions. Symptoms are seen when the polyp is too large. When polyps obstruct the airway, it can cause respiratory discomfort. Individuals who are not treated may suffer asphyxia. Asphyxia, which can occur when the polyp closes the glottis, is the most severe complication [3]. Malignant degeneration in fibrovascular polyps is uncommon. However, sarcomatous alterations in lipomatous components, squamous carcinoma in squamous mucosa, and adenocarcinoma in small polyps have all been documented in the literature [7]. Endoscopy is the most effective diagnostic and therapeutic option, despite the fact that ultrasonography (USG), computed tomography (CT), and magnetic resonance imaging (MRI) can be used to diagnosis. Fine needle aspiration biopsy under EUS guidance can be helpful for histological diagnosis. The vascular structure of the polyp can be evaluated with EUS [8]. Endoscopic polyp electrocautery, Nd: YAG laser ablation, cervical esophagotomy, transthoracic esophagotomy, and esophagectomy are all alternatives for treatment. Endoscopy is mostly used for the treatment of polyps that are less than 2 cm in diameter, have a small stem, and are less vascularized. Endoscopic treatment is difficult to control bleeding if the polyp is vascularly rich and/or big (greater than 8 cm in diameter). In these cases, open surgical treatments are required. Fibrovascular polyps are mostly in the upper third of the esophagus, and for their treatment, esophagotomy through a cervical incision is used. Distally located and large polyps need a thoracotomy [4]. Endoscopic diagnosis of a polyp at the cricopharyngo-esophageal junction can be difficult because of its location. Furthermore, because of the intact mucosa on the polyp, the difficulty of its location, and the polyp's mobile nature, endoscopic biopsy may be difficult to take [6, 7].

Many cases of esophageal fibrovascular polyps have been documented in the literature. A 59-year-old male patient with a giant fibrovascular polyp and progressive dysphagia was reported in a case published in the Saudi Medical Journal in 2015. The 14x3x2 cm intraluminal esophageal mass originated from the cervical esophageal region and extended to the lower esophagus with no connection to the esophageal wall. That mass was surgically removed with a left cervical approach [9]. In another case published in 2008, the patient was presented with dysphagia and a polyp in the esophagus was detected on CT and diagnosed as a fibrovascular polyp after biopsy. It was treated surgically using a pharyngotomy and gastrostomy [10]. In another case, a 45-year-old female patient had a feeling of being stuck in the throat, having difficulty swallowing, especially solid foods, and respiratory distress for the previous 6 months. Endoscopy showed a large polyp with a diameter of 4 cm at the beginning of the upper esophagus. Because of the mass's large diameter and vascular density, surgical treatment was planned. After esophagotomy over the mass, the polyp below the cricopharyngeal muscle was removed after the left transverse cervical incision [11]. In other cases of fibrovascular polyps reported in the literature, the polyps were surgically resected. Our case is the largest fibrovascular polyp case ever documented in the literature. He was hospitalized for gastrointestinal bleeding and endoscopically resected and surgically removed from the incision region.

Conflict of interest: No conflict of interest was declared by the authors.

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Informed consent: A written, informed consent was obtained from the patient.

Authors' contributions to the article

M.I., M.E., A.Y., and A.C. performed endoscopic tests and treatments on the patient who presented with upper gastrointestinal hemorrhage. M.I., G.K., and K.T. all contributed to the case report's preparation and writing. M.I. and M.E. researched the literature, and the case was prepared as a case report. M.I. and M.E. examined radiological imaging during the case's care. Furthermore, all authors discussed and approved the final version of the paper.