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Short Report

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Donut-like esophageal leiomyoma enucleation in very critical patient

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Abstract

We present here a case of 61 year old man, heavy smoker with hepatic cirrhosis Child-Pugh A alcohol associated. Patient underwent endoscopy and chest CT scan beacause of severe dysphagia and cough. The diagnosis was mid-esopahgeal leiomyoma. We performed a complete enucleoresection of leiomyoma of the mid-esophagus with direct reconstruction of the muscular wall of the esophagus. This leiomyoma was shaped such as Donut-like (Figure 1). The patient was discharged after 9 days and he was very good with free diet.

Introduction

Esophageal leiomyomas are benign mesenchymal esophageal tumors, typically involving the distal two-thirds of the esophagus. They are uncommon, and they represent less than 10% of esophageal tumors [1].

Case presentation

A 61-year-old man, heavy smoker with cirrhosis Child-Pugh a alcohol associated, was admitted for surgery. The lesion had a donut-like shape and arised from the muscular layer of the mid-esophagus. The patient was studied with CT scan, Endoscopy and EBUS with biopsy and with PET scan showing a SUVmax = 1,9 [2]. Because of the poor functional value of spirometry and DLCO, we preferred a fast mono-pulmonary ventilation, so we choosed right lateral muscle-sparing thoracotomy of about 12 cm. The other reason to perform an open surgical access, was the cirrhosis: we were very afraid that a smallest hole in esophageal mucosa could have constituted a high risk of fistula with catastrophic outcome. So we performed a very care-

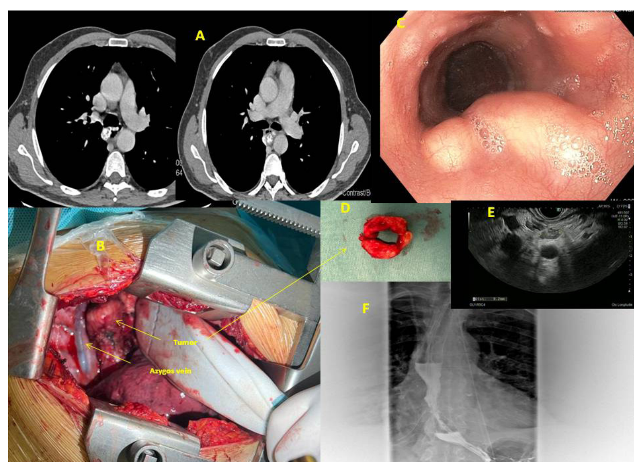

Figure 1: (A) CT pre-operative image of the leiomyoma; **(B)** Intra-operative image of the tumor; **(C)** Endoscopic view; **(D)** Donut-like leiomyoma; **(E)** EBUS image; **(F)** gastriographin swallow control after surgery.

ful myotomy and enucleoresection of the leomyoma with very great attention to separate the tumor from the mucosa which was very tiny and fragile because of tumoral growth, consistency and weight. The tumor was entirely enulceoresected and the mucosa remained intact [3]. During the hospitalization, we had to control him 3 times every day, with great attention to hepatic function, especially coagulative blood tests and albumin and protein serum levels. Nevertheless, the drainage was removed in eighth post-operative day, when the out-put was <300 ml. We began to reefed the patients after 5 days, previous gastrographin swallow and blu/methylene test. The patient was discharged after 9 days, he was very good with free diet.

Conclusion

Although the esophageal leiomyoma are treated with mini-invasive technique (as we usually do) [4,5], in this very difficult patient we are very happy and proud to have choosed the right lateral thoracotomy. Because of our previous experience of leiomyoma, we knew that is a delicate surgery and that very serious problems such as fistula or esophageal longitudinal laceration could be created. So we treated this esophagus such as crystal glass, dissecting one millemeter for one millimetre, all the contact area between the tumor and mucosa and for 360 degree because of its shape.

Conflict of interest: None.

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