

INTRODUCTION

Esophageal lipomas are rare accounting for 1% of all benign esophageal neoplasms. Fibrovascular polyps are a subset of esophageal lipomas that can present with dysphagia, hematemesis, melena and/or profound anemia.

We describe a case of a giant esophageal fibrovascular polyp (GFVP) which was treated with endoscopic submucosal dissection (ESD).

CASE DISCUSSION

- **Patient:** A 62-year-old man presented for evaluation of a two-month history of dysphagia to solids and liquids, 4 kg weight loss, and melena.
- **Physical Exam:** Chronically ill pale man with no palpable neck masses, a nontender, nondistended, soft abdomen, and melena confirmed by digital rectal exam.
- **Laboratory Workup:** Hemoglobin of 4.7g/dL, MCV of 78.1 fL and albumin of 3.6 g/dL.
- **CT Imaging:** Chest CT with IV contrast showed a soft tissue mass filling the entire length of the esophagus (Figure 1).
- **Differential Diagnosis:** Differential diagnosis included esophageal carcinoma, pedunculated fibrovascular polyp, and leiomyomatosis.
- **Barium Esophagram:** Barium swallow showed smooth lobular defects filling the entire esophageal lumen (Figure 2).
- **EGD:** Upper endoscopy and endoscopic ultrasound (EUS) revealed a near circumferential large stalk starting at the upper esophageal sphincter and diverging into 3 separate stalks measuring 15, 18, and 20 cm respectively with a small distal hematoma (Figure 3).
- **Resection Decision Making:** Neither a 33mm snare nor endoloop could encircle the polyp heads, so a technically complex ESD was performed using ERBE I knife and Endo Cut Q for submucosal incision.
- **Endoscopic Submucosal Dissection:** Standard SB knife was used for submucosal release before dissection with DryCut and the Olympus ITknife2.
- **Pathology:** H&E staining confirmed the diagnosis of a GFVP.
- **Follow Up:** On 1-month follow up, the patient's dysphagia had resolved completely, he had no recurrence of melena, and hemoglobin was stable.

FIGURE 1

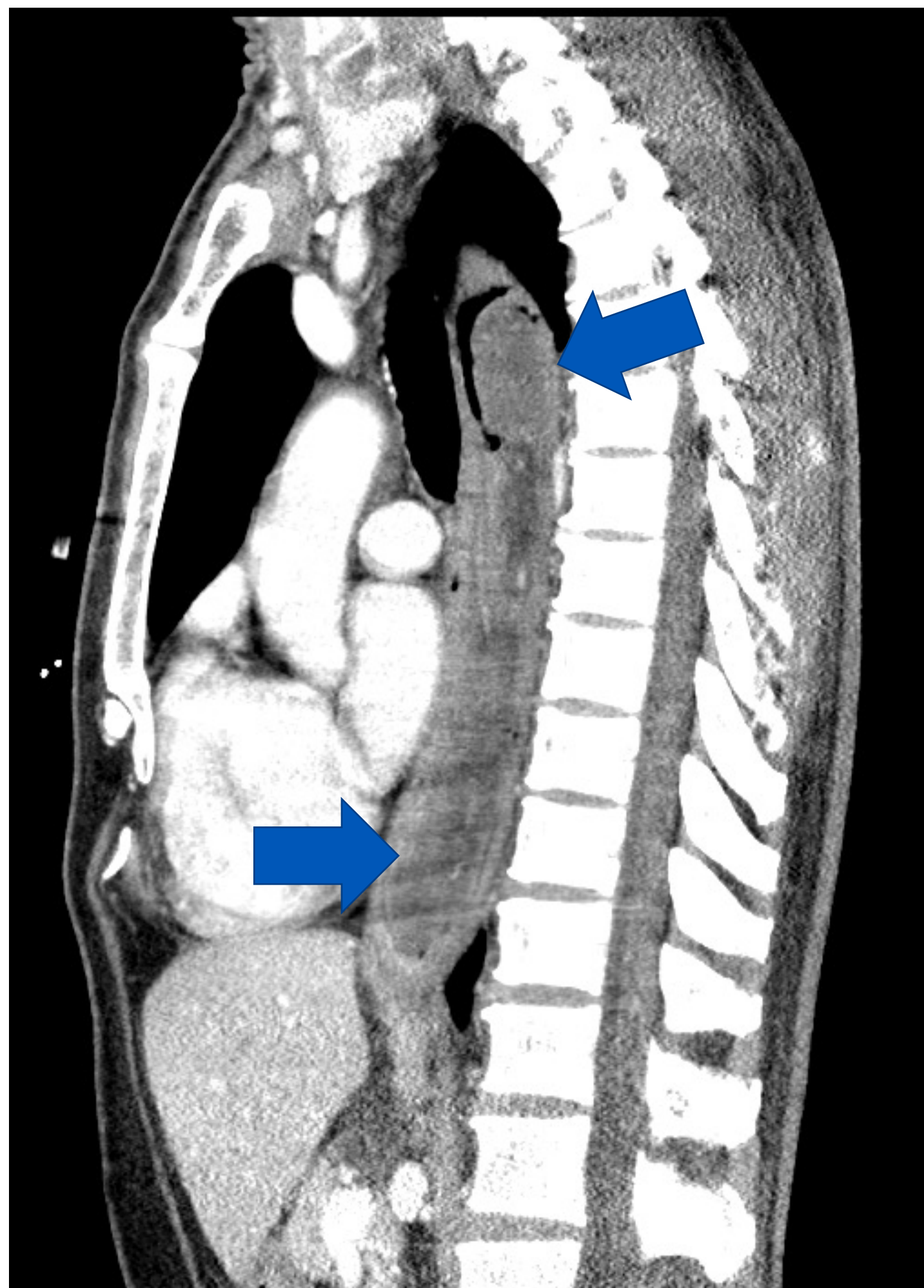


Figure 1. Sagittal CT view. Entire esophageal lumen filled with soft tissue mass (arrows).

FIGURE 2

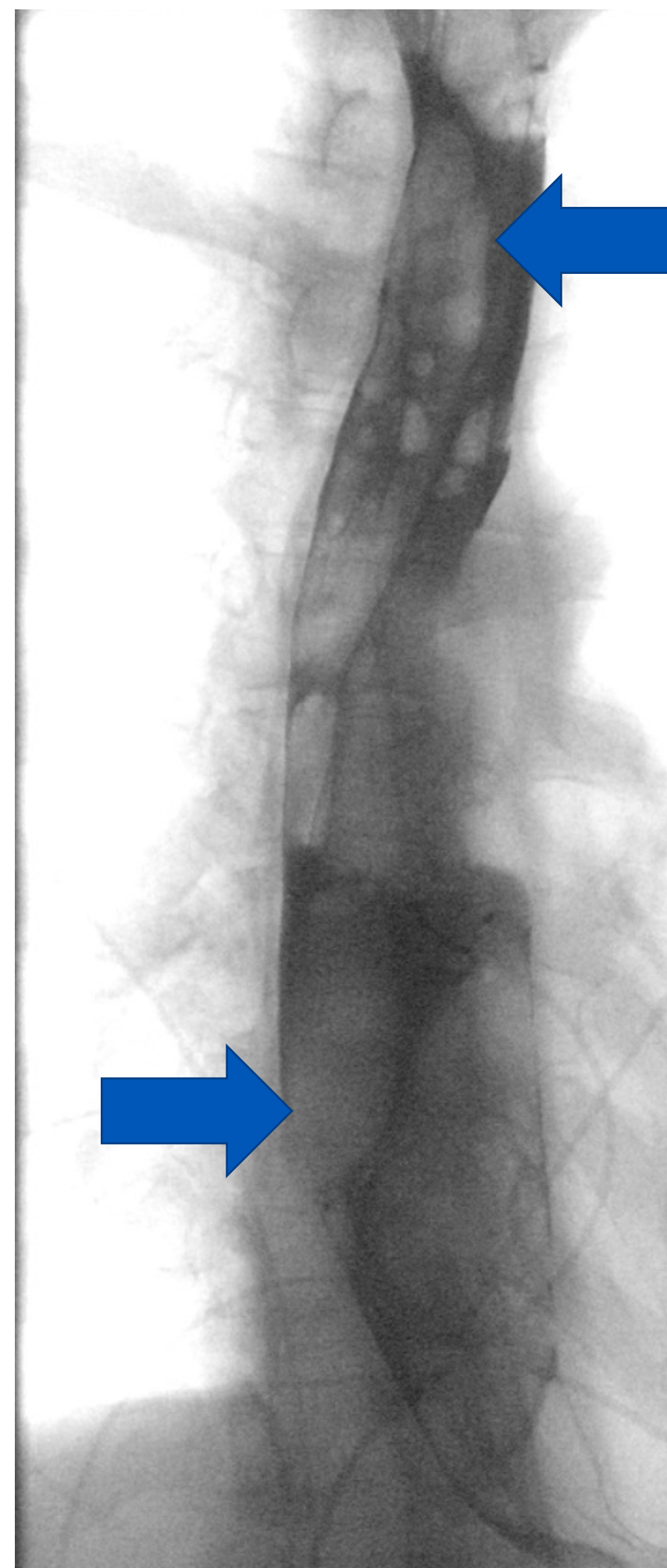


Figure 2. Water soluble contrast esophagram: Smooth lobular filling defects (arrows) filling the entire esophageal lumen.

FIGURE 3

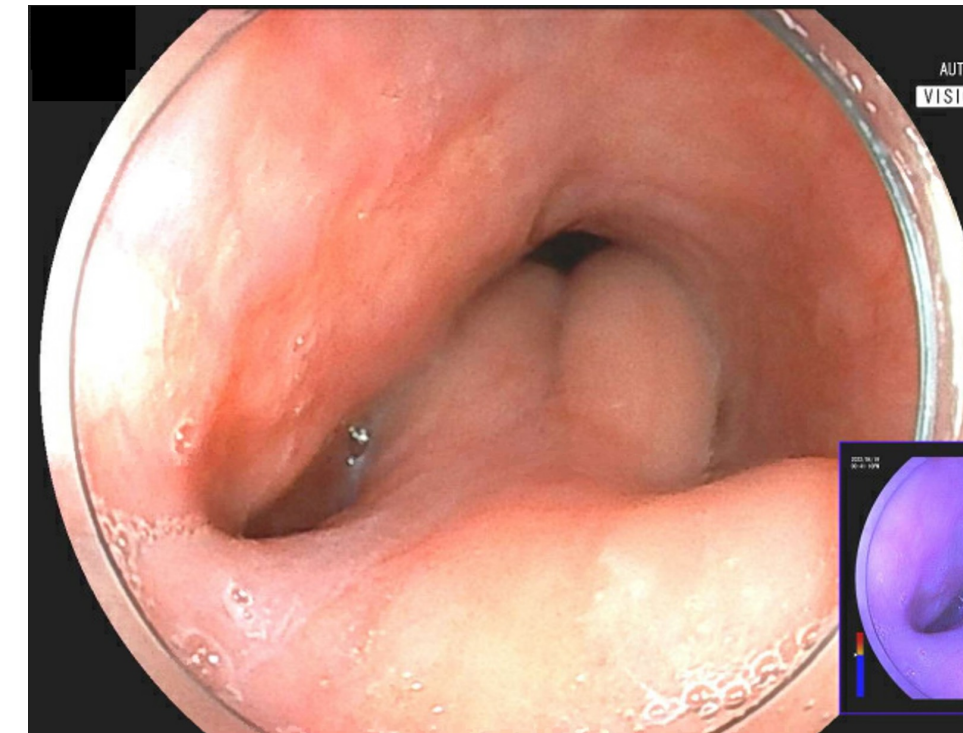


Figure 3. Endoscopic view. Stalk of giant fibrovascular polyp inserting at inferior margin of the upper esophageal sphincter.

DISCUSSION

- **GVFP Symptoms:** Dysphagia, coughing, and a sensation of throat fullness.
- **Asphyxia:** There are rare reports of large upper esophageal polyps regurgitating into the oropharynx and leading to subsequent asphyxiation.
- **Visualization:** Although GVFPs can be seen on cross sectional imaging and modified barium swallow studies, direct visualization with endoscopy is favored.
- **Management:** Prompt removal via cervicotomy or thoracotomy are the most common interventions, but upper endoscopy with ESD is a minimally invasive option that may facilitate improved recovery especially in high surgery risk patients.
- **ESD Advantages:**
 1. Minimally Invasive
 2. Lower risk of intra and post procedural bleeding
 3. Scenarios with technical prevention of loop ligation given polyp head size
 4. Superiority in achievement of complete resection.

CONCLUSIONS

ESD should be considered as a first line minimally invasive option to achieve clear excision margins and prevent polyp recurrence.