Case Report

Giant hypopharyngeal fibroepithelial polyp: a case report and literature review

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Abstract

Fibroepithelial pharyngeal polyps are rare. We herein report a case of a 56-year-old Asian woman who presented with voice hoarseness and throat discomfort for several years because of a giant pharyngeal polyp. We resected the polyp under general anesthesia. It originated in the left hypopharyngeal wall. Postoperative recovery was uneventful. Her sore throat was diminished within 1 week after the operation. Pathological findings revealed a benign fibroepithelial polyp. At the time of this writing, the polyp had shown no regrowth. To our knowledge, this report describes the second largest fibroepithelial polyp among those reported previously.

Keywords: fibroepithelial polyp, hypopharynx, nasoendoscopy

Introduction

Large fibroepithelial polyps of the pharynx are benign tumors that are rarely seen in our practice. They represent only about 0.03% of all pharyngeal and esophageal neoplasms.1 The upper third of the esophagus is the most common site at which these lesions are found, followed by the hypopharynx; in contrast, they are seldom found in the oropharynx. Fibroepithelial polyps exhibit great differences in size and may extend throughout the whole length of the esophagus until they reach the gastric cavity.2 They are mostly asymptomatic and are discovered incidentally. Globus pharyngeus, intermittent choking, and coughing can occasionally occur.3,4 Anemia caused by chronic bleeding has also been reported.5 However, on rare occasions, these polyps can lead to suffocation and may become life-threatening by occluding the oral cavity and laryngeal lumen.6 We herein report a case involving a middle-aged woman who presented with a 2-year history of voice hoarseness and throat discomfort because of a giant pharyngeal polyp.

Case Presentation

A 56-year-old Asian woman presented with a 2-year history of voice hoarseness and discomfort in her throat with no history of other medical problems, regular medications, or smoking. She consulted an otorhinolaryngologist and was diagnosed with chronic pharyngitis. Three months later while performing yoga exercises, she unexpectedly spat out a long piece of mucous membrane, which she then forced down her throat. Because she did not feel discomfort in her throat for a while thereafter, she did not consult a doctor. However, her throat discomfort later returned and gradually worsened, and she therefore consulted a gastroenterologist. Gastrointestinal endoscopy revealed a hanging sausage-like polyp that originated in her left hypopharyngeal wall and extended to the middle portion of her esophagus. Examination of a biopsy specimen showed a benign tumor. Her gastroenterologist referred her to our university hospital for surgical treatment.

Intraoperative or postoperative complications occurred. At the time of this writing, the polyp had shown no regrowth.

Discussion

Fibroepithelial pharyngeal polyps are a rare entity in our practice. To our knowledge, only five cases of pharyngeal polyps have been reported in the literature, as shown in Table.7,8 Few theories regarding the etiology of these polyps have been postulated. One of these theories suggests that these polyps are secondary to focal losses of elastic tissue, but formal proof of this proposal is lacking.9 Another theory claimed that...
these polyps are a collection of several tissue elements that represent a hamartoma of the lamina propria with a slow rate of growth or a fibroma that exhibits the features of a benign lesion. Pharyngeal polyps are rarely symptomatic, and when present, the symptoms vary according to the site of origin.

Globus pharyngeus is the usual presentation. The previously reported large polyps originating in the nasopharynx or oropharynx were accompanied by choking, respiratory distress, and coughing of abnormal tissue masses. Furthermore, chronic bleeding from the polyp can occur, resulting in iron...
deficiency anemia. Our patient presented with a 2-year history of throat discomfort and slight voice hoarseness. These vague presentations, in addition to a lack of proper early investigations, may have been the cause of the delay in diagnosis.

Our case highlights several key points. Despite the high risk of suffocation, this patient remained relatively asymptomatic for a long period. Although the location of the polyp in the hypopharynx enabled a gastrointestinal endoscopist to visualize the attachment of the polyp, we could not find the polyp by nasoendoscopy. In addition, magnetic resonance imaging was not an effective examination technique with which to determine the exact location or extension of this polyp. Accordingly, if the presence of a fibroepithelial polyp in the esophagus is suspected, we suggest that a barium meal and computed tomography might be more valuable in patients with a long history of deceptive complaints and no positive findings on clinical examination. Although we were able to successfully remove this polyp via endoscopic guidance, it might be difficult to manage the removal endoscopically in some cases, and an open approach via pharyngotomy might be needed. Regardless of the approach, we believe that prompt management with surgical resection is indispensable, especially when polyps are associated with laryngeal airway obstruction that results in cerebral anoxia and death. Early recognition and resection of such a polyp is highly recommended.

In conclusion, we have herein reported a rare case of a fibroepithelial pharyngeal polyp and discussed its management. We conclude that such pharyngeal polyps must be kept in mind and diagnosed early via proper imaging to alleviate the patient’s symptoms and prevent serious complications such as airway obstruction.

Conflict of interest

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References