Cervical Esophageal Hemangioma

Hemangiomas are benign vascular tumors that usually derive from organs such as the skin, liver or kidneys and are usually diagnosed in childhood. Histologically, there are 3 types: cavernous, hamartomatous and arteriovenous malformations. The esophageal location of hemangiomas is uncommon, representing 3% of all benign tumors of this organ; they are usually single lesions situated in the lower third of the esophagus. Esophageal hemangiomas may cause obstructive and/or hemorrhagic symptoms: dysphagia, dyspnea, hyper-salivation, episodes of aspiration, recurring respiratory infection, hematemesis and melanomas. Diagnosis in adults of a hemangioma in the hypopharynx or the cervical esophagus is a clinical rarity, and only a few isolated cases have been published in the medical literature.1 We present the clinical case of a cervical esophageal hemangioma diagnosed in an adult.

The patient was a 68-year-old woman with no medical history of interest. During computed tomography (CT) study for chronic cough (Fig. 1) a lesion measuring 2.6 cm × 2.1 cm × 3.3 cm was detected in the proximal third of the esophagus, which obstructed almost the entire lumen and protruded over the upper wall of the trachea. After the administration of intravenous contrast, there was mild homogeneous uptake, giving the mass a solid appearance. These findings were not considered conclusive for diagnosis. Endoscopic ultrasound (EUS), after passing Killian’s area, showed a subepithelial lesion in the right lateral-cervical region that was completely passable and measured 26 mm × 17 mm, which seemed dependent upon the muscular tissue itself. It was rather heterogeneous and presented hypo- and hyperechoic images. The differential diagnosis included leiomyoma and gastrointestinal stromal tumor (GIST). Therefore, a positron emission tomography-CT (PET-CT) was performed, which detected no fluorodeoxyglucose (FDG) uptake in the mass.

With the findings from the EUS and PET-CT, the probable diagnosis of leiomyoma was established. Although the patient reported no digestive symptoms, we decided to operate because of the uncertain exact nature of the lesion and its possible subsequent evolution. We used a left lateral cervical approach, which is the usual approach to the cervical esophagus in our department, and the mass was identified in the esophageal wall. After longitudinal myotomy, the lesion was observed to be benign in appearance, lobulated, dark blue in color and soft in consistency, which are characteristics compatible with hemangioma. We decided to perform an enucleation of the mass. It was closely adhered to the mucous membrane, which we opened in order to complete the separation from the mucosa without rupturing the tumor.

Fig. 1 – Cervicothoracic computed tomography: lesion in the cervical esophagus that practically closes the esophageal lumen.

---


Elena Romera Barba, Juan Castañer Ramón-Llín, Ainhoa Sánchez Pérez, José Antonio García Marcilla, José Luis Vázquez Rojas

Servicio de Cirugía General y del Aparato Digestivo, Hospital General Universitario Santa Lucía, Cartagena, Spain

*Corresponding author.
E-mail address: percentila@hotmail.com (E. Romera Barba).

2173-5077/$ – see front matter
© 2013 AEC. Published by Elsevier España, S.L.U. All rights reserved.
surgery is reserved for those cases in which other therapeutic modalities are not possible. Different surgical approaches have been used, from esophagectomy to the enucleation of the tumor by means of thoracotomy or laparoscopy. Surgical resection by esophagotomy is a safe and simple technique, especially when the tumor is large or located in the cervical esophagus.

With this clinical case, we want to insist on the need for refining the preoperative differential diagnosis of submucosal esophageal lesions. In spite of its low incidence, hemangioma should be considered as it could substantially condition both the type of treatment as well as the approach and technique.

REFERENCES


María Jesús Alvarez Martín**, Ana García Navarro*, Jose Luis Diez Vigil*, Patricia Becerra Massaré*, Antonio Ferrón Orihuela*

*Servicio de Cirugía General, Hospital Universitario Virgen de las Nieves, Granada, Spain

**Servicio de Anatomía Patológica, Hospital Universitario Virgen de las Nieves, Granada, Spain

*Corresponding author.
E-mail address: mjalvarezmartin@gmail.com
(M.J. Alvarez Martín).

2173-5077/$ – see front matter © 2013 AEC. Published by Elsevier España, S.L.U. All rights reserved.