Intussuspecting giant liposarcoma of the oesophagus

Sir,

Liposarcoma of the oesophagus is exceedingly rare. There are only thirteen previous reports in the world literature. We present the first incidence of oesophageal liposarcoma presenting as an acute upper gastrointestinal bleed and a previously unreported technique of surgical management.

A 44 year old man presented to the accident and emergency department with collapse following acute upper gastrointestinal bleed. In recent months he had suffered from progressive dysphagia and odynophagia.

Following stabilisation, upper gastrointestinal endoscopy was performed. This revealed a large submucosal lesion arising 22 cm from the incisors. The lesion occupied the entire oesophageal lumen, distending it considerably. It extended down towards the gastro-oesophageal junction and was intermittently prolapsing into the gastric body.

Computerised tomography (CT) [Figure 1] and magnetic resonance imaging (MRI) [Figure 2] confirmed the presence of a lesion contained within the submucosal plane of the oesophagus. Radiological features the lesion to be mainly fatty but with significant vascularity within it. No extra-oesophageal disease was seen.

An Ivor Lewis oesophagectomy was planned due to the high index of suspicion of malignancy within the lesion. At laparotomy, the mass was found prolapsing into the antrum of the stomach. It was not possible to get above the mass and it was irreducible. Access via the right thoracotomy revealed that a formal oesophagectomy was not technically feasible due to the shear size and length of the lesion and it’s proximal extent. The lower oesophagus therefore was opened longitudinally and the lesion assessed to see if it could be enucleated. An uninvolved mucosal pedicle was identified as arising from the upper third oesophagus. The mass was delivered into the thoracic cavity with gentle traction and the pedicle was transected with a GIA-stapler. The lesion delivered in its entirety and the oesophagotomy closed in two layers.

Histological analysis confirmed that the lesion was that of a well-differentiated liposarcoma. The transected pedicle was free of disease and therefore all resection margins were clear. The long term follow up of the case as yet is unknown. The patient, however, remains disease free after 3 years.

Oesophageal liposarcoma is exceedingly rare. To date, we know of only thirteen previous cases reported in the world literature. The clinical presentation can be variable. All patients reported dysphagia but patients may be surprisingly symptom free until

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References

the tumour has attained a considerable size. Other symptoms include: weight loss, respiratory distress, fever, gastrointestinal bleeding, odynophagia and even oral regurgitation and protrusion of the tumour. The differential diagnosis include lymphoma, but it is difficult to establish this without surgical removal and histological examination.

With such limited worldwide experience in managing this condition, a single method by which this condition can be treated is unestablished. The unorthodox surgical management in this case was needed due to the sheer size and site of fixation of the tumour. It reveals that perhaps these rare oesophageal tumours can be resected without the need for formal oesophagectomy if a narrow pedicle can be identified.

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