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IMAGE | ENDOSCOPY

Unusual Location of an Unusual Malignancy

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CASE REPORT

A 58-year-old man with a history of reflux presented to our clinic with intermittent oropharyngeal dysphagia to solids for years. The physical examination was unremarkable, and a modified barium swallow study from 3 years earlier was normal, but he never followed up for an esophagogastroduodenoscopy. Neck computed tomography performed at another institution before presentation showed a multilobulated, septated lesion along the lumen of the esophagus, and magnetic resonance imaging showed a multilobulated mass centered in the oropharynx, extending to hypopharynx (Figure 1). He underwent an esophagogastroduodenoscopy that revealed a large, partially obstructing, submucosal, floppy, cystic lesion within the oropharynx (Figure 2). During the endoscopic ultrasonography, it was challenging to maintain oxygenation, likely because of mass obstruction from the lesion. The procedure was aborted, and the patient was intubated. Otolaryngology was consulted, and direct laryngoscopy led to the excision of the mass that appeared to be on a short stalk originating in the hypopharynx (Figure 3). Pathology was consistent with liposarcoma T3 N0 MX. A month after the surgery, a positive emission tomography scan did not show any additional lesions.

Liposarcoma is a malignant neoplasm of adipose tissue that typically occurs in the retroperitoneum in middle-aged men. These unique tumors are rarely seen in the hypopharynx, larynx, or gastrointestinal tract. Head and neck lipsosarcomas constitute less than 0.01% of head and neck tumors.[1–4] There is a paucity of literature with respect to clinical presentation, prognosis, and treatment of this neoplasm. They present in these locations with airway obstruction, chronic cough, dysphagia, reflux, and globus—as was seen in this case—in men aged 50–65 years. There are 4 subgroups of liposarcoma: well-differentiated (WDLS), dedifferentiated, myxoid, and pleomorphic.[1–4] Unfortunately, given the rarity of this disease process, it is difficult to differentiate the presentation of each subtype. Diagnosis is performed

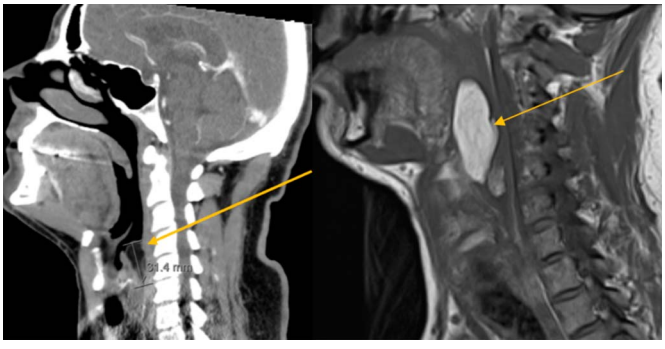

Figure 1. Neck computed tomography showing (A) a lesion measures approximately 3.1 cm in craniocaudal dimension and appears to extend minimally into the postcricoid region and (B) septated fluid and fat containing collection or mass within the palate, oropharynx, hypopharynx, and supraglottic larynx, with a focus of nodular enhancement.

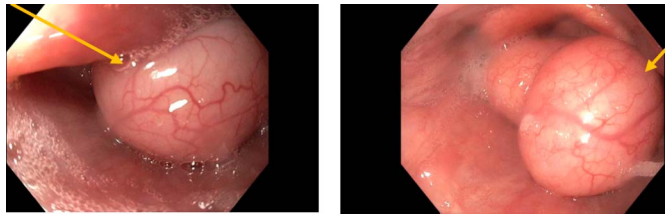

Figure 2. Esophagogastroduodenoscopy showing large, submucosal, floppy, cystic lesion in the oropharynx extending to 28 cm from the incisors.

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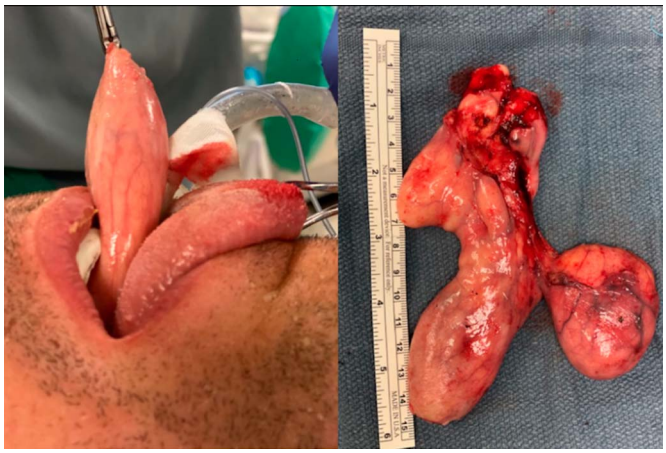

Figure 3. Gross pathology.

through fine needle aspiration or incisional biopsy; amplification of MDM2 or CDK4 through fluorescence in situ hybridization is sensitive and specific in differentiating liposarcomas from lipomas.

Literature suggests that management includes a wide surgical resection but is unclear if postoperative radiotherapy/chemotherapy results in clinical benefit. There is a small risk of WDLS to metastasize, but no clear surveillance guidelines have been created to monitor most cases with imaging.[5] Head and neck liposarcomas are extremely rare but essential to recognize. The unique aspect of this case stems from the primary differential diagnosis of a subepithelial esophageal mass. Yet, after extensive workup, the patient was diagnosed with a rare hypopharyngeal liposarcoma.

DISCLOSURES

Author contributions: J. Patel wrote the manuscript and is the article guarantor. M. Ismail wrote and edited the manuscript. N. M. Fowler, N. Maronian, and A. Faulx revised the manuscript.

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Informed consent was obtained for this case report.

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