Esophageal Hemangioma: Unusual Case of Upper GI Bleed

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Introduction

A pyogenic granuloma, which is a lobular capillary hemangioma, is typically found on cutaneous tissue (most often in the head and neck) and on the mucosa of the oral cavity. Rarely, the lesion has also been found in the upper respiratory tract, and even more uncommonly, in the gastrointestinal tract. This inflammatory, vascular lesion typically has a benign course when it presents on the skin; however, when found in the upper GI tract, can be associated with severe bleeding and iron deficiency anemia. To date, there have only been less than 50 reported cases of pyogenic granuloma found in the GI tract; of these reported cases, approximately half of these were located inside the esophageal lumen. Here we report a rare case of an esophageal pyogenic granuloma, it's acute (and chronic) sequelae, and it's endoscopic and pathologic findings.

Case Presentation

A 62-year-old female presented to the emergency department with a chief complaint of general malaise, subjective fever, palpitations, and a pounding headache of one day's duration. After thorough history with full review of systems, the patient admitted to black tarry stools, worsening in frequency within the last few months. Laboratory findings revealed that the patient was severely anemic, with a hemoglobin of 6.1 and hematocrit of 19.1. After the patient was transfused packed red blood cells, an upper endoscopy was performed which discovered what appeared to be protruding pedunculated polyp at the distal esophagus, about 0.5 cm above the GE junction. The mass was measured to be about 1.5 cm in length, appeared to be necrotic with an adherent clot, and had 7-mm stalk. After placement of an Endo Clip at the stalk for hemostasis, we used a hot snare to remove the lesion. The rest of the endoscopy and colonoscopy were unremarkable. Histopathological section of the specimen demonstrated surface ulceration, acute inflammation, and lobular proliferation of capillary-sized vessels lined with endothelial cells. The final diagnosis by the attending pathologist identified the polyp as a late stage lobular capillary hemangioma or, a pyogenic granuloma.

Imaging

Figure 1: Endoscopic view of the necrotic and pedunculated lesion at the distal esophagus, located 0.5 cm above the GE junction.

Figure 2: Endoscopic view of the antrum of the stomach. The rest of the endoscopy was unremarkable; no other potential sources of bleeding were found.

Discussion

An esophageal hemangioma is a relatively rare finding; one that can cause fatal complications, such as in our case report, is an even rarer occurrence. With respect to the patient discussed in this case, the tumor was classified as a capillary hemangioma, often referred to as a pyogenic granuloma. The etiology and the pathogenesis behind the formation of this lesion is unclear at the moment. Trauma is thought to be one of the leading causes, as evidenced by the predominance of the lesion on cutaneous tissue. Other hypothesized causes include infection, hormonal, and/or immunological causes. The lesion predominantly occurs in males, usually peaking between the fourth and sixth decades. Endoscopic mucosal resection and endoscopic snare polypectomy are the two most common options available and should be considered first-line if the lesion is located within the mucosal or submucosal layer. If endoscopic resection is not possible, other options include endoscopic injection sclerotherapy (EIS) or surgical resection, especially if the tumor is excessively large or if there is evidence of local invasion. The patient presented here underwent endoscopic snare polypectomy with very minimal bleeding; however, because the lesion is highly vascular, significant bleeding may occur without further intervention.

References


