CASE REPORT

A Rare Case of Dysphagia Secondary to a Large Oesophageal Lipoma

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SUMMARY

Dysphagia is considered a warning symptom that requires exclusion of significant pathology such as oesophageal cancer, especially in elderly patients. Benign neoplasms of the oesophagus are rare. We report the case of a 69-year-old lady who presented with a five years history of infrequent intermittent dysphagia that had rapidly progressed over one month. This was associated with globus sensation, weight loss, intermittent episodes of stridor and aspiration pneumonia. Investigations revealed a large oesophageal lipoma in the proximal oesophagus extending down to the lower oesophagus. This was successfully resected via a left cervical approach. She remained well two years after the surgery.

KEY WORDS:
Aspiration pneumonia, lipoma, oesophageal tumour, stridor

INTRODUCTION

Dysphagia is an uncommon gastrointestinal complaint and is considered a warning symptom requiring exclusion of significant underlying pathologies such as oesophageal cancer, especially among the elderly population [1]. Common benign causes include complicated gastroesophageal reflux disease such as strictures and age related dysmotility [1]. Benign neoplasms of the oesophagus are uncommon. We report the case of a large oesophageal lipoma causing chronic infrequent dysphagia that was associated with weight loss, intermittent episodes of stridor and aspiration pneumonia.

CASE REPORT

A 68-year-old lady with background history of diabetes mellitus, hypertension and hyperlipidemia was admitted with a month history of intermittent dysphagia to solid, globus and weight loss. There was no history of dysphagia to liquid, regurgitation of undigested food, odynophagia or history of heartburn. Further inquiry revealed that her symptoms had started approximately five years previously but the episodes had been infrequent and transient and had not troubled her to consult any doctors.

Physical examination revealed a thin lady and presence of neck fullness suggestive of goitre with retrosternal extension. Apart from this, there were no features of thyrotoxicosis, lymphadenopathies, or abdominal mass to suggest any underlying pathologies. Blood investigations only revealed mild microcytic anaemia. Inflammatory markers, renal, thyroid and liver profiles were all normal. Chest radiography showed chronic basal lung changes. An ultrasound scan of the neck was negative for goitre. A barium swallow showed a large filling defect in the proximal oesophagus with smooth mucosal outline suggestive of a large submucosal tumour or extrinsic compression from a large mediastinal mass. An upper gastrointestinal endoscopy showed a lobulated yellowish submucosal mass extending from the upper oesophageal sphincter to lower oesophagus. The stomach and the duodenum were normal. A computed tomography scan showed a large lobulated hypodense mass arising the proximal oesophagus extending down to the lower oesophagus (Figures 1). The findings were consistent with tumour of fat origin.

The patient's symptoms settled and she declined any surgical interventions. She was discharged with a clinic follow-up. However, she was readmitted a two weeks later with increasing frequency of stridor and aspiration pneumonia. After treatment with a course of antibiotic, the patient proceeded to an elective resection of the oesophageal lipoma via a trans-cervical approach. The intra-operative findings revealed a large oesophageal lipoma approximately 20 cm in size extending down to the lower oesophagus. Histology showed lipoma without any evidence of malignancy. There were some peri-tumour inflammations. The patient made a good recovery post-surgery and did not experience any further symptoms. She also gained 20 kg of weight when she was last seen 24 months after her surgery.

DISCUSSION

Lipomas are the most common soft tissue neoplasm accounting for 50% of all soft tissue neoplasms. However, it only accounts for approximately 0.4% of all benign neoplasms of the alimentary tract [2]. They are frequently diagnosed in the fifth to seventh decades, predominantly in men [3]. Most gastrointestinal lipomas encountered in clinical practice are small and detected incidentally.

Histologically, oesophageal lipomas originate from undifferentiated mesenchymal cells in the submucosal layer. Some lipomas have fibrous component and are referred to as fibrolipoma.

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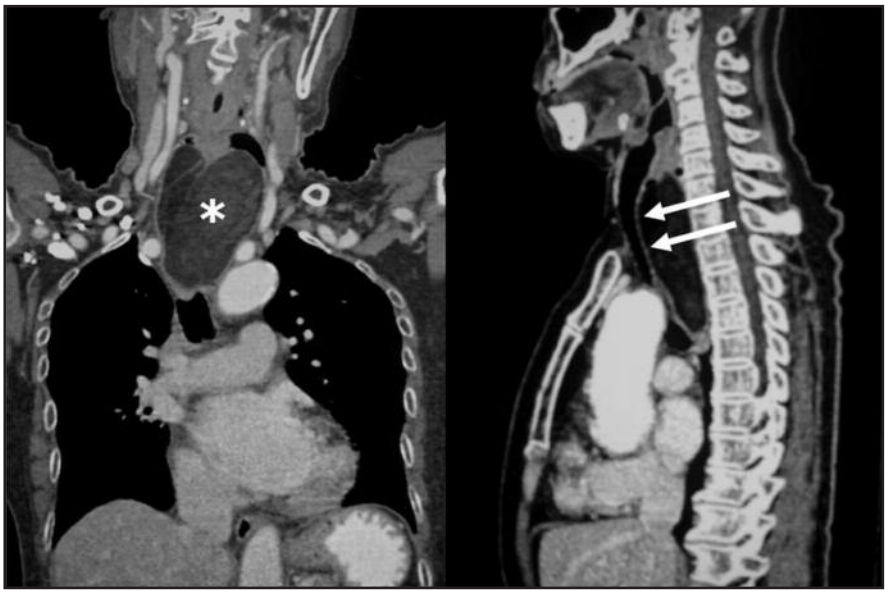

Fig. 1 : a) Reconstructured computed tomographic images showing a large lobulated tumour (asterisk) arising from the hypopharynx region extending down into the thorax alongside the oesophagus, b) reconstructed sagittal view showing compression of the trachea (Arrows).

Oesophageal lipoma can be pedunculated or sessile, and can grow to very large sizes sometimes exceeding 10 cm in length [2]. However, such large tumours are exceedingly rare. Large lesions have a predilection to arise from the cervical and upper thoracic oesophagus.

Clinical symptoms have been reported to be directly proportional to the tumour size, with most being asymptomatic until they have reached a certain size [3]. Dysphagia is the most common symptom and usually progress as the tumour size increase, initially with solids and then liquids. This may be associated with regurgitation, and globus. Other reported symptoms include chest discomfort, odynophagia, sore throat, abdominal pain, weight loss and compressions of the aerodigestive tracts. Tumours that are polypoidal and located close to the upper oesophageal sphincter can prolapse into the hypopharynx with fatal consequence [4].

The overall rate of malignant changes or recurrence after resection is considered low but has been reported [5]. However, due to their potential to cause mechanical complications, large tumours should be resected. Both endoscopic and surgical interventions have been reported with good success. Endoscopic resection can be done for smaller symptomatic lesions either sessile or polypoidal. Large tumours are best treated with surgery, either trans-oral, trans-cervical, trans-gastric or trans-thoracic approaches.

In conclusion, oesophageal lipomatous tumours are rare cause of dysphagia. It can present with chronic intermittent obstructive symptoms but as the tumour grows, the symptoms can become progressive.

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