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OROPHARYNGEAL CHORISTOMA – A CASE REPORT & REVIEW OF LITERATURE

Pathology

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ABSTRACT

We report an unusual case of a 9 year old boy who presented with a posterior pharyngeal wall lesion which on excision biopsy was diagnosed as oropharyngeal gastric choristoma. Gastric choristoma in the pharynx is extremely rare and only a few cases have been reported so far.

Summary: Oropharyngeal gastric choristoma presenting with features of obstruction in a child is unusual and necessitates surgical excision.

KEYWORDS

tumor like lesion, choristoma, oropharyngeal mass

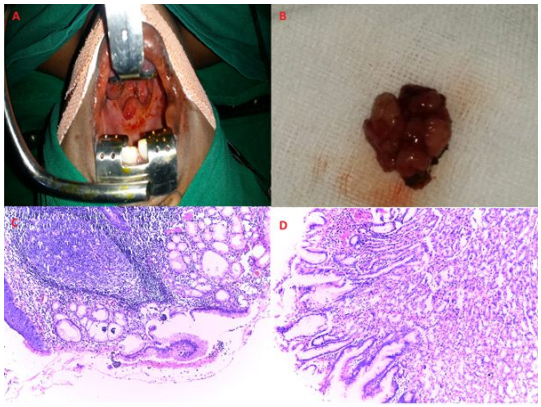
Introduction:

Choristoma is defined as the presence of histologically normal appearing tissue of a type which is not normally found in that anatomic site. They are tumorlike lesions which usually can occur in a wide range of anatomical locations. In the GIT,it has been found throughout the alimentary tract, ranging from scattered rests of cells to well formed mucosa with submucosal smooth muscle.[1] They are considered as developmental anomalies or embryological accidents and not neoplastic. They are mostly seen in the younger age group especially infants and neonates . In the older age group they are usually smaller in size , asymptomatic and hence incidental findings.They are also known as heterotopias and is composed of a single type of tissue but can show a mixed tissue pattern as well. Gastroinestinal or gastric type of choristoma is rare in the head and neck region.Most of these cases are reported in the oral cavity especially floor of the mouth. Pharyngeal gastric choristoma is extremly rare.

Case history:

9 year old child presented with history of growth retardation and snoring O/E Child was malnourished and short statured. Oropharyngeal mass lesion was seen with attachment to posterior pharyngeal wall(fig A)There was no attachment to the tongue. With a clinical diagnosis of aberrant adenoids, the child was referred to ENT department where an excisiom biopsy of the mass was done.

Grossly the excised specimen (figure B) was a nodular firm mass measuring 2x2x1.5cm. Cut surface showed a solid brownish homogeneous appearance. Under the microscope(figure C & D) it was a circumscribed lesion composed predominantly of full thickness normal gastric mucosal tissue with surface epithelium,lamina propria and muscle layer. It was was covered by oropharyngeal mucosa and a diagnosis of oropharyngeal choristoma was made.



A. Oropharyngeal mass lesion attached to posterior pharyngeal wall

B. Excised specimen

C. Oropharyngeal mucosal epithelium on the left side and gastric mucosal tissue on the right side

D. Gastric mucosal tissue

Discussion

Choristomas also called heterotopias present with normal tissues at abnormal locations.. Clinically and morphologically choristomas tend to resemble tumors. These are usually smaller asymptomatic lesions and very often incidental findings identified during endoscopic procedures.

There are reports of naso/oropharyngeal choristomas composed of brain, cartilage and skin tissues. Gastric heterotopias also can occur throughout the GIT. Upper esophagus[2] and tongue are the common sites. But pharynnx is an exceptional location for gastric choristoma and it was first reported by Stout and Lattes in 1957.[3]Clinically it can manifest as airway obstruction [4] and feeding difficulties especially in the neonate.[5] It can be swallowing/ breathing difficulties leading to developmental problems in older children as has happened in our case.

The most important differential diagnosis of choristoma is hamartoma which is considered as another tumorlike lesion. A hamatoma is a haphazardly arranged mass of tissues that are indigenous to the site where it is found. Unlike choristomas the margins of these lesions are ill defined and merges with surrounding tissues. Hamartomas and choristomas appear clinicaly as exophytic masses and the size vary from very tiny lesions to larger lesions measuring few centimetres. They have been described over a wide age range from birth to old age. Histologically these two lesions may show overlapping morphological features and sometimes may even be misdiagnosed as benign tumors.

Surgical excision is the treatment option as was done in our case and is curative. Even in asymptomatic patients excision biopsy is needed to establish the diagnosis

Conclusion :

Only very few cases of oropharyngeal choristomas are so far reported in literature and here we report one more case with review of relevant medical literature.

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