Research Paper

Volume : 3 | Issue : 12 | December 2014 • ISSN No 2277 - 8179

Oesophageal cavernous haemangioma-A rare cause of dysphagia.

Medical Science

KEYWORDS : *Oesophagus, cavernous haemangioma, Submucosal tumors, Histopathological examination.*

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ABSTRACT

Haemangioma of the oesophagus is uncommon in patients with benign oesophageal tumours. We present a patient with complaints of progressive dysphagia for 1 year duration. Endoscopic examination revealed a blue-coloured (approximately 5 cm in diameter) broad based, pedunculated submucosal tumour arising from just below cricopharynx extending down to the oesophagus , suggestive of polypoid lesion.

However, a CT imaging scan did not give a typical image for oesophageal haemangioma. The impression was fibrovascular polyp with supraclavicular, mediastinal and axillary lymphadenopathy. Left cervical oesophagotomy with excision of tumour was performed. Histological examination of the resected tissue showed a cavernous haemangioma in the oesophagus and reactive hyperplasia of the resected lymphnodes. Even if oesophageal hemangioma is uncommon, careful consideration during endoscopy is required to avoid the misdiagnosis of varices.

Introduction

Submucosal tumors (SMTs) of GI tract are usually asymptomatic and discovered fortuitously during routine endoscopy. They appear as smooth intraluminal protrusions with normal covering mucosa.[1]

Hemangiomas are tumors of vascular origin and represent less than 3% of benign neoplasm of the esophagus.[2] According to the literature, these hemangiomas originate from embryologic sequestrations of mesodermal tissue.

To the best of literature search only a few cases of Cavernous Haemangioma of oesophagus have been reported.

This entity has been frequently misdiagnosed and diagnosis implies high index of suspicion and proper diagnostic workup. We report a case of cavernous Haemangioma of oesophagus presented clinically as dysphagia.

Cavernous Haemangioma of oesophagus

A 48 years old female presented with complaints of progressive dysphagia for 1 year duration. Dysphagia was more for solids than liquids. She gave a family history of carcinoma oesophagus due to which her sister died. Clinically, dysphagia was graded as 2-3. Upper GI scopy showed a large (5 cm) broad based, pedunculated, bluish tinged mass arising from just below cricopharynx extending down to the oesophagus, suggestive of polypoid lesion(figure 1).

CT scan neck was taken. It showed a pedunculated, polypoid mass(figure 2) lesion in cervical oesophagus 4x2.7x2.1 cm with supraclavicular node(1.4cm), pre-tracheal node(2 cm) and axillary node(1.4 cm). The impression was fibrovascular polyp with supraclavicular, mediastinal and axillary lymphadenopathy.

Lymph node excision biopsy was done which showed reactive hyperplasia. She was planned for elective surgery for excision of polypoidal lesion after appropriate pre-operative assessment. Her biochemical and haematological parameters were normal.

Left cervical oesophagotomy with excision of tumour was performed.

Through oblique neck incision and by standard approach to cervical oesophagus, longitudinal oesophagotomy was done. Broad based polyp extending to the lower part of cervical oesophagus pedicled. Plane created with submucosal saline injection. A benign looking tumour was excised.

Post operative period was uneventful. Gastrograffin swallow on day 5 revealed no leak and oral fluid started.

The tumour was sent to histopathological examination. Gross morphology showed dark, tan polypoidal mass with a stalk 2.5x2.5x1.5 cm. Sectioning reveals haemorrhagic discolouration.

Histopathological examination showed benign vascular lesion, composed of several dilated venous channels(figure 3). Overlying squamous epithelium was unremarkable suggestive of cavernous haemangioma. There was no evidence of malignancy. Resected lymph node showed reactive hyperplasia.

Discussion

Haemangiomas are well known to arise from organs such as skin, liver, kidney and brain. Oesophageal haemangioma is a relatively a rare diagnosis, and although is known to be a submucosal tumour of the oesophagus it has been reported to be <5% of oesophageal benign tumours.[3]The majority of cases are found incidentally at post-mortem or during a surgical operation. However, they can cause haematemesis or dysphagia due to their size. [4] It occurs in men predominantly between the fourth and seventh decades. [5] Benign haemangioma of the oesophagus can be grouped histologically into cavernous, capillary and hamartomatous and arteriovenous malformations subtypes. A cavernous haemangioma is defined by the size of venous channels that are larger than capillaries. The differential diagnosis includes: malignant haemangioma, Kaposi's sarcoma, benign metastasizing haemangioma and angiosarcoma. [2]

The findings at endoscopy have been described as a blue coloured protruding submucosal-like tumour appearing anywhere in the oesophagus and can also have atypical appearances including a reddish discolouration, a normal-appearing mucosa or an ulcerated appearance. [6] In our case, the lesion looked very much like a broad based pedunculated polypoid mass.

On CT scan, oesophageal cavernous haemangiomas appear homogenous and isodense mass with calcification found. [7] However, a CT imaging scan did not give a typical image for oesophageal haemangioma in our patient.[4] Further the finding of lymphadenopathy confused the clinical picture.

Though Endoscopy is regarded as the first choice to diagnose hemangiomas at times it may not clinch the diagnosis. EUS could be used in some instances. In EUS, the typical finding of cavernous hemangioma is shown as multiple cystic mass arising

within the submucosa.

Diagnosis can be aided with a biopsy of the mass; however, this is often deferred due to the potential risk of haemorrhage (a rare occurrence). Malignancy has been reported in some tumours predicating the need for surgical evaluation of the tumour; however, the risk of malignancy is greater with tumours >3 cm in size. [8] Treatment when indicated for a patient with symptomatic dysphagia, bleeding, for clarification of diagnosis [2] or to exclude malignancy is via the surgical approach.

Treatment options include resection by thoracoscopic approach or laparoscopic approach. Esophagectomy has been described as a surgical procedure often carrying great morbidity and mortality, especially when for a benign lesion.

The case illustrates the following: (a) a diagnosis of oesophageal cavernous haemangiomas though rare, must be considered in all patients with dysphagia (b) endoscopy and CT scan may fail to identify the lesion (c) surgical resection may become necessary for symptomatic patients.

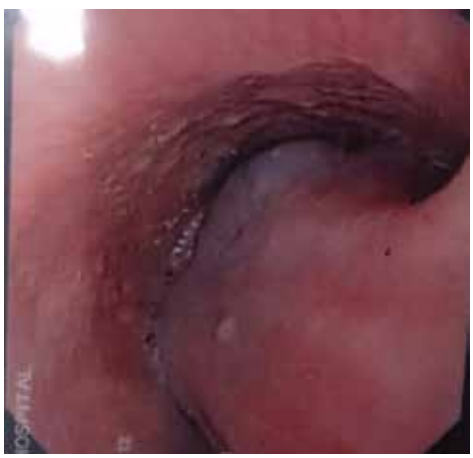

Fig 1 Upper GI scope showing a large broad based, pedunculated, bluish tinged mass.

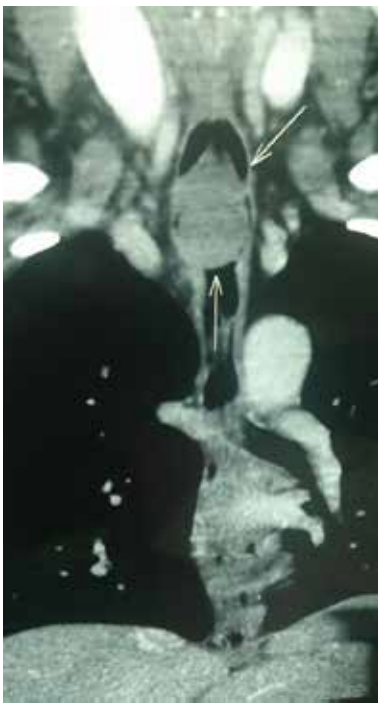

Fig 2 CT scan image showing pedunculated, polypoid mass lesion in cervical oesophagus.

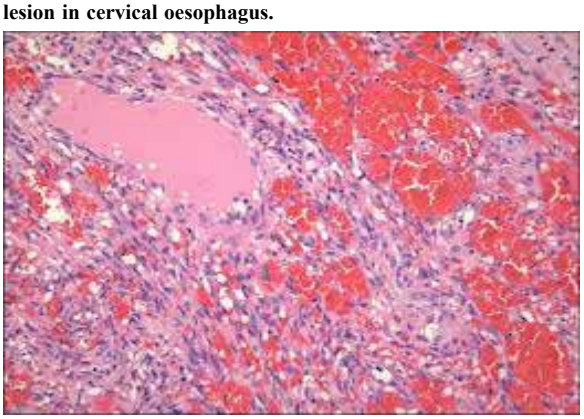

Fig 3 Histopathological examination showing benign vascular lesion with several dilated venous channels.

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