A 65-year-old lady was admitted with a principal complaint of heartburn. Upper GI endoscopy revealed an intraluminal polypoid mass with a stalk occupying ¾ of the esophageal lumen, originating at 20 cm from the incisors, with its body extending downward to 30 cm, which measured about 25 mm in its widest diameter (Fig. 1), associated with grade B esophagitis [1]. Esophagography showed a filling-defect with luminal narrowing in the proximal esophagus. Computed tomography (CT) scans demonstrated a central fatty mass with a lower density tissue absorption surrounded by a single ring of normal esophagus (Fig. 2). Endoscopic ultrasonography (EUS) confirmed the submucosal origin of the mass on the right proximal wall of the esophagus which was homogeneously hyperechoic with regular margins, image consistent with lipoma (Fig. 3).

Since she was reluctant to undergo any surgical or endoscopic excision of the mass during the 3 year follow-up period, dimensions of the mass lesion were stable and symptoms of GERD were controlled on esomeprazole therapy. Despite the fact that management depends on tumor size, origin and presence of symptoms, larger tumors may also be followed endoscopically and endosonographically in the absence of life-threatening symptoms.

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Conflicts of interest: None to declare.

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