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Benign Tumours of the Oesophagus

Benign oesophageal tumours are infrequent. Although these tumours of the oesophagus are rare lesions they are attracting increasing interest owing to development of surgical treatment for oesophageal diseases. The growing number of reported cases enables certain conclusions of clinical, therapeutic, and prognostic value to be drawn. Benign, oesophageal tumours are usually small, well circumscribed, seemingly encapsulated and round or egg-shaped. Such tumours are of little clinical importance, are usually asymptomatic and are often not discovered except at post-mortem examination. Some benign tumours may occasionally grow out from the lumen, protrude from the surface and present as a mass, but oesophageal obstruction from a tumour surrounding the oesophagus is extremely rare. Drews was able to observe two such cases (3), Cornell and his co-workers reported only one (1) and a similar case is presented below.

Case report

Mrs. A. J., aged 72 years was admitted to the Second Surgical Clinic with dysphagia and weight loss of a few years' duration. Occasionally, she had had difficulty in swallowing both solids and liquids but sought no medical advice prior to this admission. On physical examination following admission, she was seen to be emaciated but all other findings were essentially normal. The patient's blood pressure was 110/70 mms Hg.; weight 51 kgs.; pulse 80 beats/min. and temperature, 36.7 C.

Initial laboratory results on admission were as follows: — blood sedimentation rate — 12 mms in one hour and 24 mms in two hours; haemoglobin 70 per cent; red blood cells, 3,520,000 per cu. mm.; white blood cells 3,800 per cu. mm. and differential count showed no abnormalities. Urine analysis, blood electrolyte values and the urea level were also normal.

Radiological examination of the oesophagus revealed a circular funneling defect, immediately above the diaphragm which corresponded to a dilatation of the oesophagus at this site. Barium swallow X-Rays gave pictures similar to those in cardiospasm and a barium reached the stomach through a very narrow oesophageal lumen. A clinical diagnosis of cardiospasm was suspected.



Fig. 1. U-shaped tumour surrounding the oesophagus

On 21st May, 1965, the oesophagus was exposed via a left, 7th—rib thoracotomy and the 7th rib was removed. Close inspection revealed a hard, nodular, U-shaped tumour at the level of the diaphragm (Fig. 1). This tumour surrounded the oesophagus and seemed to be causing oesophageal obstruction. It was enucleated without difficulty. In the tumour bed induration was seen surrounding the oesophagus and it was this which was really the cause of the oesophageal stricture. The oesophagus was mobilized with surprising ease and, because of the indurative stricture, partial oesophagectomy was performed. Oesophageal continuity was restored by a simple, two-layer, end-to-end anastomosis with interrupted silk sutures, followed by a standard thoracotomy closure. The patient made an uneventful recovery and was discharged on the 16th postoperative day when she was feeling well. Radiological examination of the oesophagus showed that the lumen was then almost

normal. The patient was seen at intervals after discharge and, one year after the operation, she had a good appetite, had gained in weight and had remained asymptomatic on a regular diet.

Subsequent pathological diagnosis was of a *leiomyoma* with partial hyalinization and partial calcification (Fig. 2).

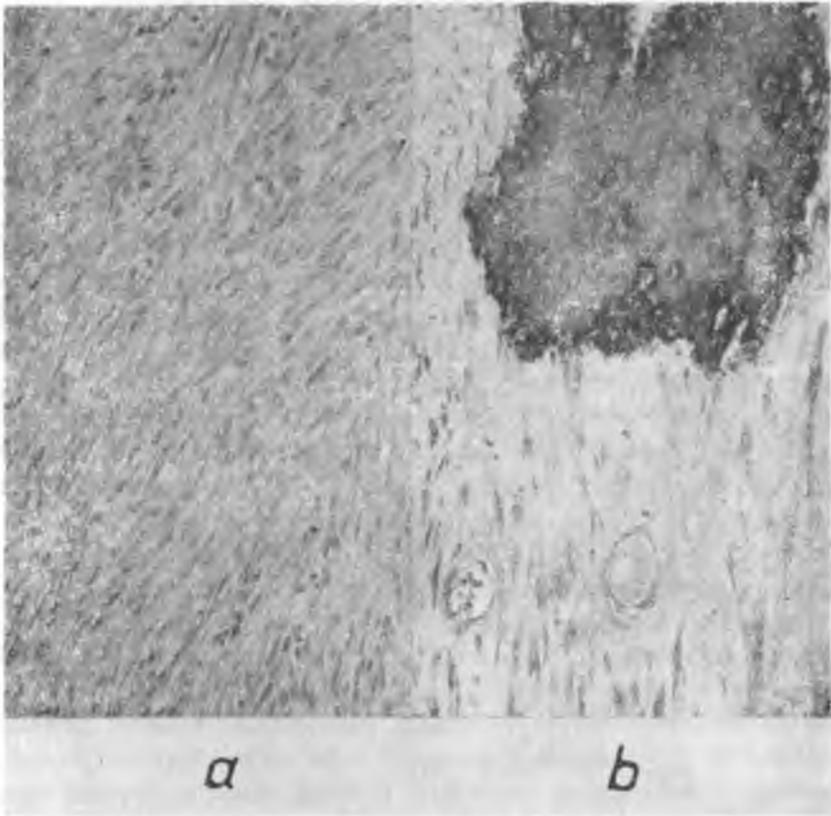


Fig. 2. Photomicrograph. (No 81271). *Leiomyoma*. (a) — Lank cells in tracts with variable directions. The cells plentiful of eosinophilic cytoplasm. (b) — The fragments of structureless masses strongly stained with haematoxylin. These fragments are surrounded by hyaline tissue. They show positive reaction while stained according to Gieson's method

Discussion

Leiomyoma is the sort of the benign tumours. *Leiomyomas* may originate from any smooth muscle fibre in the oesophagus and have been recorded at all levels, but it is thought that they are usually found in the anterior wall of the cardiac area or at the level of the tracheal bifurcation (3).

The diagnosis of *leiomyoma* of the oesophagus has always been difficult. Clinical features of smooth muscle tumours are quite variable and depend on the relationship between the size of the tumour and the size of the oesophageal lumen. One contributing factor is that these tumours grow very slowly and often become very large while remaining asymptomatic (3). When such tumours are small they are usually asymptomatic and are often not discovered until at postmortem examination. From a review of the literature it appears that the most significant symptoms consist of progressive dysphagia, vomiting and slight, substernal or epigastric pain.

Other symptoms of benign oesophageal tumours include weight loss as a natural consequence of dysphagia. Substernal discomfort with coughing is felt particularly in the intramural variety and epigastric pain occurs when the tumour is in the lower part of the oesophagus.

Most frequently the diagnosis is made by radiological studies. Results of a barium swallow give the impression of an intraluminal mass in the oesophagus or show a rounded, moderately well-defined oesophageal defect with smooth contours. There is usually no disturbance of peristalsis. An oesophageal constriction from a *leiomyoma* may produce the picture of cardiospasm and this sometimes creates difficulties in differential diagnosis. Because of the rarity of the condition, it is not surprising that a pre-operative diagnosis is rarely made.

Operation is the only treatment. Nora emphasizes surgical removal as a definitive treatment for benign tumours as he believes that these tumours seldom undergo malignant change but that their chief danger lies in the fact that a person with such a tumour may starve to death if the obstructing growth interferes with deglutition.

In the majority of cases, simple enucleation is the procedure of choice and, of the remainder, adequate excision is often performed with restoration of oesophageal continuity. In some cases, segmental resection of the oesophagus and oesophago-gastrostomy may be required.

Examination of the literature shows that the prognosis in recorded cases has been very good, and patients usually make a good recovery.

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Łagodne nowotwory przełyku

Streszczenie

Autorzy omawiają etiopatogenezę, klinikę i postępowanie operacyjne w przypadkach łagodnych nowotworów przełyku. Przytaczają własny niezwykle przypadek mięśniaka gładkokomórkowego przełyku u chorej lat 72. Chorą operowano z wynikiem pomyślnym.

Ryc. 1. Guz w kształcie rogalika obejmujący przełyk.

Ryc. 2. Mikrofotografia. Nr preparatu 81271. *Leiomyoma*. (a) — Smukłe komórki ułożone w pasma o różnokierunkowym przebiegu. Cytoplazma obfita, eozynochłonna. (b) — Fragmenty bezpostaciowych mas barwiące się intensywnie hematoxyliną. Otoczone są zeszkliwiałą tkanką dającą dodatni odczyn przy barwieniu metodą van Gieson'a.

Доброкачественные опухоли пищевода

Резюме

Рассматривается этиопатогенез, клиника и ход операции при доброкачественных опухолях пищевода. Авторы описывают наблюдаемый ими необычный случай гладкомышечной миомы пищевода у больной 72 лет, которая была успешно оперирована.

Рис. 1. Опухоль в форме рожка, охватывающая пищевод.

Рис. 2. Mikrofotografia. № препарата 81271. Лейомиома. (a) — Тонкие клетки, уложенные полосами в различных направлениях протекания. Цитоплазма обильная, эозинофильная. (b) — Фрагменты аморфных масс, интенсивно окрашиваемые гематоксилином, окруженные витрифицированной тканью, вызывающей положительную реакцию при окрашивании по методу van Gieson'a.

