CASE STUDY

Hamartomatous Polyp of the Hypopharynx

Teresa Millás-Gómez, José Ignacio Benito-Orejas, Darío Morais-Pérez, Luis Fernández-Salazar, María Álvarez-Quiñones Sanz

Servicio de Otorrinolaringología, Hospital Clínico Universitario, Valladolid, Spain
Servicio de Aparato Digestivo, Hospital Clínico Universitario, Valladolid, Spain
Servicio de Anatomía Patológica, Hospital Clínico Universitario, Valladolid, Spain

KEYWORDS
Hamartoma; Hypopharynx; Polyp

Abstract

We present the clinical case of a polyp in the hypopharynx discovered incidentally while performing an upper digestive endoscopy in a middle aged woman. Endoscopic resection was performed, and the histological result was a hamartomatous polyp. We review the diagnosis and treatment of this rare entity.

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PALABRAS CLAVE
Hamartoma; Hipofaringe; Pólipo

Pólipo hamartomatoso de la hipofaringe

Resumen

Presentamos el caso clínico de una mujer de mediana edad a la que se le descubre de forma casual, practicándole una endoscopia digestiva, una formación polipoide en hipofaringe. La extirpación tumoral por vía endoscópica reveló el diagnóstico histológico de hamartoma. Revisamos los procedimientos diagnósticos y terapéuticos utilizados en esta rara entidad.

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Introduction

Most hypopharyngeal tumours are squamous cell carcinomas. Benign polypoid neoplasms represent less than 1% of tumours in this location, with the diagnosis of hamartoma being extremely rare. In general, benign pharyngo-oesophageal polyps are predominant in middle-aged males, with dysphagia being the most common symptom. One peculiarity of these polypoid formations is their ability to reach large sizes, starting with 'astonishing' symptoms that can be manifested by a pro lapse of the mass within the mouth or asphyxiation caused by an aspiration mechanism.

Faced with the possibility of these serious complications and malignant transformation, which is infrequent but has been described occasionally, surgical resection is recommended.

Clinical Case

We report the case of a 58-year-old female patient with a history of chronic inflammatory disease of the middle ear. She was referred to our department upon accidental discovery during an upper endoscopy in the context of gastritis, of a polypoid lesion emerging from the hypopharynx (Fig. 1).

During the anamnesis, the patient reported suffering intermittent hoarseness and rough throat, of 8 years
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We established the diagnosis of hypopharyngeal hamartoma.

Discussion

In the case presented, the peculiar composition of the polyp (with a mixture of normal stromal tissue, typical of the organ where it was established but which did not reproduce the architecture of the surrounding tissue) led us to establish the diagnosis of hamartomatous polyp. From the pathological point of view, this entity is different from a "fibrovascular polyp", although both terms are often confused in medical literature. Hamartoma is a benign neoplasm present from birth. It is very rarely described in the head and neck, with counted cases in the pharynx.

Pharyngo-oesophageal polyps are often located in areas where the musculature is weaker (lower portion of the pharynx - Killian’s triangle – and upper oesophagus - Laimer’s triangle). Perhaps, the tension generated on the mucosa in these areas through deglutitive movements could be a causal factor. Peristaltic activity would facilitate a further growth of the polyp, which might reach up to 30 cm in length.

Diagnosis depends on the location and clinical presentation. When large polypoid formations regurgitate to the mouth, the diagnosis is simpler. However, these are often non-specific discomforts, occasionally mislabelled as functional, which require complementary studies. The initial test is usually an oesophageal transit test, which generally shows the intraluminal defect and which is complemented by endoscopic examination and radiological imaging tests. Although CT and MRI may confirm the diagnosis, 22% of contrast studies and 33% of endoscopies resulted negative in the early stages because the polyps became adhered to the oesophageal wall and offered a normal appearance.

In the case presented, it was a digestive endoscopy guided visually from the mouth that warned of the presence of a growth with pedunculated appearance in the pharynx. Given the possibility of serious complications and even malignization, we recommend surgical resection of all pharyngeal polyps. The approach may be oral (the most commonly used), transcervical or transthoracic, depending on the location and size of the polyp.

Pathological Anatomy

At the histological level, we observed a lesion of hamartomatous aspect with polypoid architecture (Fig. 2). It presented a flat, stratified, squamous epithelial lining and loose stroma with pseudomucinous glands, prominent vascularity and clefts lined by cylindrical epithelium of respiratory type. We also noted adipose and cartilaginous tissue.

Figure 1  Finger-like polypoid growth, 3×0.9 cm in size, with a rough surface, pinkish colour and medium consistency.

Figure 2  Smooth, stratified epithelial lining together with vascularized and loose stroma, with glands and adipose and destructured cartilaginous tissue. Hamartoma. Haematoxylin–eosin (100×).

References
