Pyogenic Granuloma of the Esophagus: A Cause of Dysphagia

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ABSTRACT

Pyogenic granulomas are benign vascular lesions commonly involving the skin or mucous membranes of the head and neck. Most often they are found on the gingiva or other sites of the oral cavity such as the labial or buccal mucosa. Their exact mechanism of development is not known; however, they are thought to arise as a result of trauma, hormonal influences, and/or viral and bacterial infections.

Although benign lesions, pyogenic granulomas often present as rapidly enlarging, pedunculated masses. They are commonly friable and are made up of oversize, ulcerative or crusted lesions (Figure 1). They may bleed easily and can be associated with significant discomfort depending on their location. Their name is actually a misnomer as they are neither infectious nor granulomatous in nature. Rather, the histology of pyogenic granulomas consists of profuse arborizing vascular channels, and perhaps a more appropriate name for this type of lesion is a lobular capillary hemangioma.

While overall prevalence of pyogenic granulomas is about 1 lesion per 25,000 people, even fewer are seen in the esophagus. Less than 10 cases of pyogenic granulomas of the esophagus have been reported in the English literature and, to our knowledge, none in the ENT literature. Presentation of a pyogenic granuloma of the esophagus or elsewhere in the GI tract is usually with bleeding, although symptoms may vary. Cases of patients being asymptomatic to having dysphagia to presenting with chest discomfort and pain have been reported. Consequently, patients with pyogenic granulomas of the esophagus often present amidst a broad differential diagnosis, and workup often involves multiple radiologic studies plus endoscopy to discover their true identity.

METHODS & MATERIALS

Retrospective chart review

One 61-year-old Caucasian female with a 10-year history of Barrett’s esophagus and multiple EGDs presented to the Feist-Weiller Cancer Center ENT clinic with symptoms of increasing dysphagia of solids > liquids, as well as occasional hoarseness.

Biopsy performed by a gastroenterologist showed necrosis with bacterial colonies. The patient was sent for a modified barium swallow study and CT scan of the neck with contrast. A repeat esophagoscopy was performed at which time cupped forcepts were used to remove the pedunculated mass at its stalk. The lesion was sent to pathology for further examination.

RESULTS

Imaging studies: Modified barium swallow revealed a 2 x 1.5 cm polypoid filling defect located at the upper esophageal sphincter (Figure 2). CT scan of the neck showed a 3 x 1.5 cm intraluminal, enhancing esophageal lesion (Figure 3).

Esophagoscopy: Esophagoscopy with a rigid esophageoscope found a 2.5 x 1.5 cm polypoid, pedunculated lesion (Figure 1) approximately 14.5 cm from the upper incisors. Successful resection of the mass was achieved by amputating the lesion at its base with cupped forcepts. Minimal bleeding occurred. No other masses or lesions were seen.

Gross Pathological review: Gross examination of the specimen revealed a nodular, pedunculated mass.

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REFERENCES