The Curious Case of a "Second Tongue"

Original Image

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Fibrovascular polyps (FVPs) of the esophagus are benign, intraluminal tumor-like lesions (1) arising from the submucosal layer of the cervical esophagus, in the region of the Laimer Hackermann triangle (2). They account for less than 2% of all esophageal tumors (3). They may not undergo detailed investigations due to bizarre symptoms like chest discomfort, vomiting, weight loss, and prolonged cough or hiccups. Lack of awareness and suspicion of this entity makes the diagnosis difficult and up to 30 percent of the patients may die without a correct diagnosis (3).

A 56-year-old male patient presented to the outpatient department claiming he had two tongues (Figure 1). He took great pride in the fact as he was held in high esteem in his village, as a fortune-teller because of his "special gift." He could regurgitate his "tongue" at will and it would also come out with vomiting. He presented to the clinic due to gradually developing dysphagia and one episode of sudden dyspnea during an attempt to regurgitate the polyp. No history of loss of weight, cough, or hematemesis was noted. Barium swallow and contrast-enhanced computed tomography (CECT) scan of the neck and chest showed a large intraluminal sausage-shaped soft tissue lesion extending from the level of the cervical esophagus to the lower esophagus filling and distending the esophageal lumen (Figure 2, Figure 3).

The polypoidal mass was excised via a longitudinal cervical incision (Figure 4). It was connected to the pharyngoesophageal junction through a narrow stalk and measured 15x5.3x3 cm (Figure 5). Esophagus was closed in two layers with 3'0 vicryl suture (Figure 6). The final histopathologic examination revealed a FVP with no evidence of malignancy. No complication was noted in the postoperative period.

FVPs are benign lesions but may have life-threatening complications. They can be classified as fibromas, fibro-lipomas, myxomas, or fibroepithelial polyps depending upon the amount of tissue present. Asphyxia can result due to the impaction of the regurgitated polyp in the glottis, leading to sudden death or pressure on the tracheal lumen as it expands in the esophagus (4). FVPs may remain clinically silent, even though they acquire an enormous size in the esophageal lumen or grow intramurally (5). Patients may be reluctant to seek medical advice due to vague symptoms or rarely personal gains (as in our case). Due to the rarity and non-specific symptomatology, they

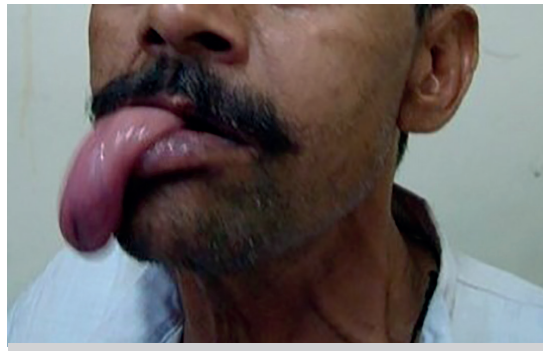

Figure 1. Patient regurgitating his "second tongue"

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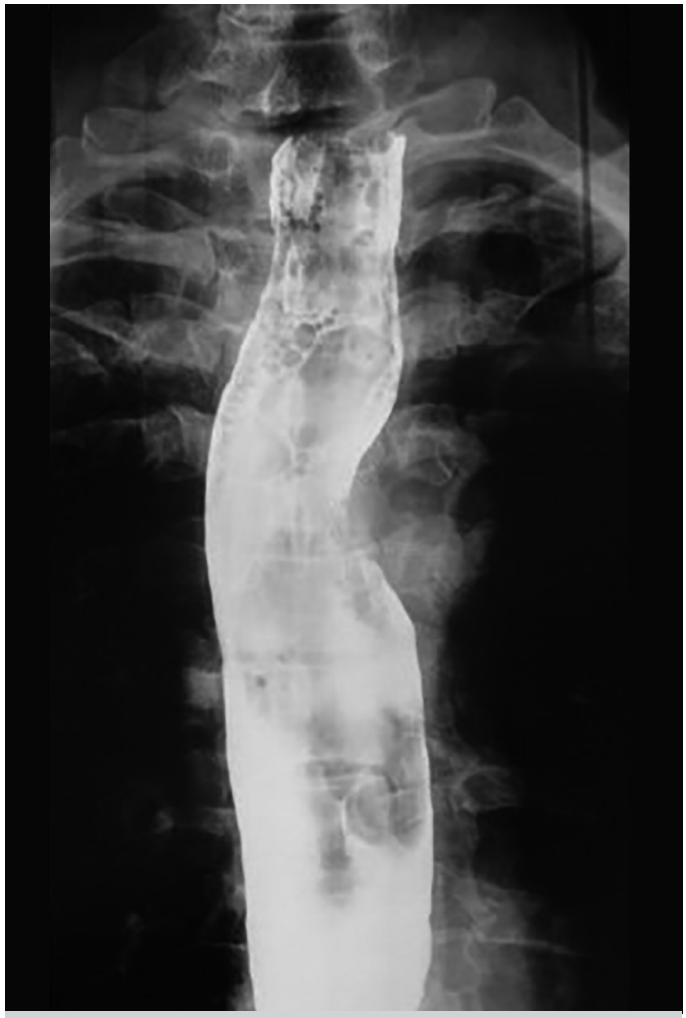

Figure 2. Barium esophagogram demonstrating a long polypoidal filling defect in the esophagus

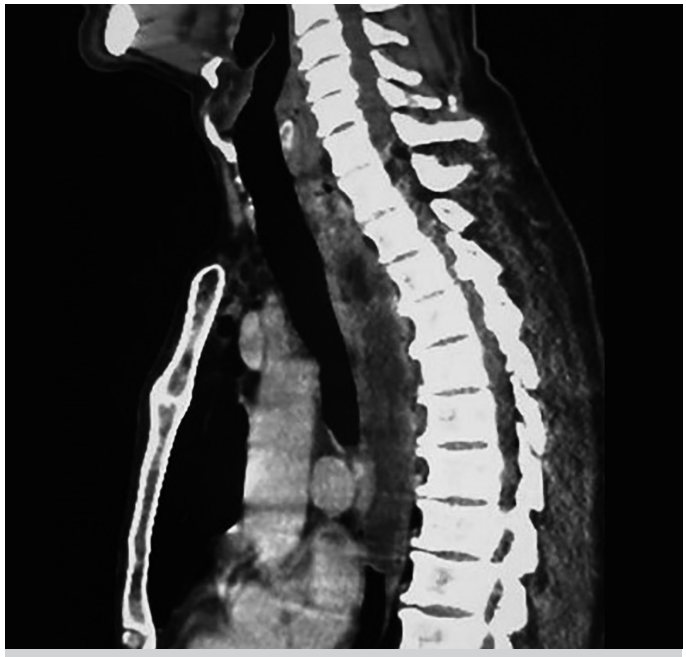

Figure 3. Contrast-enhanced CT scan, sagittal section, showing intraluminal sausage-shaped mixed soft tissue and fat density lesion arising from the proximal esophageal wall, filling and distending the esophageal lumen

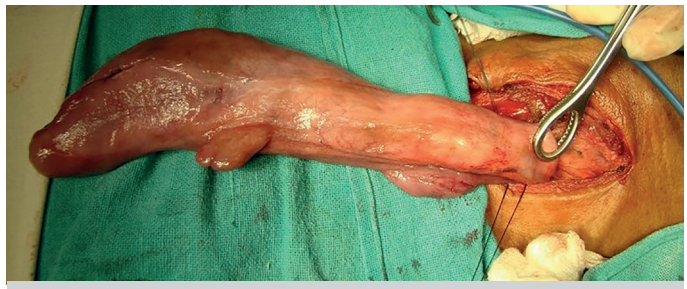

Figure 4. Excision of the fibrovascular polyp from the esophagus

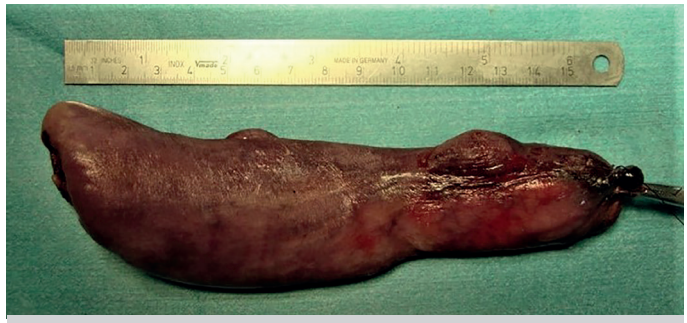

Figure 5. Final specimen measuring 15x5.3x3 cm in size

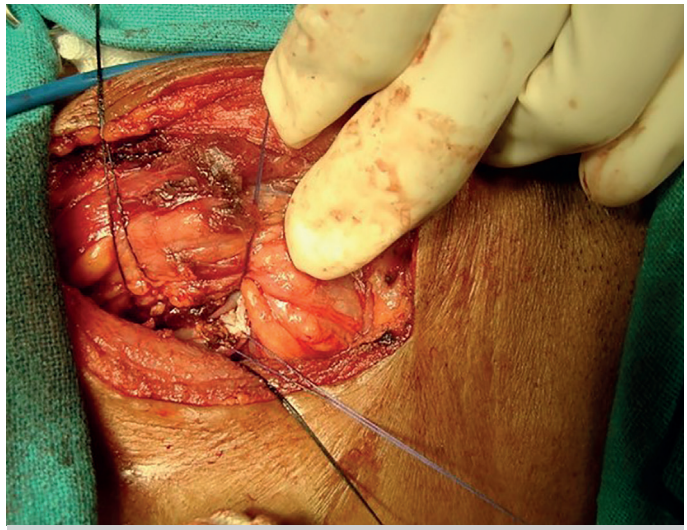

Figure 6. Cervical esophagus closed in 2 layers with 3'0 vicryl

may not be suspected and investigated adequately. Barium swallow and CECT show characteristic findings that aid in diagnosis. A preoperative esophagoscopy is also recommended to determine the site of attachment and extension (4).

The best approach to management depends upon the location of this tumor along with the vascularity and thickness of the pedicle. Incomplete excision of the pedicle may lead to recurrence. Lesions less than 2 cm can be safely removed endoscopically with electrocoagulation or laser excision of the pedicle. Larger polyps require an open cervical or thoracotomy approach. A combined approach involving esophagostomy and gastrostomy has also been described (5).

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Peer-review: Externally peer-reviewed

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